



School of Law
UNIVERSITY OF GEORGIA

Digital Commons @ University of Georgia
School of Law

Scholarly Works

Faculty Scholarship

1-1-2011

Can You Really Keep Your Health Care Plan? The Limits of Grandfathering under the Affordable Care Act

Elizabeth Weeks Leonard

University of Georgia School of Law, weeksleo@uga.edu

bepress

The frontier of scholarly publishing since 1998



Repository Citation

Elizabeth Weeks Leonard, *Can You Really Keep Your Health Care Plan? The Limits of Grandfathering under the Affordable Care Act*, 36 J. Corp. L. 753 (2011),

Available at: https://digitalcommons.law.uga.edu/fac_artchop/686

This Article is brought to you for free and open access by the Faculty Scholarship at Digital Commons @ University of Georgia School of Law. It has been accepted for inclusion in Scholarly Works by an authorized administrator of Digital Commons @ University of Georgia School of Law. [Please share how you have benefited from this access](#)
For more information, please contact tstriepe@uga.edu.

Can You Really Keep Your Health Plan? The Limits of Grandfathering Under the Affordable Care Act

Elizabeth Weeks Leonard*

I. INTRODUCTION	753
II. BACKGROUND	757
III. THE RHETORIC: YOU CAN KEEP YOUR HEALTH PLAN	760
IV. DEREGULATION OF EMPLOYER HEALTH INSURANCE: ERISA	763
V. THE REALITY: IT DEPENDS ON WHAT YOU CONSIDER “YOUR PLAN”	765
A. <i>ACA Requirements Applicable to Grandfathered Plans</i>	766
B. <i>ACA Exemptions for Grandfathered Plans</i>	766
C. <i>Effect of Requirements and Exemptions on Grandfathered Plans</i>	767
VI. REREGULATION OF EMPLOYER HEALTH INSURANCE:	
GRANDFATHER REGULATIONS	769
A. <i>Implementing Regulations</i>	769
B. <i>Other ACA Constraints</i>	772
C. <i>Predicted Impact on Small and Large Firms</i>	775
1. <i>Small Firms</i>	776
2. <i>Large Firms</i>	777
VII. CONCLUSION	779

I. INTRODUCTION

Recent reform of the American health care system has been bait-and-switch. The bait is populist rhetoric; the switch is reregulation. The Obama Administration (the Administration) promises us one thing but gives us something else. Administration experts assure us that what we are getting is what we should prefer, if we could be trusted to make good decisions for ourselves. Amid the comprehensive federal health reform debate culminating in passage of the Patient Protection and Affordable Care Act of 2010 (ACA or Affordable Care Act),¹ President Obama promised, “if you like your health

*Professor of Law, University of Kansas School of Law. I am grateful to Dean Agrawal and Professor Hovenkamp for inviting me to participate in this Symposium on “Reregulation and the Business Firm,” Brad Flynt (University of Georgia, J.D./M.B.A. 2011) for initial ideas for this project, my co-panelists, David Orentlicher and Amy Monahan, for a stimulating discussion, and Tim Jost and Peter Jacobson for excellent comments and suggestions for improving the draft.

plan, you can keep your health plan.”² If you were already happy with your current health care plan, nothing would have to change.³ The Affordable Care Act codified that promise as the “grandfather rule.”⁴ This Article examines the validity of the promise, concluding that, in fact, our plans will change and will have to comply with ACA’s extensive new federal health insurance regulatory regime. It may well be that we will neither notice nor object to the changes. Nevertheless, the reality is different than the rhetoric.

This Article describes the operation of the Affordable Care Act’s grandfather rule as one example of the Obama Administration’s decidedly paternalistic approach to reregulation, despite sounding populist themes.⁵ For a presidential candidate who touted his community organizer roots,⁶ the Administration’s methodology is notably top-down and expert-driven. Rather than convince the electorate of the merits of sometimes controversial reforms, the Administration has shown a preference for proceeding through the executive branch rulemaking process. Through this approach, the Administration leaves politically popular promises apparently undisturbed while otherwise bringing about the desired changes through less transparent, more expedited channels. The trend is especially evident in the context of federal health reform.

Before returning to ACA’s grandfather rule, consider two additional examples of regulatory paternalism amid health reform: first, the “death panels” controversy, which arose from a House proposal to provide Medicare coverage for end-of-life counseling between patients and doctors.⁷ Popular protest over the grossly misperceived provision as authorizing government panels of experts to make end-of-life decisions for patients resulted in Congress striking it from the Bill.⁸ Then, several months after the Affordable Care Act passed, the very same Medicare end-of-life counseling provision reappeared

1. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010), *amended by* Health Care and Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (2010).

2. See President Barack Obama, remarks in Town Hall on Health Care, Central High School, Grand Junction, Colorado (Aug. 15, 2009), *available at* http://www.whitehouse.gov/the_press_office/Remarks-By-The-President-In-Town-Hall-On-Health-Care-Grand-Junction-Colorado/ (“Nobody is going to force you to leave your health care plan. If you like your doctor, you keep seeing your doctor. I don’t want government bureaucrats meddling in your health care.”).

3. See, e.g., *id.* and accompanying text (quoting President Obama’s August 2009 health care town hall meeting).

4. ACA § 1251(a)(1) (“Nothing in this Act (or an amendment made by this Act) shall be construed to require that an individual terminate coverage under a group health plan or health insurance coverage in which such individual was enrolled on the date of enactment of this Act.”).

5. See Tom Cohen, *Obama’s Stump Speech Blends Partisan Rhetoric with Populist Themes*, CNN.COM, (Aug. 19, 2010), <http://www.cnn.com/2010/POLITICS/08/19/obama.stump.speech/index.html> (describing President Obama as “honoring a humor-laced stump speech that is part pep talk, part populist ideology”); Michael Powell & Jeff Zeleny, *Tagged as Elitist, Obama Shifts Campaign From High-Flown to Folksy*, N.Y. TIMES (May 6, 2001), http://www.nytimes.com/2008/05/06/us/politics/06obama.html?_r=1&partner=rssuserland&emc=rss&pagewanted=all (noting President Obama’s shift in campaign strategy from “high-flown to folksy”).

6. See David Moberg, *Obama’s Community Roots*, THE NATION (Apr. 16, 2007), <http://www.thenation.com/article/obamas-community-roots> (discussing President Obama’s background as a community organizer).

7. H.R. 3200, 111th Cong. § 1233(a) (2009).

8. See Joshua E. Perry, *A Missed Opportunity: Health Care Reform, Rhetoric, Ethics, and Economics at the End of Life*, 29 MISS. C. L. REV. 409, 411–12 (2010) (citing Sarah Palin’s Facebook post and describing controversy surrounding proposed Section 1233).

deep within pages of regulatory rulemaking, backed by studies published in British and American medical journals and unnamed “physicians, health care providers, and others.”⁹ After the media brought the rule to light,¹⁰ the end-of-life counseling provision was quickly excised by regulatory amendment.¹¹ Although that particular attempt to bypass the political process was thwarted, the sequence of events reveals the administration’s apparent deference to popular opinion followed by executive branch rulemaking to achieve reregulatory objectives.

Another example of regulatory bait-and-switch involves the Affordable Care Act’s provision for state innovation waivers. As strong protest over the individual health insurance mandate and other state-based objections mounted in the year after ACA’s enactment,¹² President Obama highlighted the possibility of state waivers from his hard-fought signature legislation.¹³ Under ACA Section 1332, “Waiver for State Innovation,” states may apply to the federal government for waivers from a number of specific ACA requirements, effective January 1, 2017.¹⁴ In a speech to the National Governors Association in February 2011, President Obama expressed support for amendments allowing states to obtain waivers, including from the individual mandate, three years sooner than 2017.¹⁵ Section 1332 and the President’s willingness to fast-track state waivers are consistent with popular preferences for state flexibility, innovation, and diversity.¹⁶

But the reality, again, belies the rhetoric. States may qualify for waivers only if they can demonstrate that the coverage provided under their waiver plans will be “at least as

9. Medicare Program; Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2011; Final Rule, 75 Fed. Reg. 73,169, 73,406 (Nov. 29, 2010).

10. Robert Pear, *Obama Returns to End-of-Life Plan that Caused Stir*, N.Y. TIMES, Dec. 26, 2010, at A1, available at www.nytimes.com/2010/12/26/us/politics/26death.html (stating the Obama administration used the regulation writing process to achieve its goal); *Death Panels Revisited*, WALL ST. J. (Dec. 29, 2010), <http://online.wsj.com/article/SB10001424052970203731004576045702803914780.html> (“The regulatory process isn’t supposed to be a black-ops exercise, but expect many more such nontransparent improvisations under the vast powers ObamaCare handed the executive branch.”).

11. Medicare Program; Amendment to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2011, 76 Fed. Reg. 1366, 1366 (Jan. 10, 2011).

12. See Jason Millman, *Another State Wants Healthcare Reform Waiver*, HEALTHWATCH (Mar. 19, 2011, 9:48 AM), <http://thehill.com/blogs/healthwatch/health-reform-implementation/150819-another-state-wants-health-reform-waiver> (listing states requesting waivers and noting that “[w]aivers have become a hot-button issue for the administration almost a year into the law’s implementation”); see generally Elizabeth Weeks Leonard, *Rhetorical Federalism: The Value of State-Based Dissent to Federal Health Reform*, 39 HOFSTRA L. REV. 111 (2010) (examining state resistance to ACA).

13. See Sheryl Gay Stolberg & Kevin Sack, *Obama Backs Easing State Health Law Mandates*, N.Y. TIMES (Feb. 28, 2011), <http://www.nytimes.com/2011/03/01/us/politics/01health.html>.

14. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1332(a)(1), (2), 124 Stat. 119, 203–04 (2010) (listing ACA requirements subject to waiver); see Katherine Hayes & Sara Rosenbaum, *Waivers for State Innovation*, HEALTH REFORM GPS (Mar. 21, 2011), <http://www.healthreformgps.org/resources/waivers-for-state-innovation/> (listing essential health benefit requirement, exchanges, premium assistance, employer responsibility, and individual mandate among waivable requirements).

15. See Stolberg & Sack, *supra* note 13 (discussing President Obama’s support for state waivers).

16. See *Preparing for Innovation: Proposed Process for States to Adopt Innovative Strategies to Meet the Goals of the Affordable Care Act*, HEALTHCARE.GOV (Mar. 10, 2011), <http://www.healthcare.gov/news/factsheets/stateinnovation03102011a.html> (describing proposed regulations, “[b]uilding on President Obama’s commitment to give states the flexibility to innovate and implement health care solutions that work best for them”).

comprehensive” as the exchanges, with “coverage and cost sharing protections” that are “as least as affordable” as ACA.¹⁷ States also must demonstrate that their plans will provide coverage to “at least a comparable number of [state] residents” as ACA’s provisions and will not increase the federal deficit.¹⁸ In effect, states may obtain waivers only if they can, on their own, using different strategies, figure out how to achieve the same coverage, consumer protection, and cost-containment goals as the comprehensive federal legislation. Given the innumerable hours spent and compromises brokered in order to enact ACA at the federal level, it seems a pipe-dream to suggest that states will be able to come up with novel plans that meet the strict statutory and regulatory waiver conditions. Accordingly, the broad federal requirements will almost certainly take effect nationwide, with few if any meaningful state waivers granted.¹⁹ The Administration voices support for state innovation while effectively making federal law the only plausible approach.

Similarly, ACA’s grandfather rule promises that we can keep our health plans, but in reality, our health plans will likely not be able to keep their grandfathered status for very long. Section 1251 of the Affordable Care Act expressly preserves plans in existence on the date of enactment,²⁰ March 23, 2010, and excepts them from a number of new federal requirements under ACA.²¹ Like the end-of-life counseling and state innovation waiver provisions, the Administration enacted reregulation not at the level of public, congressional debate, but through the intricacies of administrative rulemaking. The regulations implementing ACA’s grandfather rule establish narrow parameters for plans to retain grandfathered status.²² In essence, plans can make changes only for the benefit of plan participants and at the expense of the plan.²³ Under those strictures, it will be nearly impossible for most plans to meet the requirements; accordingly, most will almost surely forfeit grandfathered status.

The Administration acknowledges that grandfathered plans will likely cease to exist within a few years of ACA’s enactment, but assures us that we will not notice the change

17. ACA § 1332(b)(1)(A), (B); *see also* Application, Review, and Reporting Process for Waivers for State Innovation, 76 Fed. Reg. 13,553, 13,561 (proposed Mar. 14, 2011) (to be codified as 31 C.F.R. § 33.108(a)(2)(iv)(C)(4)(i), (ii)) (listing and explaining application conditions).

18. ACA § 1332(b)(1)(C), (D); *see also* 76 Fed. Reg. at 13,561 (proposed Mar. 14, 2011) (to be codified as 31 C.F.R. § 33.108(a)(2)(iv)(C)(4)(iii), (iv)).

19. So far, states have obtained waivers for very modest variations from ACA’s requirements, such as Maine’s waiver from the medical-loss ratio, or very sweeping reforms that were not politically viable at the federal level, such as Vermont’s single-payer plan. *See* Letter from Steven B. Larsen, Deputy Adm’r & Director, Ctr. for Consumer Info. & Ins. Oversight, to Mila Kofman, Superintendent of Ins., State of Me. Bureau of Ins., Dep’t of Prof’l & Fin. Regulation (Mar. 8, 2011), *available at* <http://healthreform.kff.org/~media/Files/KHS/docfinder/mainewaiver.pdf>; Press Release, Bernie Sanders, U.S. Senator for Vt. (Feb. 28, 2011), *available at* <http://sanders.senate.gov/newsroom/news/?id=44a664de-8e92-43f4-a871-d26e0b5a252d>.

20. ACA § 1251(a)(1) (“Nothing in this Act (or an amendment made by this Act) shall be construed to require that an individual terminate coverage under a group health plan or health insurance coverage in which such individual was enrolled on the date of enactment of this Act.”).

21. *See infra* Part V.B (describing exemptions).

22. Group Health Plans and Health Insurance Coverage Relating to Status as Grandfathered Health Plan Under the Patient Protection and Affordable Care Act, 75 Fed. Reg. 34,538 (proposed June 17, 2010) (to be codified at 45 C.F.R. pt. 147) [hereinafter Grandfathering Rules].

23. *See infra* Part VI.A (describing implementing regulations).

or will prefer our new ACA plans anyway.²⁴ But that was not the promise. The bait-and-switch approach to reregulation risks credibility and trust. Moreover, the Administration achieves its ends not through direct, accountable processes, but indirectly by establishing regulatory parameters that will all but force plans to give up grandfathered status and comply with ACA. In effect, when you lose your health plan, you will blame your plan, your insurer, or your employer, not the government. The Administration, which wrote the regulations setting the requirements for grandfathered plans, technically upholds its deregulatory promise but at the same time achieves its reregulatory agenda.

II. BACKGROUND

Political observers and cognitive scientists have offered various explanations for the Republican Party's apparently greater success at controlling the political message and framing issues in ways that resonate with voters.²⁵ The suggestion is that Republicans are willing to appeal to the public's emotions and cognitive biases.²⁶ Democrats, on the other hand, cling to an enlightenment view of the electorate as dispassionate, rational thinkers who can be convinced of the right choice if given the facts, statistics, and science to support it.²⁷ Republicans, to great success, dismiss Democrats' intellectualism as "fuzzy math" and Ivy League elitism.²⁸ Bill Clinton was one recent Democratic politician who took a chapter out of the Republican playbook and succeeded with emotional appeals and messaging.²⁹ President Obama, our current Democratic "Professor in Chief," similarly made a concerted effort to overcome the Republicans' characterization of him as an unemotional, bookish leader.³⁰ His rhetoric is bottom-up, self-determinative, and deeply democratic.³¹ But in reality President Obama demonstrates a strong preference for expert

24. *Questions and Answers: Keeping the Health Plan You Have: The Affordable Care Act and 'Grandfathered' Health Plans*, HEALTHREFORM.GOV, <http://www.healthreform.gov/about/grandfathering.html> (last visited Mar. 28, 2011) [hereinafter *Questions and Answers*] ("If a plan loses its grandfathered status, then consumers in these plans will gain additional new benefits . . .").

25. See, e.g., GEORGE LAKOFF, *THE POLITICAL MIND* 12 (2008) (asserting that Republicans "have a better sense of how brains and minds work. That's why they are more effective."); DREW WESTEN, *THE POLITICAL BRAIN* 13 (2007) ("Republican strategists have recognized since the days of Richard Nixon that the road to victory is paved with emotional intentions.").

26. See LAKOFF, *supra* note 25, at 33–35; WESTEN, *supra* note 25, at 12–13.

27. See LAKOFF, *supra* note 25, at 51–60 (criticizing "neoliberals for assuming that just citing facts and figures will carry the day politically, when what is needed is an honest, morally based framing of the facts and figures"); WESTEN, *supra* note 25, at 25–26 (describing social contract philosophy that the Framers followed, assuming that "people came together to create a state and govern themselves through rational autonomous choice"); see also Dan M. Kahan, *The Cognitively Illiberal State*, 60 STAN. L. REV. 115, 116–17, 119–22 (2007) (suggesting that "we lack the psychological capacity . . . to make, interpret, and administer law without indulging sensibilities pervaded by our attachments to highly contested visions of the good").

28. See WESTEN, *supra* note 25, at 31–34 (recounting George W. Bush's response to Al Gore in the 2000 Presidential debate: "Look at this man who has great numbers. He talks about numbers. I'm beginning to think not only did he invent the internet, but he invented the calculator. It's fuzzy math.").

29. See *id.* at 1–7; Jedediah Purdy, *Presidential Popular Constitutionalism*, 77 FORDHAM L. REV. 1837, 1858–62 (2009) (describing Clinton's presidential rhetoric as extolling personal virtue).

30. See Paul Krugman, *Professor in Chief*, N.Y. TIMES (July 22, 2009), <http://krugman.blogs.nytimes.com/2009/07/22/professor-in-chief/>; *Professor in Chief*, INSIDE HIGHER ED (Feb. 20, 2010), <http://www.insidehighered.com/news/2010/02/10/obama>.

31. See *supra* notes 4–6 and accompanying text (introducing the idea that the Affordable Care Act is an

decision-making and a firm guiding hand.³² Consistent with that approach, the Administration hired some of the academy's brightest minds to nudge Americans in the right direction.³³

President Obama's perhaps most effective slogan in the health reform debate is the promise, "if you like your health plan, you can keep your health plan."³⁴ The promise was initially made in response to the proposed "public option" health plan and was intended to assuage fears that inserting even an optional government health insurance plan into the mix would dramatically alter existing market dynamics, effectively forcing employers out of the business of health insurance.³⁵ The proposed public option was dropped from the congressional health reform bills, but President Obama stuck with the slogan, repeating it on White House health reform websites and to various audiences.³⁶

example of the Obama Administration's "paternalistic approach to reregulation, despite sounding populist themes").

32. See LAKOFF, *supra* note 25, at xvi (describing Obama's view of government as "a nurturant family" in which "it is a parent's responsibility to protect or empower his or her children and to instill an ethic of excellence The ethic of excellence can be seen in his choice of cabinet members, all clearly well-known and respected for their competence. And it shows in the priority he has given to education.").

33. See generally RICHARD H. THALER & CASS R. SUNSTEIN, *NUDGE: IMPROVING DECISIONS ABOUT HEALTH, WEALTH, AND HAPPINESS* (2008) (introducing "libertarian paternalism" and "choice architecture" strategies to nudge individuals toward better choices for themselves, their families, and society); Michael Grunwald, *How Obama Is Using the Science of Change*, TIME (Apr. 2, 2009), available at <http://www.time.com/time/magazine/article/0,9171,1889153,00.html> (describing Obama's "nudge factor" as his campaign promise to bring change to America); Jonathan Weisman, *Economic Policy 'Nudge' Gives Way to a Shove*, WALL ST. J. (Mar. 8, 2010), <http://online.wsj.com> (noting Sunstein's "co-author of the behavioralist bible" position at the White House Office of Information and Regulatory Affairs, and other behavioral economists' posts in the Administration).

34. See *supra* note 2 and accompanying text (quoting President Obama's health reform town hall meeting).

35. See David A. Hyman, *Employment-Based Health Insurance: Is Health Reform a "Game Changer?"* 11 n.25 (Univ. of Ill. Pub. L. and Legal Theory Research Paper, No. 10-17, 2010), available at http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1624311 (explaining how employment-based coverage "became such an important part of American health policy, and evaluat[ing] the likely impact of [ACA]"); Helen Darling, *Health Care Reform: Perspectives From Large Employers*, HEALTH AFF. 1220, 1220-21 (2010), available at <http://content.healthaffairs.org/content/29/6/1220.full.pdf> ("Most large employers favored health reform, but they were relieved when the public option was eliminated.").

36. See Hyman, *supra* note 35, at 11-12 (citing when Senator Obama's promise "if you like your coverage you can keep it" was used); see, e.g., *Obama Addresses Physicians at AMA Meeting: Transcript of President Obama's Remarks*, AM. MED. ASSOC., 2009 Annual Meeting of the AMA House of Delegates (June 15, 2009), <http://www.ama-assn.org/ama/pub/about-ama/our-people/house-delegates/2009-annual-meeting/speeches/president-obama-speech.shtml> ("No matter how we reform health care, we will keep this promise: if you like your doctor, you will be able to keep your doctor."); Stephanie Cutter, *Yes, You Can Keep Your Health Plan*, THE WHITE HOUSE BLOG (May 18, 2010), <http://www.whitehouse.gov/blog/2010/05/18/yes-you-can-keep-your-health-plan> ("The bottom line is that the Act allows people to keep the insurance they have, while also providing more and better options for all."); Macon Phillips, *Facts Are Stubborn Things*, THE WHITE HOUSE BLOG (Aug. 4, 2009), <http://www.whitehouse.gov/blog/Facts-Are-Stubborn-Things> (referring to Linda Douglass's health reform video); *Keeping the Health Plan You Have: The Affordable Care Act and "Grandfathered" Health Plans*, Fact Sheet under *Newsroom*, HEALTHREFORM.GOV (June 14, 2009), http://www.healthcare.gov/news/factsheets/keeping_the_health_plan_you_have_grandfathered.html [hereinafter *Newsroom*] (attempting to debunk "the myth that reform will force you out of your current insurance plan"); *Questions and Answers*, *supra* note 24 ("The new [grandfather rule] will allow you to keep your current coverage if you like it.").

As a matter of framing, the promise works on several fronts.³⁷ It allays voters' concerns about "socialized medicine" and "big government." The implicit rejection of the public option or robust federal regulation of the health insurance market comports with the public's apparent preference for private, market-based solutions.³⁸ The slogan champions individual rights, freedom of choice, self-reliance, and other endemic American libertarian values.³⁹ In that view, deregulation, not reregulation, is the preferred approach.⁴⁰ President Obama vocally embraced the rhetoric of deregulation⁴¹ while still pursuing a strongly reregulatory agenda.⁴² That equivocal messaging is demonstrated by the Administration's approach to implementing ACA's grandfather rule.⁴³

The "you can keep your health plan" promise also appeals to Americans' status quo bias and loss aversion.⁴⁴ We fear giving up a known quantity for something unknown and

37. See LAKOFF, *supra* note 25, at 140–44 (discussing the framing of the health care debate); Marjorie E. Kornhauser, *Cognitive Theory and the Delivery of Welfare Benefits*, 40 LOY. U. CHI. L.J. 253, 256 (2009) (describing different frames for social welfare policies). On framing political messages generally, see GEORGE LAKOFF, "DON'T EVEN THINK OF AN ELEPHANT! KNOW YOUR VALUES AND FRAME THE DEBATE" (2004); THALER & SUNSTEIN, *supra* note 33, at 36–37; WESTEN, *supra* note 25, at 263–69.

38. George Lakoff terms this trend "privateering." See LAKOFF, *supra* note 25, at 133, 140–42 ("Privateering is a special case of privatization in which the capacity of government to carry out critical moral missions is systematically destroyed from within the government itself, while public funds are used to provide capital for private corporations to take over those critical functions of government."); see also Darling, *supra* note 35, at 1220 ("[T]he law actually reflects a very centrist philosophy, with strong support for a mostly private sector approach to health care.").

39. See LAKOFF, *supra* note 25, at 62–63 (suggesting that both conservative and neoliberal perspectives favor free trade and individual wealth maximization); Kahan, *supra* note 27, at 122–23 (contrasting individualistic and communitarian world views); Kornhauser, *supra* note 37, at 258 ("Since Americans treasure individualism, self-reliance, and independence, they value the free market as the mechanism that best allows the individual to flourish."); see also Purdy, *supra* note 29, at 1857 (describing Nixon's vision, as one example), 1864–65, 1870 (noting presidential rhetoric that "takes on the new circumstances of individuality, diversity, consumerism, and the centrality of markets").

40. See LAKOFF, *supra* note 25 at 63 ("The myth is that the deregulation or privatization of a moral mission of government eliminates government."); Purdy, *supra* note 29, at 1845–52 (describing early presidents' vision).

41. See Barack Obama, *Toward a 21st-Century Regulatory System*, WALL ST. J. (Jan. 18, 2011), <http://online.wsj.com/article/SB10001424052748703396604576088272112103698.html> ("[T]hroughout our history, one of the reasons the free market has worked is that we have sought the proper balance. We have preserved freedom of commerce while applying those rules and regulations necessary to protect the public against threats to our health and safety and to safeguard people and businesses from abuse Over the past two years, the goal of my administration has been to strike the right balance."); Robert Scheer, *Obama Pulls a Clinton on Deregulation*, THE NATION (Jan. 19, 2011), <http://www.thenation.com/article/157865/obama-pulls-clinton-deregulation> (comparing President Obama's regulatory stance to former President Clinton's).

42. See Binyamin Appelbaum & Edward Wyatt, *Obama May Find Useless Regulations Are Scarcer Than Thought*, N.Y. TIMES (Jan. 21, 2011), http://www.nytimes.com/2011/01/22/business/22regulate.html?_r=1&ref=binyaminappelbaum (noting that the "Obama administration has championed expansions of financial and health care regulation, and it has toughened a wide range of other rules"); Eric Lipton, *With Obama, Regulations Are Back in Fashion*, N.Y. TIMES (May 10, 2010), <http://www.nytimes.com/2010/05/13/us/politics/13rules.html> (commenting on the "new age of regulation [that] is well under way in Washington").

43. See *infra* Part VI (discussing regulations implementing the grandfather rule).

44. THALER & SUNSTEIN, *supra* note 33, at 33–35; Russell Korobkin, *The Status Quo Bias and Contract Default Rules*, 83 CORNELL L. REV. 608, 609–12 (1998).

untested.⁴⁵ Our calculus may not even get that far; we may simply prefer to stay with our current plan rather than expend energy and resources to switch.⁴⁶ Our current health plans, for all their exclusions and restrictions, may be the coffee mug that we cherish simply because we already have it.⁴⁷ President Obama's promise comports with and does not challenge our biases. Instead, the regulatory paternalism approach gradually, and largely without our notice, replaces our current plans with new, ACA-compliant plans through operation of the executive branch regulations implementing the grandfather rule. If the strategy is successful, the Administration stands to gain on both the merits of health reform and the politics of messaging. The strategy turns the individualism, privateering frame on its head, casting private actors—insurers and employers—as the bad guys and big government as the white horse, riding in with a host of reforms that we might not have thought we wanted but, the Administration assures us, we will come to appreciate.

III. THE RHETORIC: YOU CAN KEEP YOUR HEALTH PLAN

For most Americans—61% of the non-elderly population, or 160.6 million people⁴⁸—our current health insurance plan is an employer-based plan. The United States' reliance on employer-based health insurance is a product of historical anachronism but is deeply entrenched.⁴⁹ Wage-hour laws, tax rules, and union pressure combined to create strong incentives for employers to offer health benefits, although they are not required to do so.⁵⁰ The tax code provides the strongest incentive, allowing employers above-the-line exemption for income spent on employee benefit plans.⁵¹ At the same time, employers may deduct the cost of purchasing health insurance for their

45. THALER & SUNSTEIN, *supra* note 33, at 34 (“Loss aversion helps produce inertia, meaning a strong desire to stick with your current holdings.”).

46. *Id.* at 35 (describing the “yeah, whatever” heuristic and noting that even when switching costs are very slight we are disinclined to change).

47. See Korobkin, *supra* note 44, at 627–28 (describing experiments randomly endowing subjects with either a coffee mug or six dollars and finding that mug holders tended to value the mugs twice as high as cash holders).

48. Stephen Blakely, *Employers, Workers, and the Future of Employment-Based Health Benefits*, EMP. BENEFIT RES. INST., Feb. 2010, at 3, available at http://www.ebri.org/pdf/briefspdf/EBRI_IB_02-2010_No339_EB-Bens.pdf; Kathryn Linehan, *Self-Insurance and the Potential Effects of Health Reform on the Small Group Market*, NAT'L HEALTH POL'Y F., at 2 (Dec. 21 2010), available at http://www.nhpf.org/library/issue-briefs/IB840_PPACASmallGroup_12-21-10.pdf; Hyman, *supra* note 35, at 4–5.

49. See John Bronsteen et al., *ERISA, Agency Costs, and the Future of Health Care in the United States*, 76 FORDHAM L. REV. 2297, 2300–02 (2008) (discussing the prevalence of health care as an employee benefit); David A. Hyman & Mark Hall, *Two Cheers for Employment-Based Health Insurance*, 2 YALE J. HEALTH POL'Y, L. & ETHICS 23, 25–26 (2001) (discussing the historical rise of employment-based coverage).

50. See I.R.C. § 106 (2006) (“[G]ross income of an employee does not include employer-provided coverage under an accident or health plan.”); Hyman & Hall, *supra* note 49, at 25.

51. 26 U.S.C. § 106(a) (2006) (“gross income of an employee does not include employer-provided coverage under an accident or health plan”); Hyman & Hall, *supra* note 49, at 25; see also James F. Blumstein, *The Clinton Administration Health Care Reform Plan: Some Preliminary Thoughts*, 19 J. HEALTH POL. POL'Y & L. 201, 203 n.2 (noting incentives for private sector health care delivery, including “the unlimited tax deductibility of employer outlays on health insurance”); Bradley W. Joondeph, *Tax Policy and Health Care Reform: Rethinking the Tax Treatment of Employer-Sponsored Health Insurance*, 1995 B.Y.U. L. REV. 1229, 1229–32 (describing tax treatment of employer-sponsored health insurance).

employees as a business expense.⁵² Employers are better off providing generous health insurance and maintaining a productive, healthy workforce. At the same time, if employers simply increase salary or wages to cover the cost of employees' purchasing insurance on their own, employees would not receive the same tax benefit for their health plan expenditures. Beyond the economic incentives, we simply have come to expect health insurance as part of employment compensation.⁵³

Rather than radically changing the predominantly employer-based system, ACA incorporates employer health insurance as a core component of the reforms. Employer health plans operate as a baseline from which ACA's substantive new requirements for all health plans are defined. For example, ACA defines "essential health benefits," which plans sold under the exchanges must cover, by reference to the "typical employer plan."⁵⁴ Also, the grandfather rule purports to preserve existing employer health plans, providing that nothing in the Affordable Care Act "shall be construed to require that an individual terminate coverage under a group health plan or health insurance coverage in which such individual was enrolled on the date of enactment of this Act."⁵⁵ Then-existing plans that meet certain requirements are "grandfathered" and apparently may continue to operate as they have before ACA, as alternatives to new plans issued after ACA.⁵⁶ Accordingly, for the majority of Americans already covered by employer-based plans, ACA appears to maintain the status quo.

Although the statutory language of ACA is true to the "you can keep your health plan" promise, the implementing regulations belie it. In combined administrative rulemaking by the Departments of Labor, Treasury, and Health and Human Services, federal regulators developed a specific list of changes that would cause plans to lose grandfathered status.⁵⁷ Closer examination of those regulations, as well as attention to other provisions of ACA bearing on employer and employee incentives, reveal that most employer health plans will fairly quickly relinquish grandfathered status.⁵⁸ According to

52. 26 U.S.C. § 162(a)(1) (allowing deduction for "reasonable allowance for salaries or other compensation for personal services actually rendered"); Joondeph, *supra* note 51, at 1229 (noting same).

53. See Leslie Pickering Francis, *Consumer Expectations and Access to Health Care*, 140 U. PA. L. REV. 1881, 1887–88 (1992) (describing evolution of expectations for job-related health insurance); cf. Joondeph, *supra* note 51, at 1248 (noting that employers are "the dominant vehicle through which Americans purchase their health insurance" and challenges of separating health insurance from employment).

54. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1302(b)(2)(A), 124 Stat. 119, 163–64 (2010).

55. *Id.* § 1251(a).

56. See, e.g., *id.* § 2715 (requiring uniform explanation of coverage documents and standardized definitions); *id.* § 2718 (requiring clear accounting for costs); Bernadette Fernandez, CONG. RESEARCH SERV., R41166, GRANDFATHERED HEALTH PLANS UNDER PPACA (P.L. 111-148) 2 (2010), available at http://coburn.senate.gov/public//index.cfm?a=Files.Serve&File_id=ebc9c6f3-6ca8-47c9-a5fc-ab9488ddf61c; Timothy Jost, *Implementing Health Reform: Grandfathered Plans*, HEALTH AFF. BLOG (June 15, 2010), <http://healthaffairs.org/blog/2010/06/15/implementing-health-reform-grandfathered-plans/> [hereinafter Jost, HEALTH AFF. BLOG].

57. See Grandfathering Rules, 75 Fed. Reg. 34,538, 34,543–44 (June 17, 2010) (to be codified at 45 C.F.R. § 147.140(g)) (listing changes that would result in cessation of grandfather status); *infra* Part VI (describing regulations).

58. Press Release, Mercer, Even as Reform Pushes up Benefit Cost, Employers Will Take Steps to Hold 2011 Increase to 5.9% (Sept. 8, 2010), available at <http://www.mercer.com/press-releases/1391585> (reporting results of employer survey regarding cost advantages of changing plans versus retaining grandfathered status); Ricardo Alonso-Zaldívar, *Health Overhaul to Force Changes in Employer Plans*, ABC NEWS, June 11, 2010,

the Administration's own health reform website, the most hopeful estimates are that 66% of large employers and 51% of small employers will retain grandfathered status by 2013.⁵⁹ The most pessimistic estimates are that only 36% of large employers and a mere 20% of small employer plans will be grandfathered in 2013.⁶⁰ Estimates for the individual market suggest that grandfathered plans will be practically nonexistent over the next few years.⁶¹

In response to the question whether employer health plans will eventually lose their grandfathered status, the Administration's consumer-oriented online health reform guide assures us that the grandfather rule "helps to implement the Affordable Care Act" and "put[s] us on a glide path toward the competitive, patient-centered market of the future."⁶² Further, we are comforted that "[i]f a plan loses its grandfathered status, then consumers in these plans will gain additional benefits" and that the grandfather rule "is designed to strike a balance between allowing existing plans to make routine changes and preventing plans from making such large changes that they are no longer the plans people once had and liked."⁶³ Most cynically, the strategy is a form of illiberal paternalism to "help" us get past our irrational preference for the status quo and accept the new-and-improved reregulated federal health insurance regime. Most generously, it replaces employer paternalism with government paternalism.

The evolution of the "you can keep your health plan" promise from political rhetoric, to statutory provision, to administrative rulemaking, to market incentives, is much more than a libertarian paternalistic nudge.⁶⁴ While the approach appears to preserve our freedom to choose between an existing grandfathered plan and a new ACA-regulated plan, in operation, existing plans will almost surely disappear. The regulatory strategy obscures the government's accountability and privatizes blame. This strategy makes it appear that insurers and employers, not the government, broke the promise. When plans inevitably fail to operate within the regulatory requirements and lose grandfathered status, Americans will blame their plan administrators. As a result, the federal government achieves a policy goal of requiring all health plans to comply with new coverage, underwriting, and operational requirements without expending political capital to get there.⁶⁵

available at <http://abcnews.go.com/Politics/wireStory?id=10890753>.

59. See *Newsroom*, *supra* note 36 (projecting the percent of large and small employers that will retain grandfather status in 2013); see also *Grandfathering Rules*, 75 Fed. Reg. 34,538, 34,553 tbl.3 (estimating that 49% of small employers and 34% of large employers will relinquish grandfathered status by 2013).

60. See *Newsroom*, *supra* note 36; *Grandfathering Rules*, 75 Fed. Reg. at 34,553 tbl.3 (estimating that 80% of small employers and 64% of large employers will relinquish grandfathered status by 2013).

61. *Newsroom*, *supra* note 36; see also Jost, HEALTH AFF. BLOG, *supra* note 56 (concluding that "relatively few [individual] policies will remain grandfathered for any significant period of time").

62. *Fact Sheet: Keeping the Health Plan You Have: The Affordable Care Act and "Grandfathered" Health Plans*, HEALTHREFORM.GOV, http://www.healthreform.gov/newsroom/keeping_the_health_Plan_you_have.htm (last visited Mar. 28, 2011).

63. *Questions and Answers*, *supra* note 24.

64. See THALER & SUNSTEIN, *supra* note 33, at 229–35 (describing examples of "[a] Dozen Nudges").

65. A similar dynamic operates between federal and state governments in the context of conditional spending programs. The federal government incentivizes states to implement federal policies, but leaves states bearing the brunt of public resistance to the new program. See *Printz v. United States*, 521 U.S. 898, 930 (1997) ("By forcing state governments to absorb the financial burden of implementing a federal regulatory program, Members of Congress can take credit for 'solving' problems without having to ask their constituents to pay for

IV. DEREGULATION OF EMPLOYER HEALTH INSURANCE: ERISA

Before ACA, federal regulation of health insurance was relatively limited. For much of the existence of health insurance plans, they were regulated, if at all, at the state level.⁶⁶ Insurance companies are incorporated and licensed under state law.⁶⁷ States' reserved powers accord them primary authority to regulate insurance, as affirmed by the McCarran-Ferguson Act.⁶⁸ Under that power, states have imposed various requirements, including coverage mandates, rate regulation, and consumer protection rules.⁶⁹ The number and diversity of separate state requirements became increasingly burdensome as firms expanded and operated nationwide.⁷⁰ As employer health plans became more prevalent, employers and insurers sought relief in uniform federal regulations.⁷¹

The federal Employee Retirement Income Security Act of 1974 (ERISA), aimed

the solutions"); *New York v. United States*, 505 U.S. 144, 168 (1992) ("[W]here the Federal Government compels States to regulate, the accountability of both state and federal officials is diminished.").

66. See Jay Conison, *ERISA and the Language of Preemption*, 72 WASH. U. L.Q. 619, 644–45 (1994) (noting that "before ERISA state law was viewed as the primary source of standards for plans" and discussing paucity of state laws); Peter D. Jacobson, *The Role of ERISA Preemption in Health Reform: Opportunities and Limits*, 37 J.L. MED. & ETHICS 88, 89 (2009) ("Traditionally, states are responsible for regulating health care delivery, and litigation against health care providers is resolved under state law."); Jana K. Strain & Eleanor D. Kinney, *The Road Paved With Good Intentions: Problems and Potential for Employer-Sponsored Health Insurance Under ERISA*, 31 LOY. U. CHI. L.J. 29, 33 (1999) (noting that states' inherent police powers include the authority to regulate insurance).

67. See Strain & Kinney, *supra* note 66, at 34 (noting that states historically have regulated insurance companies that operate in their borders); Stephanie Kanwit, *The Purchase of Insurance Across State Lines in the Individual Market*, 37 J.L. MED. & ETHICS 152, 153 (2009) ("Under current law, companies may only sell policies to individuals who reside or work in the state in which the company is licensed (although large insurers license products in every state).").

68. 15 U.S.C. § 1012(b) (2006) (*reversing* *United States v. Se. Underwriters Ass'n*, 322 U.S. 533, 553 (1944)) (extending federal antitrust authority to the business of insurance) ("No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance . . . unless such Act specifically relates to the business of insurance . . .").

69. Strain & Kinney, *supra* note 66, at 33–34 (describing state regulations); BERNADETTE FERNANDEZ, CONG. RESEARCH SERV., R41069, SELF-INSURED HEALTH INSURANCE COVERAGE 2 (2010), available at http://www.achp.org/themes/ACPH_Main/files/CRS_Report-Self-Insured-May2010.pdf (describing various types of state laws regulating insurance).

70. See *FMC Corp. v. Holliday*, 498 U.S. 52, 68–69 (1990) (Stevens, J., dissenting) (describing industry concerns, including increasing number of self-insured employer health plans underlying ERISA preemption scheme); Corey J. Ayling, *New Developments in ERISA Preemption and Judicial Oversight of Managed Care*, 31 CREIGHTON L. REV. 403, 404–05 (1998) (describing historical context for ERISA enactment, noting the prevalence of employer health insurance plans by 1974); Donald T. Bogan, *ERISA: The Savings Clause, § 502 Implied Preemption, Complete Preemption, and State Law Remedies*, 42 SANTA CLARA L. REV. 105, 118 (2001) (noting ERISA's objective of "relieving large employers from the headache of complying with multiple and divergent state and local regulations").

71. See *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 9 (1987) (citing legislative history, including concern about conflicting state laws); *Metro. Life Ins. Co. v. Mass.*, 471 U.S. 724, 745–46 n.23 (citing same); *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 99 (1983) (citing legislative history emphasizing the goal of uniformity and concern over eliminating "conflicting or inconsistent State and local regulation of employee benefit plans"); Mary A. Bobinski, *Unhealthy Federalism: Barriers to Increasing Health Care Access for the Uninsured*, 24 U.C. DAVIS L. REV. 255, 274–76 (1990) (discussing the uniformity goal of ERISA); Conison, *supra* note 66, at 646 n.98, 647 n.103 (citing H.R. REP. NO. 93-533, at 2364 (1973); 120 CONG. REC. 29, 197 (1974) (statement of Rep. Dent)); Strain & Kinney, *supra* note 66, at 30 (describing factors leading to increased federal regulation of employee benefits).

primarily at underfunded employer pension plans, also nominally addressed employer health plans.⁷² As a product of eleventh hour compromise, ERISA contains a perplexing, push-me-pull-me preemption scheme.⁷³ At first, ERISA section 514 broadly preempts any and all state laws that “relate to” employer health plans.⁷⁴ Section 514’s broad preemption would seem to alleviate employers and insurance companies that offer employer health plans of the burden of complying with inconsistent, diverse state regulation.⁷⁵ But states, concerned with the usurpation of their traditional authority to regulate insurance companies operating within their borders,⁷⁶ lobbied for an exception, which “saves” any state laws that regulate insurance from broad ERISA preemption.⁷⁷ Not content to let states reclaim too much regulatory discretion, large group employers sought an exception to the exception, providing that self-insured plans in which the employer itself bears the risk of employees’ health care costs shall not be “deemed” insurers for purposes of state regulation.⁷⁸ Even after ACA, self-insured plans remain fairly comfortable within ERISA preemption and free from state regulation.⁷⁹ More than half of all individuals with private health insurance are enrolled in self-insured plans.⁸⁰

The beauty of the ERISA preemption compromise, from the perspective of the firm, is that ERISA contains almost no substantive regulation of employer health plans.⁸¹

72. Bronsteen et al., *supra* note 49, at 2302–03; Hyman & Hall, *supra* note 49, at 29.

73. See Conison, *supra* note 66, at 648–50 (describing conflicting constituent interests during ERISA drafting); Strain & Kinney, *supra* note 66, at 45 (characterizing statutory scheme’s effect on state regulatory powers as “ERISA taketh away; ERISA giveth; ERISA taketh away again”); William Pierron & Paul Fronstin, *ERISA Pre-emption: Implications for Health Reform and Coverage*, EMP. BENEFIT RES. INST., Feb. 2008, at 4–6, available at http://www.ebri.org/pdf/briefspdf/EBRI_IB_02-20086.pdf (discussing ERISA legislative history); see also *Metropolitan Life*, 471 U.S. at 739 (acknowledging that the ERISA preemption scheme is “not a model of legislative drafting”).

74. 29 U.S.C. § 1144(a) (2006).

75. See *Metropolitan Life*, 471 U.S. at 739 (discussing ERISA’s impact on insurance plans); *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 46 (1987) (discussing the legislators’ intent that the bill eliminate inconsistent regulation of employee benefit plans).

76. See *Metropolitan Life*, 471 U.S. at 739–40 (“[W]hile the general pre-emption clause broadly pre-empts state law, the saving clause appears broadly to preserve the States’ lawmaking power over much of the same regulation.”); Conison, *supra* note 66, at 646–49 (describing states’ interests); Strain & Kinney, *supra* note 66, at 46 (“[T]he savings clause creates a loophole that allows states to protect their citizens’ interests through regulation of health plans.”).

77. 29 U.S.C. § 1144(b)(2)(A) (2006).

78. *Id.* § 1144(b)(2)(B); Conison, *supra* note 66, at 648–49 (noting, in particular, concern over a Missouri court decision “holding self-insured medical benefit plan to be insurance companies for purposes of state regulation”).

79. See generally FERNANDEZ, *supra* note 69, at 6 (tbl.1) (demonstrating ACA provisions applicable to self-insured plans); Tim Jost, *How Does the Health Reform Legislation Affect Self-Insured Plans?*, O’NEILL INST. FOR NAT’L & GLOBAL HEALTH L., LEGAL SOLUTIONS IN HEALTH REFORM (Mar. 31, 2010, 5:24 PM), available at <http://oneillhealthreform.wordpress.com/2010/03/31/how-does-the-health-reform-legislation-affect-self-insured-plans/> [hereinafter Jost, LEGAL SOLUTIONS] (describing ACA provisions applicable to self-insured plans); Linehan, *supra* note 48, at 4 (discussing self-insured plans in the context of health reform).

80. See FERNANDEZ, *supra* note 69, at 4 (noting that 55% of private-sector employees are enrolled in self-insured plans); see also Linehan, *supra* note 48, at 3 (noting that 57% of employees are enrolled in a partially or fully self-insured health plan).

81. See Hyman & Hall, *supra* note 49, at 29 (“The result of this statutory framework is to leave employment-based health insurance effectively unregulated, since ERISA contains no substantive regulation of health benefits.”); Jacobson, *supra* note 66, at 89 (noting that ERISA provides “minimal federal regulation”).

Pension plans, which were the focus of the legislation, are subject to numerous particular requirements under ERISA.⁸² But the meat of ERISA, when it comes to health plans, is the preemption scheme.⁸³ ERISA's very few substantive requirements for health plans include mental health parity, coverage of breast reconstruction after mastectomy, and minimum hospital stays after birth of a child.⁸⁴ By and large, the law is deregulatory when it comes to employer health plans.⁸⁵ Plans are exempt from most state regulation, especially if they self-insure. At the same time, they do not face any particularly onerous federal regulations under ERISA.

Subsequent federal laws, namely the Health Insurance Portability and Accountability Act of 1996 (HIPAA)⁸⁶ and the Consolidated Omnibus Reconciliation Act of 1986 (COBRA),⁸⁷ impose additional requirements on employer group health plans. Most relevant to the grandfather rule, HIPAA amended ERISA and prohibits group health plans from discriminating on the basis of health status for enrollment, premiums, and coverage.⁸⁸ Against this backdrop, ACA's extensive list of new substantive requirements significantly expands federal regulation of health plans.

V. THE REALITY: IT DEPENDS ON WHAT YOU CONSIDER "YOUR PLAN"

The grandfather rule specifies that plans in existence as of the date of ACA's enactment shall not be terminated,⁸⁹ but it does not promise that your plan will remain forever unchanged.⁹⁰ ACA expressly exempts grandfathered plans from many, but certainly not all, of the new federal requirements for health insurance plans. In one view, those new requirements necessarily alter the plan that you currently have and thereby break the promise.⁹¹ In another view, ACA's exemptions and requirements for

82. See Bronsteen et al., *supra* note 49, at 2302–03 (noting “little doubt that ERISA was drafted and passed with the primary aim of protecting employees' pension benefits” and that health benefit plans received “scant attention during ERISA's coalescence”); Hyman & Hall, *supra* note 49, at 29 (noting that protecting pension funds was ERISA's primary focus, and health benefits were included as an afterthought).

83. See Bobinski, *supra* note 71, at 277 (“Given the lack of substantive regulation, the most significant aspect of ERISA is its preemption provision . . .”).

84. 29 U.S.C. §§ 1185(a)–(b) (2006).

85. See Catherine L. Fisk, *The Last Article About the Language of ERISA Preemption? A Case Study of the Failure of Textualism*, 33 HARV. J. ON LEGIS. 35, 37 (1996) (noting that “ERISA preemption has created an enormous, unanticipated ‘regulatory vacuum’”).

86. Health Insurance Portability and Accounting Act of 1996, Pub. L. No. 104-191, 110 Stat. 1936 (1996).

87. Consolidated Omnibus Reconciliation Act of 1986, Pub. L. No. 99-272, 100 Stat. 82 (1986). COBRA requires employers with 20 or more employees that sponsor a group health plan to offer continuing health insurance coverage for “qualified individuals” whose group health insurance is terminated by a “qualifying event.” 29 U.S.C. § 1161.

88. 29 U.S.C. §§ 1181–83.

89. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1251, 124 Stat. 119, 161–62 (2010).

90. See *Health Policy Brief: ‘Grandfathered’ Health Plans*, HEALTH AFF. 1, 5 (Oct. 29, 2010), http://www.healthaffairs.org/healthpolicybriefs/brief_pdfs/healthpolicybrief_29.pdf (noting commenters' view “that anyone who interpreted that promise as meaning that their coverage would never change in any way was bound to be disappointed”); Jost, *LEGAL SOLUTIONS*, *supra* note 79 (suggesting that Obama's promise never meant “if you don't like the plan you have, you will be stuck with it forever”).

91. But see *Health Policy Brief: ‘Grandfathered’ Health Plans*, *supra* note 90, at 5 (noting that “insurance plans have always changed in the past, and would have done so in the future with or without the health reform

grandfathered plans roughly approximate existing plans and thereby preserve the status quo.⁹² Accordingly, the validity of the “you can keep your health plan” promise turns on what you consider “your plan.” Is “your plan” the precise coverage terms, provider networks, premiums, cost-sharing obligations, and other provisions of the plan in which you were enrolled on March 23, 2010? Or is “your plan” a set of standards or hallmarks of typical employer health benefit plans that you have come to expect?

A. ACA Requirements Applicable to Grandfathered Plans

Grandfathered plans are subject to a number of ACA provisions.⁹³ First, all plans must develop and utilize standardized explanation of coverage documents.⁹⁴ As early as 2011, grandfathered plans must extend coverage to dependent children up to age 26.⁹⁵ New and grandfathered plans cannot impose lifetime limits and are restricted in imposing annual limits on coverage.⁹⁶ No plan may cancel coverage except in cases of intentional misrepresentation or fraud.⁹⁷ Both new and grandfathered plans must meet specific medical-loss ratios (MLR), meaning that large plans must spend 85% of premium revenue on medical care, and small plans must spend 80%.⁹⁸ If plans fail to meet the spending requirements, they are required to rebate the excess revenue to plan enrollees.⁹⁹ One of ACA’s most popular reforms, the prohibition on preexisting condition exclusions,¹⁰⁰ applies to both new and grandfathered plans. Also, all plans are prohibited from imposing waiting periods longer than 90 days.¹⁰¹

B. ACA Exemptions for Grandfathered Plans

Grandfathered plans are expressly exempted from several key ACA provisions.¹⁰² One of the most significant exemptions is the Essential Health Benefits (EHB) provision, which defines the package of services that individual and small group plans sold in the exchanges must cover.¹⁰³ EHB includes ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance abuse treatment, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services, chronic disease management, and pediatric services, including oral and vision care.¹⁰⁴ The EHB provisions cap out-of-

law”).

92. See Jost, HEALTH AFF. BLOG, *supra* note 56 (noting that the grandfather rule is not intended to prevent you from escaping your insurance plan if it changes dramatically to your disadvantage).

93. ACA § 1251(a)(3), (4).

94. *Id.* § 2715.

95. *Id.* § 2714.

96. *Id.* § 2711.

97. *Id.* § 2712.

98. ACA § 2718(b).

99. *Id.*

100. *Id.* § 2704(a).

101. *Id.* § 2708.

102. *Id.* § 1251(a)(2).

103. ACA §§ 1302(b), 2707.

104. *Id.* § 1302(b)(1)(A)–(J); see Amy B. Monahan, *Initial Thoughts on Essential Health Benefits*, (University of Minnesota Law School, Legal Studies Research Paper Series No. 10-36, (2010)), available at http://papers.ssm.com/sol3/papers.cfm?abstract_id=1646723 (describing EHB).

pocket expenditures, and grandfathered plans are also exempt from those limits.¹⁰⁵ Also, grandfathered plans are not required to cover preventive care without cost-sharing,¹⁰⁶ allow direct access to emergency care, pediatricians, and obstetrical and gynecological care,¹⁰⁷ or cover experimental treatment as part of approved clinical trials.¹⁰⁸ Grandfathered plans are also not subject to ACA's guaranteed issue and renewability requirements,¹⁰⁹ or prohibitions on discrimination based on health status or employee compensation.¹¹⁰ ACA's limits on premium rate variation based on age and tobacco use do not apply to grandfathered plans.¹¹¹ Grandfathered plans also are not required to provide statutorily specified grievance and appeals processes,¹¹² report on quality of care improvement activities,¹¹³ or pay an annual assessment to fund patient-centered outcomes research.¹¹⁴

C. *Effect of Requirements and Exemptions on Grandfathered Plans*

Many of the new requirements and exemptions may have little effect on employer group plans because those plans already voluntarily, or as required under existing laws, comply with similar standards. First, ACA operates from the presumption that employer health plans currently provide at least the statutory EHB¹¹⁵ and likely even more generous benefits. Similarly, it is presumed that grandfathered plans already allow access to emergency care, pediatricians, and obstetrical-gynecological care without significant gatekeeping barriers.¹¹⁶ Accordingly, those ACA exemptions seem merely to maintain the status quo. Most employer health plans also already provide fairly generous grievance and appeals processes, if not the exact processes required by ACA.¹¹⁷ ERISA expressly requires self-insured plans to provide internal, although not external, appeals.¹¹⁸ In effect, those ACA exemptions simply avoid duplication of existing legal requirements or industry customs rather than alleviate grandfathered plans from significant new ACA

105. See ACA § 1302(c)(2) (defining the annual limitation on deductibles for employer sponsored plans); see Jost, HEALTH AFF. BLOG, *supra* note 56 (stating that grandfathered plans are exempt from the EHB); *Health Policy Brief: 'Grandfathered' Health Plans*, *supra* note 90, at 2 (discussing the effect of the ACA on grandfathered plans).

106. ACA § 2713(a).

107. *Id.* § 2719A(b)–(d).

108. *Id.* § 2709.

109. *Id.* §§ 2702, 2703.

110. *Id.* §§ 2701, 2716.

111. ACA § 2701(a)(1)(A)(iv).

112. *Id.* §§ 2715, 2719.

113. *Id.* § 2717.

114. *Id.* § 6301.

115. See *id.* § 1302(b)(2)(A) (requiring the Secretary of Health and Human Services to ensure that the scope of EHB “is equal to the scope of benefits provided under a typical employer plan”).

116. See *Questions and Answers*, *supra* note 24 (suggesting that most Americans receive health insurance from employer health plans, and that most of those plans “are likely to already give their workers and families some additional protections in the [ACA], like a choice of OB-GYN and pediatrician and access to emergency rooms in other states without prior authorization”).

117. See ACA § 10101(g) (amending Public Health Service Act Section 2719).

118. See 29 U.S.C.A. § 1133 (West 2011) (providing for a claims appeal process); 29 C.F.R. § 2560.503-1(k)(2)(ii) (2010) (specifying that state law external review procedures are not part of ERISA's full and fair review procedures under Section 503).

requirements.

Likewise, some of ACA's most dramatic changes for the individual and small group markets, including the prohibition on preexisting condition exclusions and restrictions on health status discrimination, are generally unremarkable for employer group health plans. Most grandfathered plans are already subject to similar requirements under HIPAA.¹¹⁹ Specifically, group health plans, including employer plans, are already restricted in excluding enrollees based on preexisting health conditions or discriminating in premium rates among group members based on health status.¹²⁰ HIPAA also provides its own restrictions on waiting periods, which, in many cases, are stricter than ACA's 90-day limit.¹²¹

ACA's other required changes for grandfathered plans, however, could be significant. The requirement to extend coverage to young-adult dependents could increase employer health plan enrollment and, thereby, employers' premium contributions.¹²² The MLR requirement also restricts plans' profitability and management discretion by strictly regulating how insurers spend premium revenues.¹²³ Restrictions on lifetime and annual limits could impose significant burdens on plans because certain covered services can generate very high costs.¹²⁴ The transparency, disclosure, and reporting requirements, grievance and appeals procedures, and other consumer protection requirements also significantly increase the cost of administering health plans.¹²⁵

Interpreting the "you can keep your health plan" promise to mean, literally, that your plan will not change after March 23, 2010, is unrealistic. Most employees are well accustomed to periodic changes to their employer health benefits and annual open enrollment periods during which they have the opportunity to review the available plans and change their elections.¹²⁶ Thus, even before ACA, we did not expect our plans to remain fixed in time. The grandfather rule and related ACA provisions in many ways merely codify existing employer group health plan enrollment, coverage, and grievance practices. If your health plan currently allows relatively unimpeded access to certain specialists, does not require you to pay a deductible or copayment for preventive care, and guarantees coverage at the same premium rate for all group members, then ACA ensures that your grandfathered plan will continue to operate within those expectations.

119. See Health Insurance Portability and Accounting Act of 1996, Pub. L. No. 104-191, 110 Stat. 1936 (1996); *supra* notes 86, 88 and accompanying text (describing HIPAA requirements).

120. 29 U.S.C. §§ 1181-1183 (2006).

121. *Id.* § 1181 (limiting waiting periods to 12 months, reduced by aggregate periods of creditable coverage).

122. See Darling, *supra* note 35, at 1222 (discussing employers' concerns about the added costs of adult children); Mercer, *supra* note 58 (reporting results of employer survey about cost impact of new ACA requirements, including extending dependent child coverage).

123. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 2718(b), 124 Stat. 119, 137 (2010).

124. See Darling, *supra* note 35, at 1223 (citing chiropractic, infertility, and orthodontia as examples).

125. See Blakely, *supra* note 48, at 16 (citing industry consultant and actuary noting additional administration as one of the biggest changes from health care reform).

126. See *Consumer Alert: Health Insurance Open Enrollment: Choosing the Best Option for You and Your Family*, NAT'L ASSOC. OF INS. COMM'NS (Oct. 2008), http://www.naic.org/documents/consumer_alert_health_insurance_open_enrollment.htm.

Moreover, if ACA requires your plan to make changes that seem to your advantage, such as eliminating or reducing benefit caps, extending coverage to dependent young adults, requiring additional disclosure and grievance procedures, and expecting leaner operations under the MLR, you likely will not object to those consumer-friendly changes. But those requirements also impose costs on plan sponsors, administrators, and insurers, which cost-pressures could necessitate other changes to plans. The regulations implementing ACA's grandfather rule, along with other provisions of the statute, severely limit the types of changes that plans can make if they desire to retain grandfathered status. When a plan violates those limits, it will lose grandfathered status and will have to come into full compliance with ACA.¹²⁷

VI. REREGULATION OF EMPLOYER HEALTH INSURANCE: GRANDFATHER REGULATIONS

ACA left unanswered the question whether and to what extent grandfathered plans can change without losing grandfathered status.¹²⁸ ACA's statutory requirements and exemptions for grandfathered plans generally comport with the promise that you can keep at least the general contours and defining features of your plan, if not the precise plan you had on March 23, 2010.¹²⁹ But the implementing regulations tell a different story. The Administration's health reform rhetoric was deregulatory, but the reality of health reform implementation is reregulatory. As an industry consultant summarized, "The rules for maintaining grandfathered status were tougher than many employers expected."¹³⁰ The challenges of complying with those rules will likely result in most plans relinquishing grandfathered status.

A. Implementing Regulations

Regulations released on June 17, 2010 flesh out the requirements for plans to maintain grandfathered status. First, the regulations impose additional disclosure and documentation requirements on grandfathered plans, the burdens of which the government concluded would be de minimis.¹³¹ The heart of the implementing regulations is a list of "changes causing cessation of grandfather status."¹³² The six listed changes include: significantly cutting benefits; significantly raising deductibles, copayments, or out-of-pocket limits; increasing coinsurance; significantly lowering employer contributions; and adopting annual limits lower than existing lifetime limits on coverage, or decreasing existing annual limits on coverage.¹³³ Much fleshing out remains to be done, but the regulations provide descriptions of the limits and examples of changes

127. See FERNANDEZ, *supra* note 69, at 6 (tbl.1) (illustrating "Private Health Insurance Reforms Applicable to Self-Insured Plans").

128. See Fernandez, *supra* note 56, at 3 (observing that ACA "is silent on the question about whether changes to a plan or coverage could make it a new plan"); Jost, HEALTH AFF. BLOG, *supra* note 56, at 2 (noting that ACA "does not identify the circumstances under which a grandfathered plan might cease to be grandfathered").

129. See *supra* Part V (discussing grandfather regulations).

130. Mercer, *supra* note 58 (quoting Mercer partner, Tracy Watts).

131. Grandfathering Rules, 75 Fed. Reg. 34,538, 34,541, 34,555 (June 17, 2010) (to be codified at 45 C.F.R. pt. 147).

132. *Id.* at 34,543–44, 34,568–69 (to be codified at 45 C.F.R. § 147.140(g)(1)).

133. *Id.*

that would result in loss of grandfathered status.

With respect to coverage changes, plans may not eliminate benefits for a particular condition or for services essential to treat the condition.¹³⁴ For example, a plan that currently covers diabetes or HIV treatment cannot exclude that condition from coverage. The regulations define “significant” increases to deductibles and out-of-pocket limits as the rate of medical price inflation plus 15%.¹³⁵ Accordingly, a plan that raises the deductible from \$500 to \$1000 would violate the rule and thereby surrender grandfathered status. The plan may increase copayments by the greater of \$5 dollars, or medical inflation plus 15%.¹³⁶ If office visits require \$10 copayment now, the copayment cannot be raised to \$20 dollars without losing grandfathered status. Coinsurance charges cannot be raised by any amount.¹³⁷ Employer contributions toward employee health plans may not be reduced by more than 5%.¹³⁸

The June 17, 2010 regulations suggested that plans would lose grandfathered status if they changed vendors¹³⁹ or switched from insured to self-insured status. The employer health plan industry opposed these regulations.¹⁴⁰ Putting plans out to bid is a common strategy for keeping down costs,¹⁴¹ and ACA’s exceptional treatment for self-insured plans may make changing to self-insured status an ever more attractive option for employers.¹⁴² Final rules, issued on November 15, 2010, clarify that plans in place as of that later rulemaking date may change insurance carriers or switch to self-insured status without losing grandfathered status, as long as the plan does not otherwise violate the previous regulatory requirements.¹⁴³ Those clarifications, however, came too late for plans that already relinquished grandfathered status before November 15, 2010—they are subject to ACA’s full requirements.¹⁴⁴

Additional changes that plans may make without losing grandfathered status include adding benefits, enrolling new employees and dependents,¹⁴⁵ making changes to comply with federal and state laws or voluntary changes to comply with ACA, and changing plan

134. *Id.* at 34,564 (to be codified at 45 C.F.R. § 147.140(g)(1)(i)).

135. *Id.* at 34,564–65 (to be codified at 45 C.F.R. §§ 147.140(g)(1)(iii), (g)(3)(i)–(ii) (defining medical inflation and maximum percentage increase)).

136. Grandfathering Rules, 75 Fed. Reg. at 34,564–65 (to be codified at 45 C.F.R. §§ 147.140(g)(1)(iv), (g)(3)(i)–(ii)).

137. *Id.* at 34,564 (to be codified at 45 C.F.R. § 147.140(g)(1)(ii)).

138. *Id.* at 34,564 (to be codified at 45 C.F.R. § 147.140(g)(1)(v)).

139. *Id.* at 34,562 (to be codified at 29 C.F.R. § 2590.715-1251(a)(1)(ii)).

140. See Amendment to the Interim Final Rules for Group Health plans and Health Insurance Coverage Relating to Status as a Grandfathered Health Plan under the Patient Protection and Affordable Care Act, 75 Fed. Reg. 70,114, 70,116 (Nov. 17, 2010) [hereinafter Grandfathering Amendment].

141. See Mercer, *supra* note 58.

142. See *supra* notes 86–88 and accompanying text (discussing HIPPA and COBRA); Timothy S. Jost, *Health Insurance Exchanges and the Affordable Care Act: Eight Difficult Issues*, THE COMMONWEALTH FUND, at 18–20 (Sept. 2010), available at http://www.commonwealthfund.org/~media/Files/Publications/Fund%20Report/2010/Sep/1444_Jost_hlt_ins_exchanges_ACA_eight_difficult_issues_v2.pdf (discussing attractions of self-insuring and potential adverse impact on state exchanges); Linehan, *supra* note 48, at 9 (suggesting advantages of self-insuring under ACA, especially for smaller employers).

143. See Grandfathering Amendment, 75 Fed. Reg. at 70,116–17.

144. *Id.* at 70,120 (to be codified at 26 C.F.R. § 54.9815-1251T(a)(1)(ii)).

145. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1251, 124 Stat 119, 161–62 (2010).

administrators.¹⁴⁶ Plans may also increase premiums as long as employer contributions to the premiums remain roughly the same.¹⁴⁷ The grandfathering regulations further specify that employers remain free to drop employer health insurance altogether.¹⁴⁸ ACA does not expressly mandate employers to offer health care benefits to their employees. The law does, however, impose a relatively minor penalty, or “free-rider assessment,” under limited circumstances.¹⁴⁹ The penalty applies only to employers with 50 or more full-time employees, and only if the employer fails to offer “minimum essential coverage” or if any full-time employee obtains coverage on the exchanges and qualifies for government subsidy.¹⁵⁰ If those criteria are met, the penalty is \$2000 per employee, minus the first 30 employees.¹⁵¹ Significant unanswered questions include whether grandfathered plans can change or reduce provider networks, prescription drug formularies, or utilization limits.¹⁵²

The requirements developed in the grandfathering regulations leave employers little wiggle room for managing ever-increasing health care costs, and ACA does little to bend the cost curve.¹⁵³ Although a few optimists predict that ACA will lower employer health plan costs in the long run, most expect that employers’ costs will continue to rise at an even greater pace than recent years.¹⁵⁴ Currently, employer health insurance costs increase by an average of 6% per year.¹⁵⁵ A recent report predicts that 2011 employer

146. See Grandfathering Rules, 75 Fed. Reg. 34,538, 34,544 (June 17, 2010) (listing changes that will not cause a plan to lose grandfathered status).

147. See *id.* (noting that changes to premiums will not cause a plan to lose grandfathered status); Jost, HEALTH AFF. BLOG, *supra* note 56 (noting permitted changes by grandfathered plans, including “most importantly—rais[ing] premiums”).

148. See Grandfathering Rules, 75 Fed. Reg. at 34,548 (listing, among choices for plan sponsors, “cease to offer any plan”).

149. See Darling, *supra* note 35, at 1221 (noting lack of “classic” employer mandate but describing penalties and options for employers).

150. See ACA § 1513 (amending I.R.C. by adding § 4980H(a), (c)) (providing details of penalties for large employers).

151. See FERNANDEZ, *supra* note 69, at 4, 7 n.19 (discussing penalties); KOSALI SIMON, CENTER FOR AMERICAN PROGRESS, IMPLICATIONS OF HEALTH CARE REFORM FOR EMPLOYERS 6, 33 n.14 (May 2010), available at http://www.americanprogress.org/issues/2010/05/pdf/health_employers.pdf (explaining some penalties). See generally HINDA CHAKind & CHRIS L. PETERSON, CONG. RESEARCH SERV., R41159, SUMMARY OF POTENTIAL EMPLOYER PENALTIES UNDER PPACA (P.L. 111-148) (Apr. 5, 2010), available at <http://www.ltgov.ri.gov/smallbusiness/employerprovisions.pdf> (describing the penalties applicable under section 1513 of ACA).

152. See Grandfathering Rules, 75 Fed. Reg. at 34,546 (recognizing that in balancing competing interests, some uncertainties remain).

153. See Darling, *supra* note 35, at 1221 (noting employers’ “greatest disappointment” with health reform was lack of cost containment and suggesting that combination of increased access and requirements to maintain current benefits “will be toxic”). See generally Chris Fleming, *Can Health Reform Bend the Cost Curve?*, HEALTH AFF. BLOG (June 22, 2010), <http://healthaffairs.org/blog/2010/06/22/can-health-reform-bend-the-cost-curve/> (evaluating whether ACA will succeed in “bending the cost curve”); Ezra Klein, *Does Health-Reform Bend the Cost Curve Up?*, WASH. POST (Sept. 10, 2010), http://voices.washingtonpost.com/ezra-klein/2010/09/does_health-care_reform_bend_t.html.

154. See Darling, *supra* note 35, at 1221 (noting that the health reform law will not contain cost growth in the short term); Blakely, *supra* note 48, at 4–7 (describing recent trends in employment based health benefits); Mercer, *supra* note 58 (discussing the health care reform’s affect on costs).

155. Mercer, *supra* note 58.

health care costs will increase by 9%, a five-year high.¹⁵⁶ Small employers anticipate 12% cost increases under ACA, while large employers predict 9% increases just to comply with ACA's new requirements, without making other changes.¹⁵⁷

In recent years, employers' typical strategies for managing health care cost increases have been to shift more of the burden onto employees by ceasing to provide coverage, reducing benefits, increasing cost-sharing, increasing employees' premium percentage, or switching plans or plan vendors.¹⁵⁸ The ACA grandfathering regulations foreclose many of those options. Plans face the baseline pressures of rising health care costs plus the added costs of complying with ACA's new requirements, including expanded coverage of young adult dependents, restrictions on lifetime and annual limits, administrative burdens, and MLR limits.¹⁵⁹ As a practical matter, under the grandfathering rule's "no substantial changes" requirements, the only way for employers to maintain grandfathered status is by bearing the inevitable cost increases on their own ledgers, rather than shifting costs onto employees. Most predict that the grandfathering limits will be nearly impossible to abide with in the near or long term.¹⁶⁰ As a result, grandfathered health plans will likely cease to exist over time.

B. Other ACA Constraints

Other provisions of ACA, specifically the MLR, "Cadillac tax," and free-choice vouchers further constrain the flexibility and options available to grandfathered health plans. Although the grandfathering regulations expressly do not limit plans from increasing premiums, the MLR and Cadillac tax effectively operate as premium caps.¹⁶¹ Grandfathered plans, unless they self-insure, are subject to the MLR. The MLR restricts the amount that plans may spend on non-patient care expenses to specified limits.¹⁶² Accordingly, plans may raise premiums but not to cover increased overhead or

156. *Employer Health Costs to Rise in 2011*, REUTERS (Sept. 27, 2010), <http://www.reuters.com/article/2010/09/27/us-usa-healthcare-costs-idUSTRE68Q3N520100927> (citing Hewitt report); see also *Behind the Numbers: Medical Cost Trends for 2012*, PWC HEALTH RESEARCH INSTITUTE, May 2011, at 4, available at <http://www.pwc.com/us/en/health-industries/publications/behind-the-numbers-medical-cost-trends-2012.jhtml> (predicting medical cost increase to 8% in 2011 and 8.5% in 2012).

157. Mercer, *supra* note 58.

158. See Grandfathering Rules, Fed. Reg. 34,538, 34,548 (June 17, 2010) ("Changes in benefits and cost sharing are typical in insurance markets. Decisions about the extent of changes will determine whether a plan retains its grandfathered status."); *Health Policy Brief: 'Grandfathered' Health Plans*, *supra* note 90, at 4 ex. 3 (citing KAISER FAM. FOUND. surveys); Blakely, *supra* note 48, at 5 fig. 2 (noting decline in coverage and increase in deductibles); Mercer, *supra* note 58 (noting increased employee cost-sharing and changes to plan vendor and type as strategies to hold down employer cost increases).

159. See *supra* Part V.A, C (listing ACA requirements applicable to grandfathered plans and effect of requirements on those plans).

160. See, e.g., Jost, HEALTH AFF. BLOG, *supra* note 56, at 3 (suggesting that full compliance with ACA may be "a more attractive alternative than continuing to live within the regulatory constraints"), *Health Policy Brief: 'Grandfathered' Health Plans*, *supra* note 90, at 4 ("It seems likely that many employers will choose to give up grandfathered status rather than live within the limits."); Alonso-Zaldivar, *supra* note 58 (noting that many employers will be forced to make changes to their plans and a majority of workers will be in plans subject to new requirements).

161. See *supra* note 160 and accompanying text.

162. See Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 2718, 124 Stat. 119, 136 (2010) (requiring health insurers to provide value for premium payments).

administrative expenses, or to increase their profitability.

Even if plans meet the MLR and spend the specified percentage of premium revenues on medical care for plan enrollees, they may run up against the so-called Cadillac tax, an excise tax imposed on insurers offering high-cost health plans.¹⁶³ Beginning in 2018, insurers, including self-insured employer health plans, will be taxed 40% of premiums above the threshold deemed EHB.¹⁶⁴ The thresholds are defined as \$8500 for individual plans, and \$23,000 for family plans in 2013, with the threshold increased in subsequent years.¹⁶⁵ Surveys suggest that 39% of employer health plans will be subject to the 40% excise tax.¹⁶⁶ The impact of that tax would be felt directly by self-insured plans and indirectly by insured plans as insurers offset their increased tax burden by charging higher rates to customers, including employers.

The Cadillac tax was designed to discourage excessive utilization of medical care as well as to generate government revenue to support other components of health reform.¹⁶⁷ The current tax-exempt treatment for contributions to employer benefit plans may encourage firms to offer ever-more generous health plans and thereby shelter that income from taxation.¹⁶⁸ But the Cadillac tax operates as a cap on that practice, strongly encouraging firms to stay under the thresholds. The Center of Medicare and Medicaid Services Chief Actuary predicts that “[i]n reaction to the tax, which would take effect in 2018, many employers would reduce the scope of their health benefits.”¹⁶⁹ As employers

163. *Id.* § 9001 (amending I.R.C. by adding Section 4980I). See SIMON, *supra* note 151, at 16 (describing “Cadillac tax”); FERNANDEZ, *supra* note 69, at 7 (describing taxes on health insurance plans).

164. ACA § 9001 (to be codified at I.R.C. § 49801(a)(2)). Many predict that the tax will be repealed or substantially revised before the implementation date, but the expected revenue nevertheless was included in overall government cost estimates for ACA. See Jenny Gold, “Cadillac” Insurance Plans Explained, KAISER HEALTH NEWS (Mar. 18, 2010), <http://www.kaiserhealthnews.org/Stories/2009/September/22/cadillac-health-explainer-npr.aspx> (suggesting that tax was intended “to generate revenue to help pay for covering the uninsured” and was expected to generate \$12 billion in the first year of implementation, 2018, and \$20 billion in the following year); JANEMARIE MULVEY, HEALTH-RELATED REVENUE PROVISIONS OF THE PATIENT PROTECTION AND AFFORDABLE CARE ACT, CONG. RES. SERV., R41128, Apr. 8, 2010, available at <http://healthreform.kff.org/~media/Files/KHS/docfinder/crsrevenueprovisions.pdf> (predicting \$32 billion revenue from excise tax in 2018); *Under Realistic Assumptions, Health Care Law Increases Deficit by up to \$500 Billion*, REPUBLICAN POL’Y COMMITTEE BLOG (Feb. 22, 2011), http://rpc.senate.gov/public/index.cfm?p=Blog&ContentRecord_id=4dbe7d21-1cab-4bc0-b025-974a20f85543&ContentType_id=3d1f05d6-ed37-4dea-897e-e41bafd0e109&Group_id=0c0f43ff-17c7-4379-abf7-1490f1bf75c5&MonthDisplay=2&YearDisplay=2011 (noting that Cadillac tax would not take effect until one year after a second Obama presidential term and citing CBO conclusion that absent the Cadillac tax and Medicare savings, ACA would increase the federal deficit by \$500 billion).

165. ACA § 9001 (to be codified at I.R.C. § 49801(b)(3)(C)(i), (iii)); see FERNANDEZ, *supra* note 69, at 7 (describing thresholds); MULVEY, *supra* note 164, at 3–4 (describing thresholds in greater detail).

166. Amita Parashar, *Health Law or No, Most Businesses Likely To Keep Offering Insurance*, KAISER HEALTH NEWS (Nov. 9, 2010), <http://www.kaiserhealthnews.org/Stories/2010/November/09/businesses-health-insurance-mercier.aspx>.

167. See Gold, *supra* note 164 (noting two-fold purpose of tax); Joseph White & Timothy Jost, *Cadillacs Or Ambulances? The Senate Tax on ‘Excessive’ Benefits*, HEALTH AFF. BLOG (Dec. 3, 2009), <http://healthaffairs.org/blog/2009/12/03/cadillacs-or-ambulances-the-senate-tax-on-excessive-benefits/> (discussing expected revenue and proponents’ belief that the tax will reduce health care costs).

168. See *supra* notes 50–52 and accompanying text (discussing tax exclusion for expenditures on employee benefit plans).

169. Memorandum from Richard S. Foster, Chief Actuary on Estimated Financial Effects of the “Patient Protection and Affordable Care Act,” as Amended to the Centers for Medicare & Medicaid Servs., 14 (Apr. 22,

adjust their plans to avoid the Cadillac tax, however, they very likely will run awry of the grandfather rules' restrictions on "significantly" reducing benefits.¹⁷⁰

While the MLR and Cadillac tax put pressure on the high end of employer health plans, the free-choice voucher program puts pressure on the low end. Beginning in 2014, employers are required to offer vouchers to certain low-income employees in lieu of employer health plans.¹⁷¹ Employees who earn less than 400% of the federal poverty level and contribute more than 8% percent but less than 9.5% of their household income to participate in an employer health plan, or whose employers offer insurance that does not cover at least 60% of allowable plan expenses, must be provided the option of purchasing insurance on the exchanges with an employer-provided voucher.¹⁷² The voucher amount is the monthly portion of the employer's contribution to the employee's health plan, based on the cost of the most generous plan offered.¹⁷³ Presumably, employers could also choose to extend free-choice vouchers to higher income employees, in lieu of employer-sponsored health insurance.¹⁷⁴ The free-choice vouchers are not taxable to the employer or the employee.¹⁷⁵ Moreover, employers who offer free-choice vouchers will not face a penalty for otherwise not offering employee health insurance.

Commentators offer mixed predictions on employees' and employers' responses to the vouchers. According to one view, voucher-eligible employees will tend to be relatively low-income employees, predominantly in retail, restaurant, and hospitality industries.¹⁷⁶ Those workers may tend to be younger and healthier and therefore able to obtain more affordable coverage through the exchanges.¹⁷⁷ If those workers opt out of employer health plans and leave older, higher risk employees in employer plans, the effect will be to further drive up employers' health care costs.¹⁷⁸ If that prediction is

2010), available at https://www.cms.gov/ActuarialStudies/Downloads/PPACA_2010-04-22.pdf; see also Blakely, *supra* note 48, at 3 (noting "widespread consensus" that the Cadillac tax "is sure to cause health benefits to be cut and may mean structural changes to the employment-based health benefits system").

170. See BARRY FURROW ET AL., *HEALTH CARE REFORM: SUPPLEMENTARY MATERIALS* 81 (2010) (predicting that the Cadillac tax will "most likely result in reduction in the generosity of insurance coverage for plans that exceed the threshold").

171. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 10108(c), 124 Stat. 119, 912 (2010).

172. *Id.* § 10108(c); I.R.C. § 36B(c)(2)(C)(ii) (added by ACA § 1401) (defining "minimum value" requirement); Darling, *supra* note 35, at 1221 (discussing free-choice voucher eligibility provisions).

173. ACA § 10101(d).

174. Amy Monahan & Daniel Schwarcz, *Will Employers Undermine Health Care Reform by Dumping Sick Employees?*, 97 VA. L. REV. 125, 160-61 (2011) (suggesting that employer might prefer to offer vouchers to high-risk employees rather than insure them on employer health plans).

175. ACA § 10108(f), (g).

176. Darling, *supra* note 35, at 1221.

177. Jerry Geisel, *Health Care Voucher Program May Inflate Employer Costs*, BUS. INS. (Apr. 19, 2010), <http://www.businessinsurance.com/article/20100418/ISSUE01/304189969> (providing example of young, low-paid employee working in a company of older, less healthy, higher risk employees who would likely be able to obtain cheaper coverage on the exchanges).

178. See Darling *supra* note 35, at 1222 (evaluating adverse selection potential); Geisel, *supra* note 177 ("Experts say the provision is almost certain to result in adverse selection, inflating employer costs."); Derek Thompson, *Why Employers Aren't Rooting for Health Reform to Die*, THE ATLANTIC (Nov. 10, 2010), <http://www.theatlantic.com/business/archive/2010/11/why-employers-arent-rooting-for-health-care-reform-to-die/66373/> (quoting Andrew Weber, President and CEO of the National Business Coalition on Health, "Maybe we're moving to a system and people get a voucher and they find insurance on the exchanges. That worries

accurate, employers may have an even more difficult time avoiding the cost-shifting and benefit-reduction changes that endanger grandfathered status.

Another view is that employers will take advantage of the voucher option to “dump” high-risk employees into the exchanges by making that option as or more attractive than employer coverage.¹⁷⁹ If employers can nudge those workers who are most costly to insure out of their risk pools, they may be able to hold down costs without having to significantly reduce benefits or shift costs onto employees. Accordingly, the voucher option may facilitate employers’ retaining grandfathered status for plans covering their remaining lower-risk employees.

One check on employers “dumping” employees into the exchanges, at least with respect to large employers, is ACA’s default enrollment rule. All new, full-time employees of firms with 200 or more employees are automatically enrolled in their employers’ health plans.¹⁸⁰ A default rule, similar to the status quo bias, has a strong effect on structuring both employees’ and employers’ choices, requiring affirmative action to achieve a different arrangement.¹⁸¹ The default enrollment rule structures the choice toward maintaining predominantly employer-based health insurance, at least for large employers.

In sum, the grandfathering regulations are only part of the story. The MLR, Cadillac tax, and free-choice voucher provisions of ACA further constrain employers’ flexibility and discretion to alter existing health plans. Although the grandfathering regulations leave open the option of increasing premiums, plans can do so only if they maintain the requisite spending ratios under the MLR. Moreover, increased premiums eventually will reach the Cadillac tax threshold, exposing insurers and employers to significant tax liability. The free-choice vouchers could either pull low-risk employees out of employer risk pools, further driving up employer health plan costs, or could offer a strategy for employers to push high-risk employees into the private market, allowing employer plans to operate at lower cost.

C. Predicted Impact on Small and Large Firms

Despite President Obama’s promise that “you can keep your health plan” and ACA’s grandfathering provision, the grandfathering regulations, other ACA constraints, and market incentives will likely result in the disappearance of grandfathered plans in the near future. That outcome is especially likely for small firms. Large firms are in a somewhat better position to maintain grandfathered status but also face pressures to come into full ACA compliance. Self-insured plans are perpetually exempt from several ACA requirements that otherwise apply to new plans. Accordingly, loss of grandfathered status for those plans may be less dramatic.

me.”).

179. See Monahan & Schwarcz, *supra* note 174; SIMON, *supra* note 151, at 3, 13 (citing Congressional Budget Office predictions).

180. ACA § 1511.

181. See *supra* notes 44–47 (describing status quo bias).

1. Small Firms

The expectation is that small employers will be especially challenged to operate within the limits necessary to maintain grandfathered status. The federal government explicitly acknowledges that most small employer plans will give up grandfathered status and shift to ACA-compliant policies fairly quickly.¹⁸² The government's low-end estimate is that close to half of small employers will relinquish grandfathered status by 2013.¹⁸³ The high-end estimate is that 80% will give up grandfathered status.¹⁸⁴ A number of factors combine to produce that result. Small employers tend to offer less comprehensive plans and make substantial changes to their plans, in particular, coverage, premium contributions, and cost-sharing, from year to year.¹⁸⁵ Those changes, if unfavorable to employees, would likely take small employer plans out of grandfathered status. In addition, small employers are less likely to self-insure and instead purchase health plans on behalf of their employees on the commercial market.¹⁸⁶ In the posture of insurance customers, rather than insurance administrators, small employers may find ACA's new consumer protections, including the ban on preexisting condition exclusions and premium discrimination based on health status, more attractive than currently available grandfathered plans.

ACA offers various incentives to small employers to encourage them to provide health insurance to their employees in the form of small business tax credits¹⁸⁷ and the Small Business Health Options Programs (SHOP),¹⁸⁸ a component of state-based insurance exchanges. Refundable tax credits are available to small firms with 25 or fewer workers and low-wage employees that offer health insurance.¹⁸⁹ The small business tax credits are variable, based on employer size, average wage, and for-profit or non-profit status, and will phase in over time, up to a maximum of 50% of the portion of the employer contribution to health insurance.¹⁹⁰ Small businesses may find the SHOP option for insuring their workers attractive because of lower administrative costs.¹⁹¹ All plans sold through the exchanges, including SHOP, must offer EHB and comply with the

182. See Grandfathering Rules, 75 Fed. Reg. 34,538, 34,551–53 (June 17, 2010) (describing predicted impact); *Newsroom*, *supra* note 36 (estimating that while 70% of small business plans will be grandfathered in the first year, “this could drop about one-third over several years”).

183. Grandfathering Rules, 75 Fed. Reg., at 34,553 (tbl.3).

184. *Id.*

185. See *Newsroom*, *supra* note 36 (projecting the impact on small business plans).

186. See Bronsteen et al., *supra* note 49, at 2313–14 (noting that self-insuring makes financial sense for firms with large risk pools but may be available to small employers by purchasing stop-loss insurance); Russell Krobin, *The Battle over Self-Insured Health Plans, or “One Good Loophole Deserves Another”*, 5 YALE J. HEALTH POL’Y L. & ETHICS 89, 106–07 (2005) (noting that large employers “have a pool of individual risks sufficiently large to minimize its insurance risk, reducing the value of purchasing third-party insurance”).

187. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, §1421, 124 Stat. 119, 237 (2010).

188. *Id.* § 1331(b).

189. *Id.* § 1421 (amending I.R.C. § 45R(d)).

190. See SIMON, *supra* note 151, at 9 (describing subsidies to small employers).

191. See Christine Ebner et al., *The Effects of the Affordable Care Act on Workers’ Health Insurance Coverage*, 363 NEW ENG. J. MED. 1393, 1395, (2010) available at <http://healthpolicyandreform.nejm.org/?p=12339> (summarizing RAND simulation, suggesting that small employers may be more likely to offer coverage because of “availability of new, often lower-cost insurance options (because of administrative savings, for example) for small businesses that offer coverage on the exchanges,” and predicting “that nearly three of four workers offered coverage by small businesses will receive that offer through the exchanges”).

other ACA requirements for new plans.¹⁹² Accordingly, small employers that elect to offer health plans through the exchanges will necessarily give up grandfathered status.

On the other hand, the better option for many small employers may be to drop employee health insurance altogether. Employers with 50 or fewer employees face no penalty for failing to offer health coverage.¹⁹³ To the extent that small employers may have lower-than-average salaries, their employees will be eligible for individual tax credits and government subsidies if they purchase individual policies on the exchanges. Beginning in 2014, Americans earning between 133 and 400% of the federal poverty level will qualify for tax credits to purchase health insurance.¹⁹⁴ That option may be a win-win for employers and employees because the individual tax credit is more generous than the existing employer tax subsidy.¹⁹⁵ Moreover, some low-income workers may qualify for Medicaid under ACA's expanded income-eligibility requirements.¹⁹⁶ Those options may further incentivize small employers to reduce or change benefits, thereby running afoul of the grandfathering requirements, or drop coverage altogether.

2. Large Firms

Large employers, by contrast, are in a somewhat better position to retain grandfathered status. The government expects that large employers will be better able to navigate the "no substantial changes" requirements, if they so desire.¹⁹⁷ By 2013, the government's low-end estimate is that one-third of large employers will relinquish grandfathered status; the high-end estimate is 64%.¹⁹⁸ Even within the grandfathering limits on employers' shifting increased costs onto employees or significantly reducing benefits, large employers have other ways of offsetting the costs. Large employers tend to have greater administrative capacity to manage plan participation.¹⁹⁹ They also have considerable bargaining power to negotiate favorable rates with health insurers and providers because they bring large, broad risk-pools to the table.²⁰⁰ In addition, large employers are better able to spread the rising costs of health insurance through lower wages to their workers or higher prices for their products and services.²⁰¹

192. ACA § 1201 (amending Public Health Service Act by adding Section 2702(a)); *id.* § 1301(a) (defining Qualified Health Plan); *id.* § 1311(d)(2) (requirements for plans sold in the Exchanges).

193. See *supra* notes 149–51 and accompanying text (describing free-rider surcharge on employers).

194. ACA §§ 1401, 1411.

195. See Hyman, *supra* note 35, at 13–14 (concluding that "low-wage workers . . . and their employers are jointly better off financially if coverage is obtained through an exchange"); Foster, *supra* note 169, at 7 (noting that firms with low average salaries "might find it to their—and their employees'—advantage to end their plans, thereby allowing their workers to qualify for heavily subsidized coverage through the Exchanges").

196. See ACA § 2001 (expanding Medicaid income eligibility levels); Foster, *supra* note 169, at 7 (stating that "a number of workers who currently have employer coverage would likely become enrolled in the expanded Medicaid program").

197. Grandfathering Rules, 75 Fed. Reg. 34,538, 34,551–53 (June 17, 2010) (describing predicted impact); *Newsroom*, *supra* note 36 (discussing that plans only lose their grandfathered status if they make "significant changes" that affect consumers).

198. Grandfathering Rules, 75 Fed. Reg. at 24,538, 34,553 (looking to the estimates provided in Table 3).

199. See Blakely, *supra* note 48, at 21 (citing business federation representative, noting large employers' advantages in offering employer-based health insurance, including ability to afford human resources departments).

200. *Id.* (noting that large companies can exert market power in purchasing health insurance).

201. *Id.* (noting that "for large employers the system is very good at creating large stable risk pools").

Although large employers are not eligible for ACA's small employer tax credits, they continue to enjoy the existing favorable tax treatment for employee benefit contributions, which operates as a strong incentive to maintain employer-sponsored health insurance.²⁰² The free-rider assessment further encourages large employers to continue offering health insurance.²⁰³ Moreover, employees, now facing an individual health insurance mandate will put strong pressure on employers to continue to offer health plans. Large employer group plans will likely continue to be more affordable than individual plans available on the exchanges, despite the possibility of dumping.²⁰⁴

Large firms are also more likely to self-insure,²⁰⁵ and this status perpetually shields them from a number of ACA requirements.²⁰⁶ ACA, in many respects, seems to preserve ERISA's deregulatory effect for self-insured plans²⁰⁷ but does specify how to resolve conflicts between group health plan requirements under ERISA and ACA.²⁰⁸ Several ACA exemptions for grandfathered plans apply to both grandfathered and new self-insured group plans, including the MLR, EHB, rating limits, cost-sharing limits, and guaranteed issue and renewability.²⁰⁹ In other words, self-insured plans, even if they lose grandfathered status by making changes in violation of the grandfathering regulations, still will not be subject to those particular ACA requirements. Moreover, several other ACA requirements that do apply to new self-insured plans, such as coverage of preexisting conditions, waiting periods, prohibitions on premium discrimination based on health status, and internal appeals processes, duplicate existing federal requirements applicable to self-insured plans.²¹⁰

Given that more than half of insured workers are enrolled in self-insured plans,²¹¹ ACA's special treatment of self-insured plans may minimize the impact of losing grandfathered status for most employees. Some commentators suggest that ACA creates even stronger incentives than ERISA for firms, including small firms, to self-insure,²¹²

202. See SIMON, *supra* note 151, at 4 (noting that the tax subsidy for employer-based coverage remains in place); see also Blakely, *supra* note 48, at 3 (noting pre-ACA employer tax incentives); Hyman, *supra* note 35, at 8 (discussing that the tax code pre-act provided financial incentives for employees to insure themselves through their employer).

203. See *supra* notes 151–53 and accompanying text (describing ACA's employer penalty for failing to offer health insurance).

204. See *supra* note 178 (discussing view that employers may use free-choice voucher program as a way to dump high-risk employees into the exchanges).

205. See FERNANDEZ, *supra* note 69, at 4 (noting that “the value of self-insurance to a firm generally is related to firm size”); Linehan, *supra* note 48, at 3 (“To realize the advantages of self-insuring, employers need to have the ability to assume risk without threatening their solvency.”).

206. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, §§ 1301(b)(1)(B), 1562(e), 124 Stat. 119, 163, 264 (2010) (technical amendment to ERISA, adding § 715(b)).

207. See Monahan, *supra* note 104, at 4 (discussing how large group plans remain regulated through ERISA). See generally *supra* Part IV (discussing deregulation under ERISA).

208. ACA § 1562(e) (adding ERISA § 715(a)).

209. See FERNANDEZ, *supra* note 69, at 5 (discussing ACA “patchwork approach to specifying which type of private plan would be subject to which reform”), 6 tbl.6 (summarizing ACA provisions applicable to self-insured plans); see generally Jost, LEGAL SOLUTIONS, *supra* note 79 (listing ACA provisions and entities to which they apply).

210. See *supra* notes 118–21 and accompanying text (describing requirements already applicable to ERISA plans).

211. See *supra* note 80 and accompanying text (noting self-insured plan enrollment).

212. See Linehan, *supra* note 48, at 9 (discussing the effect on small-group market); Timothy S. Jost,

which would extend the effect. Employees typically are not aware whether their employer health plan is self-insured or insured.²¹³ Moreover, under the grandfathering regulations, employees in self-insured plans may have little reason to notice if their plan loses grandfathered status. Self-insured plans will continue to operate more or less the same as before ACA, whether grandfathered or not. For employees in self-insured plans, the real threat to the “you can keep your health plan” promise may not be the inevitability of their plans losing grandfathered status but rather the possibility of their employers dropping health coverage altogether.²¹⁴

The administrative rules implementing the ACA grandfather rule will almost certainly drive plans to relinquish grandfathered status. The strict limits on plan changes will be nearly impossible to abide, especially for small employers. Those plans, accordingly, will lose grandfathered status and will have to comply with a number of additional ACA requirements. For employees covered by those plans the coverage and other consumer protection changes may be dramatic, although perhaps not unwelcome.²¹⁵ Large employers may have a somewhat easier time operating within the grandfathering regulatory limits by bearing the inevitable cost increases. Even when large employers do give up grandfathered status, the changes may be less noticeable to employees because those plans, as currently offered, come closer to ACA’s new requirements than small employer plans. Self-insured plans remain perpetually exempt from a number of new ACA requirements, even if they relinquish grandfathered status. Accordingly, loss of grandfathered status will likely be imperceptible to most employees of self-insured plans.

VII. CONCLUSION

In an appeal to market-based, self-determinative, deregulatory, populist rhetoric, the Obama Administration repeatedly assured the American public that despite the ACA’s sweeping reform of the U.S. health care delivery and health insurance system, the

Health Insurance Exchanges and the Affordable Care Act: Eight Difficult Issues, COMMONWEALTH FUND 22 (Sept. 2010), http://www.commonwealthfund.org/~media/Files/Publications/Fund%20Report/2010/Sep/1444_Jost_hlt_ins_exchanges_ACA_eight_difficult_issues_v2.pdf (discussing exchanges under ACA). The November 17, 2010, regulations clarify that changing from insured to self-insured status will not result in loss of grandfathered status. See Grandfathering Amendment, 75 Fed. Reg. 70,116–17 (Nov. 17, 2010); *supra* notes 143–46 (describing clarifications, allowing plans to switch from insured to self-insured status without losing grandfathered status).

213. See Russell Korobkin, *The Battle over Self-Insured Plans, or “One Good Loophole Deserves Another,”* 5 YALE J. HEALTH POL’Y, L. & ETHICS 89, 95 (2005) (noting that “few employees know whether their [employer health benefit plan] is insured or self-insured”); see, e.g., *Ins. Bd. v. Muir*, 819 F.2d 408, 409 (3d Cir. 1987) (noting that employees in a self-insured plan that contracted with Blue Cross and Blue Shield for plan administration received Blue Cross and Blue Shield insurance cards, claim forms, and reimbursement, with no indication regarding the risk-bearing status of the plan or employer).

214. See David A. Hyman, *PPACA in Theory and Practice: The Perils of Parallelism*, VA. L. REV. (forthcoming 2011), available at http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1826292 (challenging normative conclusions in Monahan & Schwarcz, *supra* note 174, regarding prospect of employers dropping employee health coverage and tying prospect to Obama’s promise).

215. See *supra* notes 62–65 and accompanying text (describing Administration’s paternalistic response to insureds’ concerns about loss of grandfathered status).

legislation would not affect those of us who were happy with our existing health plans.²¹⁶ ACA's grandfather rule largely codifies that promise, preserving plans in existence as of the date of the law's enactment and exempting grandfathered plans from a number of new federal requirements.²¹⁷ ACA's treatment of grandfathered plans, in many ways, preserves the essential defining features of most Americans' health plans.

But the administrative rules implementing ACA's grandfather rule undermine the promise by placing strict limits on the changes that plans can make without surrendering grandfathered status. The limits will be very difficult for most plans to abide and likely will result in plans relinquishing grandfathered status in the near future.²¹⁸ Loss of grandfathered status means that plans must comply with ACA's full list of requirements for new plans. For some plans, the new federal requirements will be significant, comprehensively regulating plan coverage, pricing, and administration to an unprecedented degree, at least at the federal level. For other plans, the loss of grandfathered status may not result in perceptible changes to the extent that those plans already operate under industry standards and other federal or state requirements. The impact may be even less on self-insured plans, which continue to operate mostly outside of ACA's requirements. ACA may simply codify the employer health insurance plan status quo as comprehensive federal requirements.

The Administration's suggestion that we may be better off, or at least no worse off, if our plans relinquish grandfathered status and come into ACA compliance, may be true. Moreover, that result may be unobjectionable to most Americans. The concern identified in this Article is the operation, not the ultimate outcome, of ACA's grandfather rule. The problem with promising deregulation while bringing about reregulation through "black box" means is that the public trust is undermined. There are certainly compelling reasons to support comprehensive federal reregulation of the health care system. Under the current regime, insurers and employers to define the essential contours of our health plans. Under ACA, the federal government sets those standards as a matter of law. But it would better to achieve that result openly, forthrightly, and transparently. Rather than publicly espousing a hands-off, no-change posture, while implementing deep regulatory changes through less accountable, expert-driven processes, the Administration should not shy away from defending the merits of reregulation.

216. See *supra* Parts II, III (providing background information and discussing the Administration's rhetoric).

217. See *supra* Part V (examining the reality of President Obama's promise); Patient Protection and Affordable Care Act, Pub. L. No. 111-148, §1251, 124 Stat. 119, 161 (2010) ("Preservation of right to maintain existing coverage.").

218. See *supra* Part VI.C (discussing the potential impact on both small and large firms).