

FAQS ABOUT AFFORDABLE CARE ACT IMPLEMENTATION (PART VI)

April 1, 2011

Set out below are additional Frequently Asked Questions (FAQs) regarding implementation of the market reform provisions of the Affordable Care Act. These FAQs have been prepared jointly by the Departments of Health and Human Services (HHS), Labor and the Treasury (the Departments). Like previously issued FAQs (available at <http://www.dol.gov/ebsa/healthreform/index.html>), these FAQs answer questions from stakeholders to help people understand the new law and benefit from it, as intended.

GRANDFATHERED HEALTH PLANS

Q1: What is the scope of the anti-abuse rule in paragraph (b)(2) of the interim final regulations relating to grandfather status? In particular, what is a “bona fide employment-based reason” for employees enrolled in a benefit package that is being eliminated to be transferred into another benefit package?

The interim final regulations relating to status as a grandfathered health plan generally state that transferring employees from one grandfathered plan or benefit package (transferor plan) to another (transferee plan) will cause the transferee plan to relinquish grandfather status if amending the transferor plan to replicate the terms of the transferee plan would have caused the transferor plan to relinquish grandfather status. However, the interim final regulations also provide that this rule applies only if there was no bona fide employment-based reason to transfer the employees.

For purposes of paragraph (b)(2) of the interim final regulations relating to status as a grandfathered health plan, the Departments interpret the term “bona fide employment-based reason” to embrace a variety of circumstances. These circumstances (under which a transfer would not cause cessation of grandfather status) include, but are not limited to, any of the following:

- 1) When a benefit package is being eliminated because the issuer is exiting the market;
- 2) When a benefit package is being eliminated because the issuer no longer offers the product to the employer (for example, because the employer no longer satisfies the issuer’s minimum participation requirement);
- 3) When low or declining participation by plan participants in the benefit package makes it impractical for the plan sponsor to continue to offer the benefit package;
- 4) When a benefit package is eliminated from a multiemployer plan as agreed upon as part of the collective bargaining process; or

- 5) When a benefit package is eliminated for any reason and multiple benefit packages covering a significant portion of other employees remain available to the employees being transferred.

The foregoing is not intended to be an exhaustive list of circumstances that will be deemed to satisfy the bona fide employment-based reason condition. There may be many other circumstances in which a benefit package is considered to be eliminated for a bona fide employment-based reason.

Q2: My plan bases the level of cost sharing for brand-name prescription drugs on the classification of the drugs under the plan as having or not having generic alternatives. The classification of a drug that had no generic alternative changes because a generic alternative becomes available and is added to the formulary, with a resulting increase in the cost-sharing level for the brand-name drug. Does that increase cause my plan to relinquish its grandfather status?

No. For example, if, on March 23, 2010, the terms of the plan included prescription drug benefits with different cost sharing divided into tiers as follows:

- Tier 1 includes generic drugs only;
- Tier 2 includes brand name drugs with no generic available;
- Tier 3 includes brand name drugs with a generic available in Tier 1; and
- Tier 4 includes IV chemotherapy drugs.

A drug was previously classified in Tier 2 as a brand name drug with no generic available. However, a generic alternative for the drug has just been released and is added to the formulary. Since the generic is now available, the plan moves the brand name drug into Tier 3 and adds the generic to Tier 1. This movement of the brand name drug into a higher cost-sharing tier does not cause the plan to relinquish grandfather status.

Q3: A previous FAQ addressed the interaction of value-based insurance design (VBID) and the no cost-sharing preventive care services requirements. See <http://www.dol.gov/ebsa/faqs/faq-aca5.html>. In that example, a group health plan did not impose a copayment for colorectal cancer preventive services when performed in an in-network ambulatory surgery center. In contrast, the same preventive service provided at an in-network outpatient hospital setting generally required a \$250 copayment, although the copayment was waived for individuals for whom it would be medically inappropriate to have the preventive service provided in the ambulatory setting. The FAQ indicated that this VBID did not cause the plan to fail to comply with the no cost-sharing preventive care requirements.

A question about a different situation has been raised. Under a group health plan, similar preventive services are available both at an in-network ambulatory surgery center and at an in-network outpatient hospital setting,

but currently no copayment is imposed for these services in either setting. This has been the case since March 23, 2010. If this plan wished to adopt the VBID approach described in the example above by imposing a \$250 copayment for these preventive services only when performed in the in-network outpatient hospital setting (i.e., not when performed in an in-network ambulatory surgery center), and with the same waiver of the copayment for any individuals for whom it would be medically inappropriate to have these preventive services provided in the ambulatory setting, would implementation of that new design now cause the plan to relinquish grandfather status?

No. This increase in the copayment for these preventive services solely in the in-network outpatient hospital setting (subject to the waiver arrangement described above) without any change in the copayment in the in-network ambulatory surgery center setting would not be considered to exceed the thresholds described in paragraph (g)(1) of the interim final regulations on grandfather status and thus would not cause the plan to relinquish grandfather status.

The Departments are seeking further information on VBID and wellness programs and are planning to address issues relating to those designs and programs in future regulations. Comments from plan sponsors have expressed an interest in being able to retain grandfather status notwithstanding certain changes in plan terms that are intended to implement VBID and wellness programs. As the regulatory process progresses, the Departments will be giving close attention to these comments, and further guidance may be issued addressing other circumstances in which plan changes implementing those designs and programs may be made without relinquishing grandfather status.

Q4: A plan operating on a calendar plan year is considering an amendment to plan terms that will exceed the thresholds described in paragraph (g)(1) of the interim final regulations and cause it to relinquish grandfather status. If the plan sponsor decides to adopt this amendment on July 1, 2011, and the change becomes effective for the plan year beginning on January 1, 2012, at what point in time does the plan relinquish grandfather status?

A plan or coverage will cease to be a grandfathered health plan when an amendment to plan terms, which exceeds the thresholds described in paragraph (g)(1) of the interim final regulations, becomes effective – regardless of when the amendment is adopted. Therefore, in this example, the plan would cease to be a grandfathered health plan on January 1, 2012, the first day of the first plan year for which the change is effective.

Q5: A plan operating on a calendar plan year is considering an amendment to plan terms that will cause it to relinquish grandfather status, but wants the amendment to become effective before the first day of the next plan year. If the plan sponsor decides to make this amendment effective on July 1, 2011, does the plan relinquish grandfather status in the middle of the plan year?

Yes. A plan or coverage will cease to be a grandfathered health plan when a plan amendment becomes effective. Therefore, if a plan sponsor chooses to make an amendment to plan terms effective in the middle of a plan year, the plan will cease to be a grandfathered health plan at that time.

If a plan sponsor wishes to avoid relinquishing grandfathered status in the middle of a plan year, any changes that will cause a plan or coverage to relinquish grandfather status should be made effective the first day of a plan year that begins after the change is adopted.

Q6: A plan covers both retirees and active employees and is subject to the market reform requirements of the Affordable Care Act. For retirees, the employer that sponsors the plan contributes \$300 per year multiplied by the individual's years of service for the employer, capped at \$10,000 per year. As the cost of coverage increases over time, how is it determined whether the employer's contribution rate has decreased for purposes of maintaining grandfather status?

In this example, the employer makes contributions based on a formula. Accordingly, the plan will cease to be a grandfathered health plan if the employer decreases its contribution rate towards the cost of coverage by more than five percent below the contribution rate on March 23, 2010. If the formula does not change, the employer is not considered to have reduced its contribution rate, regardless of any increase in the total cost of coverage. However, if the dollar amount that is multiplied by years of service decreases by more than five percent (or if the \$10,000 maximum employer contribution cap decreases by more than five percent), the plan will cease to be a grandfathered health plan.