New FAQs on Grandfathered Health Plans Address Formulary Changes and More

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A sixth round of Frequently Asked Questions (FAQs) was posted online on April 4, 2011 by the Department of Labor (DOL); the FAQs join others issued earlier by the DOL together with the Treasury Department and Department of Health and Human Services.

This round of guidance provides that a group health plan's grandfathered health status is **not** lost in either of the following circumstances:

–A generic version of a drug previously available only in a brand name version is added to a plan's drug formulary with a resulting increase in the applicable co-pay. The example given is when a drug moves from Tier 2 (brand name drugs with no generic available), to Tier 3 (brand name drugs with a generic available in Tier 1). The FAQ states that "[t]his movement of the brand name drug into a higher cost-sharing tier does not cause the plan to relinquish grandfather status."

–A group health plan that on March 23, 2010 (adoption date of PPACA) imposed no co-pay for preventative services delivered in either an ambulatory care setting or an hospital outpatient setting (both in-network facilities) now elects to impose a copayment requirement in the more costly hospital outpatient setting only, subject to waiver when it would be medically inappropriate for the patient to receive the preventative services in the ambulatory setting. The FAQ states that this increase in copayment in the outpatient hospital setting, subject to waiver when medically inappropriate, would not cause the plan to exceed the cost sharing and co-pay thresholds set forth in the grandfathering regulations.

The FAQ also discusses when transfers of groups of employees from one grandfathered benefit package to another grandfathered benefit package would be deemed to be for a "bona fide employment-based reason," such that the transferee plan or package would not lose grandfathered status. This relates to "anti-abuse" provisions in the grandfathering regulations meant to prevent employers from shifting participants from one grandfathered plan or package to another grandfathered plan or package offering lower benefits. (The test is whether the source plan or package, if amended to match the target plan or package, would fail to retain grandfathered status.) The FAQ lists the following as bona-fide employment based reasons for a transfer of participants:
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.

Note that each of these examples involve permissible transfers of employees from one benefit *package* to another *package* but none expressly addresses when transfers from one *plan* to another would be for bona-fide employment reasons. This may be a simple drafting oversight, however, as examples 1, 2, and 4 would seem to apply equally to instances in which an entire plan is eliminated for the reasons stated. Clarification on this point would be welcomed.

The FAQ also addresses amendments to plan terms that exceed the thresholds set forth in the regulations. A plan amended in this way would cease to be a grandfathered plan when the amendment

becomes effective, not when it is adopted. Thus, calendar year plans should be amended effective as of the first of the succeeding calendar year, in order to avoid mid-year loss of grandfathered status.

The final FAQ concerns a plan that covers both retirees and active employees, is subject to the market reform requirements of PPACA, and uses a formula to determine employer contributions ($300 times the participant's years of service for the employer, capped at $10,000 per year). As the cost of coverage for active employees increases with their years of service, the employer's rate of contribution is fluid and difficult to measure against the percentage increases in the grandfathering regulations. Per the FAQ, if the formula does not change, the plan will not lose grandfathered status as a result of reduced employer contribution rates, regardless of any increase in the total cost of coverage. However if the dollar amount in the formula that is multiplied by years of service decreases by more than 5%, or if the $10,000 cap on employer contributions decreases by more than 5%, the plan will lose grandfathered status.

http://www.dol.gov/ebsa/faqs/faq-aca6.html