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FAQs on Grandfathered Plans

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The Patient Protection and Affordable Care Act (PPACA or Affordable Care Act), which was enacted on March 23, 2010, included many changes related to health care coverage and raised a number of questions for employers. To assist in implementing these changes, the Departments of Labor, Health and Human Services and Treasury (Departments) issued a series of guidance in the form of Frequently Asked Questions (FAQs).

This Legislative Brief sets out the FAQs issued by the Departments addressing the requirements for "grandfathered" plans. The Departments' FAQs are available at: **www.dol.gov/ebsa/healthreform/**

FAQs PART I

The Departments released the following implementation FAQs on grandfathered plans on Sept. 20, 2010.

Q1: After the interim final regulations on grandfathered health plans were issued, some issuers commented that they do not always have the information needed to know whether (or when) an employer plan sponsor changes its rate of contribution towards the cost of group health plan coverage. (Generally, the interim final regulations provide that a group health plan or health insurance coverage will cease to be a grandfathered health plan if the employer decreases its contribution rate based on cost of coverage towards the cost of coverage by more than 5 percentage points below the contribution rate on March 23, 2010.)

For purposes of determining whether an insured group health plan is a grandfathered health plan, what steps should issuers and employer plan sponsors take to communicate regarding changes to the plan sponsor's contribution rate?

The Departments have determined that, until the issuance of final regulations, they will not treat an insured group health plan that is a grandfathered plan as having ceased to be a grandfathered health plan immediately based on a change in the employer contribution rate if the employer plan sponsor and issuer take the following steps:

- Upon renewal, an issuer requires a plan sponsor to make a representation regarding its contribution rate for the plan year covered by the renewal, as well as its contribution rate on March 23, 2010 (if the issuer does not already have it); and

- The issuer's policies, certificates, or contracts of insurance disclose in a prominent and effective manner that plan sponsors are required to notify the issuer if the contribution rate changes at any point during the plan year.

For policies renewed prior to Jan. 1, 2011, issuers should take these steps no later than Jan. 1, 2011. If these steps are taken, an insured group health plan that is a grandfathered health plan will continue to be considered a grandfathered health plan.

The relief in this Q&A will no longer apply as of the earlier of the first date on which the issuer knows that there has been at least a 5-percentage-point reduction or the first date on which the plan no longer qualifies for grandfathered status without regard to the 5-percentage-point reduction.

Moreover, nothing in the Affordable Care Act or the interim final regulations prevents a policy, certificate, or contract of insurance from requiring a plan sponsor to notify an issuer in advance (for example, 30 or 60 days in advance) of a change in the contribution rate. It is expected that state laws may change frequently, as states review the impact of the health care reform law. Due to the rapidly changing nature of this topic, employers should make sure to confirm state law requirements with the applicable state agency before taking any action related to taxation of the value of health benefits.

Q2: Similarly, multiemployer plans do not always know whether (or when) a contributing employer changes its contribution rate as a percentage of the cost of coverage. What steps should multiemployer plans take to communicate with contributing employers regarding employer contributions towards coverage?

If multiemployer plans and contributing employers follow steps similar to those outlined in Q&A1, above, the same relief will apply to the multiemployer plan unless or until the multiemployer plan knows that the contribution rate has changed.

Q3: Also with respect to multiemployer plan coverage, some multiemployer plans have stated that it is common for such plans to have either a fixed-dollar employee contribution or no employee contribution towards the cost of coverage. In such cases, is it relevant if a contributing employer's contribution rate changes (for example, after making up a funding deficit in the prior year or to reflect a surplus), provided any changes in the coverage terms would not otherwise cause the plan to cease to be grandfathered and there continues to be no employee contribution or no increase in the fixed-dollar employee contribution towards the cost of coverage?

In this circumstance, if there is no increase in the employee contribution towards coverage and any changes in the coverage terms would not otherwise cause the plan to cease to be grandfathered, a change in a contributing employer's contribution rate will not, in and of itself, cause a plan that is otherwise a grandfathered health plan to cease to be a grandfathered health plan.

Q4: Are the Departments receiving other comments and questions regarding the grandfather regulations? Is more guidance expected?

The Departments invited comments on their interim final grandfather regulations, as well as on the appeals regulations and other provisions whose applicability is affected by status as a grandfathered health plan. The Departments have issued some sub-regulatory guidance on the appeals regulations and will continue to review and evaluate comments on these and other regulations, and might issue further sub-regulatory guidance on selected issues as comments are evaluated. Final regulations on the various interim final regulations recently issued under the Affordable Care Act are expected to be published beginning next year.

Q5: Will the Departments change the current rules so that a grandfathered group health plan that changes carriers does not relinquish its status as a grandfathered health plan?

The Departments anticipate that they will shortly address the circumstances under which grandfathered group health plans may change carriers without relinquishing their status as grandfathered health plans.

Note: The regulations initially provided that changing insurance companies or policies would cause a health plan to lose grandfathered plan status. However, on Nov. 15, 2010, the Departments released an amended rule. Under the amendment, a group health plan will not lose grandfathered status merely because of a change in the plan's insurance policy, certificate or contract of insurance, as long as the coverage under the new policy is effective on or after Nov. 15, 2010. Also, to maintain grandfathered status, the plan must provide documentation of the prior plan's terms to the new issuer.

FAQs PART II

The Departments issued the following implementation FAQs for grandfathered plans on Oct. 8, 2010.

Q6: Our company sponsors a group health plan for our employees that has been in effect since March 23, 2010. We and the issuer of the policy under the plan are considering whether we could make various changes to the plan without losing grandfathered status. If we avoid making any of the six specific changes described in paragraph (g)(1) of the interim final regulations relating to grandfathered health plans, are there other changes to our existing plan/policy that we need to be concerned could cause it to relinquish grandfathered status?

No. Paragraph (g)(1) of the Departments' interim final grandfather regulations provides that any of six changes (measured from March 23, 2010) are considered to change a health plan so significantly that they will cause a group health plan or health insurance coverage to relinquish grandfather status. Briefly stated, these six changes are:

1. Elimination of all or substantially all benefits to diagnose or treat a particular condition;

2. Increase in a percentage cost-sharing requirement (for example, raising an individual's coinsurance requirement from 20% to 25%);

3. Increase in a deductible or out-of-pocket maximum by an amount that exceeds medical inflation plus 15 percentage points;

4. Increase in a copayment by an amount that exceeds medical inflation plus 15 percentage points (or, if greater, $5 plus medical inflation);

5. Decrease in an employer's contribution rate towards the cost of coverage by more than 5 percentage points; or

6. Imposition of annual limits on the dollar value of all benefits below specified amounts.

For a plan that is continuing the same policy, these six changes are the only changes that would cause a cessation of grandfather status under the interim final regulations. (As noted, the Departments are separately considering under what circumstances otherwise grandfathered plans may change issuers without relinquishing their status as grandfathered health plans.)

As mentioned above, the Departments released additional guidance in November 2010, permitting grandfathered plans to change issuers without losing grandfathered status.

Q7: My plan offers three benefit package options – a PPO, a POS arrangement, and an HMO. If the HMO relinquishes grandfather status, does that mean that the PPO and POS arrangement must also relinquish grandfather status?

No. The grandfather analysis applies on a benefit-package-by-benefit-package basis. In this situation, it is permissible to treat the PPO, POS arrangement, and HMO as separate benefit packages. Accordingly, if any benefit package ceases grandfather status, it does not affect the grandfather status of the other benefit packages.

Q8: How do the Departments' interim final grandfather rules regarding changes in employer contributions apply where an employer restructures its tiers of coverage?

The interim final grandfather regulations provide that the standards of paragraph (g)(1)(v) for employer contributions (listed above as item (5) in Q&A-6) apply on a tier-by-tier basis. As a result, if a group health plan modifies the tiers of coverage it had on March 23, 2010 (for example, from self-only and family to a multi-tiered structure of self-only, self-plus-one, self-plus-two, and self-plus-three-or-more), the employer contribution for any new tier would be tested by comparison to the contribution rate for the corresponding tier on March 23, 2010. In this example, if the employer contribution rate for family coverage was 50 percent on March 23, 2010, the employer contribution rate for any new tier of coverage other than self-only (that is, self-plus-one, self-plus-two, self-plus-three or more) must be within 5 percentage points of 50% (that is, at least 45 percent).

If, however, the plan adds one or more new coverage tiers without eliminating or modifying any previous tiers and those new coverage tiers cover classes of individuals that were not covered previously under the plan, the new tiers would not be analyzed under the standards of paragraph (g)(1). Therefore, for example, if a plan with only a self-only coverage tier added a family coverage tier, the level of employer contribution toward the family coverage would not cause the plan to lose grandfather status.

Q9: If an employer plan sponsor raises the copayment level for a category of services (such as outpatient or primary care) by an amount that exceeds the standards set forth in paragraph (g)(1) of the interim final regulations, but retains the copayment level for other categories of services (such as inpatient care or specialty care), will that cause the plan to relinquish grandfather status?

Yes. Each change in cost sharing is separately tested against the paragraph (g)(1) standards of the Departments' interim final grandfather regulations.

Q10: How do the Departments' interim final grandfather regulations affect wellness programs sponsored by group health plans?

Group health plans may continue to provide incentives for wellness by providing premium discounts or additional benefits to reward healthy behaviors by participants or beneficiaries, by rewarding high quality providers, and by incorporating evidence-based treatments into benefit plans. However, penalties (such as cost-sharing surcharges) may implicate the paragraph (g)(1) standards listed above in Q&A-6 and should be examined carefully. In addition, plans should take steps to ensure compliance with applicable nondiscrimination rules (such as the HIPAA nondiscrimination rules for group health plans and group health insurance coverage with respect to an individual based on a health status related factor) and any other applicable federal or state law.

FAQs PART IV

The Departments issued the following implementation FAQs for grandfathered plans on Oct. 29, 2010.

Q11: The Departments' interim final grandfather regulations provide that, to maintain status as a grandfathered health plan, a group health plan or health insurance coverage must include a statement, in any plan materials provided to a participant or beneficiary describing the benefits provided under the plan or health insurance coverage, that the plan or coverage believes it is a grandfathered health plan. Must a grandfathered health plan provide the disclosure statement every time it sends out a communication, such as an EOB (explanation of benefits), to a participant or beneficiary? If not, how does a grandfathered health plan comply with this disclosure requirement?

A grandfathered health plan will comply with this disclosure requirement if it includes the model disclosure language provided in the Departments' interim final grandfather regulations (or a similar statement) whenever a summary of the benefits under the plan is provided to participants and beneficiaries. For example, many plans distribute summary plan descriptions upon initial eligibility to receive benefits under the plan or coverage, during an open enrollment period, or upon other opportunities to enroll in, renew, or change coverage. While it is not necessary to include the disclosure statement with each plan or issuer communication to participants and beneficiaries (such as an EOB), the Departments encourage plan sponsors and issuers to identify other communications in which disclosure of grandfather status would be appropriate and consistent with the goal of providing participants and beneficiaries information necessary to understand and make informed choices regarding health coverage.

Q12: If an individual health insurance policy that was in place on March 23, 2010 included a feature that allowed a policy holder to elect an option under which he or she would pay a reduced premium in exchange for higher cost sharing, could such an election be made after March 23 without affecting the policy's grandfather status even if the increase in cost sharing for the individual would exceed the limits under the grandfather rule on increases in cost sharing?

Yes. The cost-sharing level that would apply under this option would be grandfathered as part of the policy in place on March 23, 2010 even if it did not apply for the particular individual at that time. As long as the policy holder had that option available on March 23 under the policy, he or she could exercise the option after March 23 without affecting grandfather status, even if the result would be that the particular individual's cost-sharing would increase as a result of electing this option by an amount in excess of the grandfather rule limits.

FAQs PART V

The Departments issued the following implementation FAQ for grandfathered plans in December 2010.

Q13: My plan terms include out-of-pocket spending limits that are based on a formula (a fixed percentage of an employee's prior year compensation). If the formula stays the same, but a change in earnings results in a change to the out-of-pocket limits such that the change exceeds the thresholds allowed under paragraph (g)(1) of the interim final regulations relating to grandfathered health plans, will my plan relinquish grandfather status?

No. The Departments have determined that if a plan or coverage has a fixed-amount cost-sharing requirement other than a copayment (for example, a deductible or out-of-pocket limit) that is based on a percentage-of-compensation formula, that cost-sharing arrangement will not cause the plan or coverage to cease to be a grandfathered health plan as long as the formula remains the same as that which was in effect on March 23, 2010. Accordingly, if the percentage-of-compensation formula for determining an out-of-pocket limit is unchanged and an employee's compensation increases, then the employee could face a higher out-of-pocket limit, but that change would not cause the plan to relinquish grandfather status.

FAQs PART VI

The Departments issued the following implementation FAQs for grandfathered plans in April 2011.

Q14: 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.

Q15: 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.

Q16: A previous FAQ addressed the interaction of value-based insurance design (VBID) and the no costsharing preventive care services requirements. See 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 innetwork 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.

Q17: 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.

Q18: 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 stat us 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.

Q19: 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.

Source: Departments of Health and Human Services, Labor and Treasury