New Health Care Reform FAQs Expand Grounds for Terminating Plan Options Without Losing Grandfathered Status

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Frequently Asked Questions – and the answers -- issued this month by the government may provide some welcome relief for employers with grandfathered health plans who are thinking of terminating a health plan option. They also clarify issues relating to plan amendments, employer contribution rates, prescription drug coverage and value-based insurance designs.

Terminating plan options without losing grandfathered status

Under Health Care Reform, employers with grandfathered health plans must tread carefully before terminating a medical benefit package, as it may jeopardize the grandfathered status of its other medical benefit packages. Under the grandfathering regulations' anti-abuse rule, if an employer terminates a medical benefit package and moves employees to another package, and the differences between the two packages are significant, the benefit package into which employees are moved will lose its grandfathered status if there is not a "bona fide employment-based reason" for the change. The regulations go on to explain that eliminating a medical benefit package because of its high costs would not be considered a bona fide employment-based reason, suggesting that this exception is meant to be fairly narrow.

With the new FAQs, however, the agencies are clarifying and perhaps even expanding the types of circumstances that will be considered bona fide employment-based reasons for terminating a medical benefits package. These circumstances now include:

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

- 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 FAQs also clarify that this is not intended to be an exhaustive list. There may be other facts and circumstances under which a benefit package is being eliminated for a bona fide employment-based reason.

Of course, these restrictions only apply to grandfathered plans. If your plan is no longer grandfathered, then you will not have to worry whether you have a bona fide employment-based reason for eliminating a benefit option.

Moving brand-name prescription drugs between tiers

The grandfathering rules impose significant restrictions on the ability of an employer to change the copay and coinsurance amounts in its plan. Fixed-amount copayments may only be increased by the greater of $5 or an inflation-adjustment factor from the amounts charged on March 23, 2010 (the date Health Care Reform became law). And when the co-pay is a percentage of the cost, the percentage may not change at all.

This has created some questions relating to prescription drugs, particularly when a drug moves from one tier of coverage to another. Plans offering prescription drug coverage often have one tier (with the lowest copay) for generic drugs, a second tier (with a higher copay) for brand-name drugs for which there are no generic equivalents, and a third tier (with an even higher copay) for brand-name drugs for which there are generic equivalents. In any given year, as generic drugs are introduced into the market, brand-name drugs may move from the second tier to the third tier with a higher copay. The new FAQs clarify that this movement between tiers will not cause the plan to lose its grandfathered status.

Value-based insurance designs and preventive care services

Some employers are beginning to experiment with value-based insurance designs, which seek to identify and reduce the costs of higher-valued medical services. As an incentive for cost-effective use of medical services, these kinds of plans may cover the entire cost of preventive care services when performed in certain settings (such as an in-network ambulatory surgery center) but require a copayment when the services are performed in other settings (such as an in-network outpatient hospital setting). Health Care Reform, of course, requires that preventive care services be covered 100% by the plan, but previous FAQs have indicated that the value-based plan could charge a copay for preventive services in some situations as long as there was an alternative without cost sharing and the copayment in the less-desired setting was waived when it would be medically inappropriate to have the preventive services provided in the more desirable setting.

The new FAQs now clarify that a plan that wants to implement these kinds of value-based features may do so without relinquishing grandfather status. The agencies also indicated that they are collecting more information on value-based designs and wellness programs, and will be providing more guidance in how such features can be implemented without relinquishing grandfather status.

When does a significant plan amendment cause a plan to lose its grandfathered status?

If a plan makes changes to its benefits in a way that causes it to lose its grandfathered status, when does the new non-grandfathered status take effect? The FAQs clarify that it is the date that the changes go into effect, and not the date that the plan is actually amended. Thus, if a calendar-year plan amends its benefits on November 1, 2011, but the amendments do not go into effect until January 1, 2012, the plan will not lose its grandfathered status until January 1, 2012.

On the other hand, if the amendment were to take effect immediately on November 1, 2011, the plan would immediately lose its grandfathered status and have to comply with all Health Care Reform requirements on November 1, 2011.

Employer contributions determined through a formula

An employer that wants to continue the grandfathered status of its medical plan is prohibited from decreasing its contribution rate to the plan by more than 5 percent of the rate in effect on March 23, 2010.

If the employer's contribution is based on the cost of the coverage, then the contribution rate is based on the percentage of the total cost that was covered by the employer on March 23, 2010. Under this percentage approach, if the cost of providing that coverage increases, the employer will likely have to increase the dollar amount of its contribution in order to maintain the required contribution percentage.

On the other hand, if the employer has been using a formula for determining the contribution amount (for example, a formula based on years of service or number of hours worked), the formula itself is considered the contribution rate. The new FAQs clarify that when a formula is in use, it does not matter whether the cost of coverage increases, so long as the formula itself does not decrease by more than 5 percentage points from the formula in place on March 23, 2010. Thus, the focus is on whether the formula still produces the same contribution dollar amount, and not on the overall cost of the coverage.

If you have questions about the grandfathering regulations, or about Health Care Reform in general, please contact Norbert F. Kugele (nkugele@wnj.com or at 616.752.2186) or any other member of Warner Norcross & Judd LLP's Health Care Reform Taskforce.