

Your Annual Status Checkup: Grandfathered or New?

At your last renewal, you had to determine whether your plan was “grandfathered” or “new”.

If your plan was “new” at your last renewal, then you can skip to Action Steps – New Plan Second Renewal. Your plan does not get any special considerations that a grandfathered plan gets.

If your plan was “grandfathered” last year, you will need to do this check again to make sure that it is still grandfathered.

Grandfathered plans do not have to make certain health reform-related changes. In order for a plan to be considered grandfathered, only certain changes are permitted after March 23, 2010. If you offer employees a choice of plans, such as an HMO and a PPO, each plan needs to be considered separately. One plan might be grandfathered while the other is new.

If you are transferring employees from one grandfathered plan (Plan A) to another (Plan B), then Plan B will very likely lose its grandfathered status unless there is a “bona fide employment-based reason” for the transfer. Examples of acceptable reasons are below:

- The insurer offering the plan is leaving the market.
- The plan has low or shrinking enrollment that makes it impractical for the employer to continue offering the plan.
- There are other plans available that cover a significant share of the employees.

You should consult your plan administrator or a benefits attorney if you will be discontinuing a grandfathered plan at your next renewal.

This section helps to guide you to determine your plan status

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Determining Status Checklist

Below is a quick checklist to help you determine if your plan can have grandfathered status.

At the next renewal, is the plan . . .	Yes/No
Eliminating a covered service or benefit?	
Decreasing by more than 5% the percentage of premiums paid by the employer? ¹	
Increasing the fixed cost-sharing percentage that members pay for covered services?	
Increasing the members' fixed amount deductible, coinsurance, or out-of-pocket limit by more than medical inflation ² plus 15%?	
Increasing co-pays by more than medical inflation plus 15% or, if greater, by \$5.00?	
Adding or lowering annual benefit limits?	

After completing the checklist, if you have answered "YES" to any questions, it is unlikely your plan can be considered "grandfathered." However, there are some exceptions, such as vision and dental plans, union plans, and retiree-only plans. Consult an attorney or your plan administrator.

There are some changes that you can make and still have your plan be considered "grandfathered."

The plan can do any of the following and still be considered "grandfathered":	
Have an open enrollment	
Increase benefits or the employer's contribution to premiums	
Make any changes needed to follow federal, state, or health reform requirements	
Add a benefit or expand a benefit listed in health reform voluntarily	
Change your third party administrator (TPA)	
Renew your plan's policy, contract or certificate of insurance or enter into a new contract that does not violate the grandfather rules that applied to the	

¹ If the employer contribution is based upon a formula and the formula is not changed, then the plan can still be considered "grandfathered" even if the employer's total contribution goes down by more than five percent.

² Medical inflation was 2.9% unadjusted for the 12 months ending June 2011. Source: U.S. Bureau of Labor Statistics.

original contract	
Make other changes that were legally committed to before March 23, 2010	
Move a brand name drug into a higher cost-sharing tier, when a generic version becomes available	

Requirements for Grandfathered Plans – Second Renewal

If your plan has kept its status as “grandfathered”, then there are some health reform requirements that your plan escaped last year and will escape again this year. There are, however, some steps that even your grandfathered plan had to take. At your first renewal after September 23, 2010, your grandfathered plan had to:

- Cover dependents up to age 26
- Cover pre-existing conditions for children up to age 19
- On essential health benefits, have no lifetime limits, and annual limits must increase each year
- Rescind coverage **only** if a member lied or committed fraud
- Stop covering over-the-counter drugs that are not prescribed in flexible spending account (FSA) or health reimbursement account (HRA) plans
- Give all members a notice that the plan is considered grandfathered, and maintain documents showing coverage in effect on March 23, 1010.

At your second renewal after September 23, 2010, you will not need to re-do these things. Instead, there are a few additional items for your list.

! Action Steps for Grandfathered Plans – Second Renewal

- Set up systems for reporting the cost of group health insurance on employees’ W-2 forms.
 - Take into account whether federal income tax applies to any part of your plans’ dependent coverage. (See W-2 section.)
- Review annual limits for essential health benefits and raise them to the 2012 minimum required. (See Essential Health Benefits.)

Requirements for New Plans or Those Not Grandfathered – First Renewal

If your plan(s) will be “new” for the first time this year, then your plan is required to do a few more things. Here is the list:

- On essential health services, have no lifetime limits, and annual limits must increase each year.
- Rescind coverage **only** if a member lied or committed fraud.
- Report group health insurance value on employees’ W-2 forms.
- Cover certain preventive services with no cost sharing.
- Allow members to choose out-of-network primary care providers, and see an OB-GYN without a referral.
- Lift any pre-authorization or cost-sharing penalty on emergency care.
- Have a process for members to appeal claims decisions externally. (See “Appeals.”)

! Action Steps for All Non-Grandfathered Plans – First Renewal

- Set up systems for reporting the cost of group health insurance on employees' W-2 forms.
 - Take into account whether your state is taxing any part of your plans' dependent coverage. (See W-2 section.)
- Review annual limits for essential health benefits and raise them to the minimum required. (See Essential Health Benefits section.)
- See checklists for
 - Preventive services
 - Appeals
- Review and adjust plan provisions for
 - Out-of-network providers
 - Referral requirements for OB-GYNs
 - Pre-authorization or penalties on emergency care
 - Cancellation of members' coverage

! Action Steps for All Non-Grandfathered Plans – Second Renewal

If your plan was “new” last year, then you have already made the changes to your preventive services and appeals. However, new information has come out about appeals, so we include it on your action list. Your plan provisions for out-of-network providers, referrals for OB-GYNs, emergency care, and cancelling coverage should have been updated at your first renewal as a “new” plan.

- Set up systems for reporting the cost of group health insurance on employees' W-2 forms.
 - Take into account whether federal income tax applies to any part of your plans' dependent coverage.
- See new info on appeals. (See Appeals.)

And what about . . .

Automatic enrollment?

Notably absent from the action steps is creating an automatic enrollment process for your group health plan. Indeed, the Fair Labor Standards Act was amended in 2010 to require employers with 200 or more full-time employees to automatically enroll employees into the group health plan. However, employers do not have to comply until regulations are published. The regulations should be available sometime before 2014. Until then, employers only have to enroll those who actively sign up.

Insured plans for high-paid employees?

Also missing from the action steps is discontinuing health plans that discriminated in favor of highly-compensated employees. Similar to the automatic enrollment provision, this too will be delayed until regulations are published. Though the word “plan” is used, the kinds of things that will be prohibited are not insurance plans but rather practices that give executives more health benefit. For example, a practice of giving executives a shorter waiting period or charging them less for family coverage.

Grandfathered plans will be able to keep these plans until 2014, even if regulations come out before then.

Flexible spending accounts (FSAs) annual limit?

You have another year before the \$2,500 maximum begins. If your plan allows employees to put a great deal more than \$2,500 into their FSA, you might want to forewarn them about the 2013 limit. After December 31, 2012, your FSA can offer only \$2,500 tax free (unless Congress relents to pressures from interest groups to raise or even eliminate this cap.)