



WHAT IT MEANS TO BE A GRANDFATHERED PLAN

A grandfathered plan is a plan that was in place as of March 23, 2010, or in place as part of a collective bargaining agreement that was ratified before March 23, 2010. Grandfathered plans may allow new employees to enroll as well as allow current participants to re-enroll, change coverage, and add/drop dependents. Additional changes made to a plan beyond the parameters described below will result in the loss of grandfathered status, which will cause the plan to be subject to the full requirements of the Reform laws.

Grandfathered plans must disclose to participants every time it distributes materials that the plan is grandfathered and is not subject to some requirements of the Affordable Care Act, including contact information for enrollees to have their questions and complaints addressed. This information should be incorporated into any open enrollment materials.

Changes that will result in a LOSS of grandfathered status:

1. Cannot significantly cut or reduce benefits.
2. Cannot raise the percentage of co-insurance charges required under the plan.
3. Cannot significantly raise co-payment charges- grandfathered health plans may not raise co-payment charges more than the greater of \$5 (adjusted annually for medical inflation) or a percentage equal to medical inflation plus 15 percentage points.
4. Cannot significantly lower employer contributions- grandfathered plans cannot decrease the percentage of the premium paid by the employer by more than 5 percentage points.
5. Cannot significantly raise deductibles- grandfathered plans may not raise deductibles by a percentage equal to medical inflation plus 15 percentage points.
6. Cannot add or tighten an annual limit on what the insurer pays- grandfathered plans cannot tighten any annual dollar limit in place as of 3/23/10, and plans with no annual limit cannot put one in place unless they are replacing a lifetime dollar limit with an annual dollar limit that is at least as high as the lifetime limit. This is viewed as more protective of high-cost enrollees.
7. Cannot change insurance companies- this does not apply when employers that provide their own insurance to their workers switch plan administrators or to collective bargaining agreements.
8. A plan will also lose grandfathered status if it forces participants to switch to another grandfathered plan that has less benefits or costs more or if it is bought by or merges with another plan in an effort to avoid complying with the law.

Grandfathered plans are exempt from the following requirements:

1. Nondiscrimination rules. (Effective at renewal after 9/23/10)
2. Essential benefits with no cost sharing requirements. (Effective at renewal after 9/23/10)
3. Expanded appeal process. (Effective at renewal after 9/23/10)
4. Preventive care coverage requirements. (Effective at renewal after 9/23/10)
5. Emergency services coverage with no prior authorization at in-network rates (Effective at renewal after 9/23/10)
6. Clinical trial coverage. (Effective at renewal after 9/23/10)
7. Choice of primary care physician, even if pediatrician or OB/GYN. (Effective at renewal after 9/23/10)
8. No annual reporting to Health and Human Services required regarding healthcare quality and wellness programs. (Effective at renewal after 9/23/10)
9. Cost sharing limits and deductible limitations (January 2014)

Grandfathered plans are subject to the following provisions:

Effective 2010	
Protection for Nursing Mothers	Employers covered by the Fair Labor Standards Act (FLSA) must provide “reasonable” breaks to mothers to express milk for their infants who are up to one year old; a private space other than a restroom must also be provided. This amendment does not apply to employers with fewer than 50 employees if its requirements would “impose an undue hardship by causing the employer significant difficulty or expense.” The time does not have to be paid under FLSA. Many states have similar laws and the requirements of both the federal and state laws must be complied with as applicable to provide the greatest protection to employees.
Retaliation Provisions	Employers may not discriminate or retaliate against any individual who makes a complaint about noncompliance with the Reform laws, receives any subsidy, or participates in the Exchanges.

Effective at Renewal After 9/23/10	
Limits on Coverage	Lifetime caps on coverage are prohibited. Annual caps are also prohibited; however, between now and 2014 plans may place limits on nonessential benefits only.
No Rescission of Coverage	Plans may not cancel the policies of people who fall ill. Policies can only be cancelled if the participant engaged in fraud or intentional misrepresentation of material fact.
Pre-Existing Conditions	Children under the age of 19 with pre-existing conditions can not be denied coverage.
Adult Child Coverage Requirements	Dependent children must be offered coverage under their parents’ plans until they turn 26 whether married or unmarried. Adult child coverage is exempt from federal taxes through the end of the tax year in which the dependent turns 26. For grandfathered plans an adult child is not required to be covered if other employer-sponsored group health coverage is available (applies only until 2014, when every plan will have this requirement).
W-2 Reporting	The cost of employer-sponsored coverage must be reported each year on the employee’s W-2; excludes FSAs, HRAs, and Archer medical savings accounts.
Uniform Summary of Benefits	HHS will develop standards by March 23, 2011 for providing summaries of benefits and coverage explanations. Uniform summaries of benefits must be provided to plan participants by March 23, 2012. Notice of material modifications to plan benefits thereafter must be provided at least 60 days before they become effective.
Long-Term Care	A new public long-term care program will require all employers to enroll employees unless the employee elects to opt out.
Auto-Enrollment	Employers with 200 or more employees must automatically enroll employees in their group health plan and allow employees the opportunity to opt out if they can demonstrate they have other coverage.

Effective 2012	
Per-Head Fee	Insured and self-insured plans will be charged a \$2 fee for each covered life under the plan for each plan year ending after September 30, 2012 (\$1 for plan years ending during fiscal year 2013). In 2014, the per-head charge will increase by the percentage increase in health care spending and does not apply to plan years ending after September 30, 2019. The fees collected will fund a “Patient-Centered Outcomes Research Trust Fund.”

Effective 2013	
Employee Notice	By March 1, 2013, employers must provide notice to employees regarding the availability of the insurance exchange, the availability of premium credits and cost-share reductions if the plan's share of the costs of benefits is less than 60%, and that if the employee purchases coverage through an exchange and the employer is providing minimum essential coverage the employee will lose the benefit of the employer subsidy under the plan. New employees must receive this notice at their time of hire beginning March 1, 2013.
Taxes for High-Income Families	Families with annual gross income higher than \$250,000 will have additional 3.8% tax on all investment income and contribute higher amounts to Medicare through payroll taxes.

Effective 2014	
Guaranteed Coverage	Coverage must be available to everyone with no pre-existing conditions exclusions or rescissions of coverage.
Employer-Sponsored Coverage	<ul style="list-style-type: none"> • Group health plans will be prohibited from setting rates or denying coverage based on pre-existing conditions, from placing excessive waiting periods on eligibility for benefits for new hires (90-day maximum), and from placing annual and lifetime dollar limits on benefits. Insurers will only be able to vary premiums based on geographic location, age, and tobacco use. • Employers that offer coverage must also provide a "free choice voucher" to any employees with incomes between 133% and 400% of the federal poverty level (currently about \$29,327 to \$88,000 for a family of four) if that employee's share of the premium is between 8% and 9.8% of his or her income and the employee enrolls in an exchange. The amount of the voucher is the amount the employer would have paid for the employee under the employer's group health plan. Employers providing free choice vouchers are exempt from the penalties for employees receiving premium credits for coverage purchased through the exchange. Free choice vouchers are not taxable income. • "Play or Pay" = Tax penalties will be assessed for companies with 50 or more FTE employees that do not provide health insurance of up to \$2,000 per employee, with the first 30 employees being exempt. • Any employer with more than 50 employees that does not offer coverage but has at least 1 full time employee receiving the premium assistance tax credit to purchase coverage through the exchange will be required to pay the lesser of \$3,000 for each employee receiving that credit or \$750 for each of their full time employees total.

NON-GRANDFATHERED PLANS are subject to the full Reform laws:

Effective 2010	
Protection for Nursing Mothers	Employers covered by the Fair Labor Standards Act (FLSA) must provide “reasonable” breaks to mothers to express milk for their infants who are up to one year old; a private space other than a restroom must also be provided. This amendment does not apply to employers with fewer than 50 employees if its requirements would pose an undue hardship. The time does not have to be paid under FLSA, but may be paid under applicable state law. Many states have similar laws and the requirements of both the federal and state laws must be complied with as applicable to provide the greatest protection to employees.
Retaliation Provisions	Employers may not discriminate or retaliate against any individual who makes a complaint about noncompliance with the Reform laws, receives any subsidy, or participates in the Exchanges.
Effective at Renewal After 9/23/10	
Limits on Coverage	Lifetime caps on coverage are prohibited. Annual caps are also prohibited; however, between now and 2014 plans may place limits on nonessential benefits only.
No Rescission of Coverage	Plans may not cancel the policies of people who fall ill. Policies can only be cancelled if the participant engaged in fraud or intentional misrepresentation of material fact.
Pre-Existing Conditions	Children under the age of 19 with pre-existing conditions can not be denied coverage.
Adult Child Coverage Requirements	Dependent children must be offered coverage under their parents’ plans until they turn 27 whether married or unmarried. Adult child coverage is exempt from federal taxes. For grandfathered plans an adult child is not required to be covered if other employer-sponsored group health coverage is available (applies only until 2014, when every plan will have this requirement).
Preventative Care	Coverage for preventative care must be covered without cost sharing, including immunizations, preventative care and screenings for infants and adolescents, and preventative care for women. Prior authorization and referrals for OB/GYN services are prohibited.
Emergency Services	Participants may use emergency services without prior authorization and at in-network rates, even if the emergency facility or provider is out-of-network.
Primary Care Providers	Plans that require participants to establish a primary care provider must allow any available participating provider to be used as a primary care provider, including pediatricians.
Appeals Process Expanded	Plans must establish an effective external appeals process that meets or exceeds state law or the NAIC model. Notice of these processes and the availability of any assistance must be provided to enrollees in a culturally and linguistically appropriate manner, meaning that notices may need to be provided in multiple languages. Enrollees must be allowed to review their files, present evidence and testimony, and receive continued coverage pending the outcome of the appeals process.
Non-Discrimination Rules Expanded	Insured and uninsured plans may not discriminate in favor of highly compensated employees (those earning in the top 25% at their employer).
Auto-Enrollment	Employers with 200 or more employees must automatically enroll employees in their group health plan and allow employees the opportunity to opt out if they can demonstrate they have other coverage.

Effective 2011	
Medical FSAs, HSAs, and HRAs	Over-the-counter drugs may no longer be reimbursed through medical FSAs, HSAs, or HRAs unless the health care provider provides a written prescription.
W-2 Reporting	The cost of employer-sponsored coverage must be reported each year on the employee's W-2; excludes FSAs, HRAs and Archer MSAs.
Long-Term Care	A new public long-term care program will require all employers to enroll employees unless the employee elects to opt out (CLASS Act).
Uniform Summary of Benefits	HHS will develop standards by March 23, 2011 for providing summaries of benefits and coverage explanations. Uniform summaries of benefits must be provided to plan participants by March 23, 2012. Notice of material modifications to plan benefits thereafter must be provided at least 60 days before they become effective.
Penalties for Non-Qualified Distributions from HSAs and Archer MSAs	The tax imposed on non-qualified distributions increases from 10% to 20%.

Effective 2012	
Per-Head Fee	Insured and self-insured plans will be charged a \$2 fee for each covered life under the plan for each plan year ending after September 30, 2012 (\$1 for plan years ending during fiscal year 2013). In 2014, the per-head charge will increase by the percentage increase in health care spending and does not apply to plan years ending after September 30, 2019. The fees collected will fund a "Patient-Centered Outcomes Research Trust Fund."

Effective 2013	
Medical FSA Limits	There will be an annual limit on the maximum election for medical FSAs of \$2500 per year. Cost of living increases may occur annually thereafter.
Employee Notice	By March 1, 2013, employers must provide notice to employees regarding the availability of the insurance exchange, the availability of premium credits and cost-share reductions if the plan's share of the costs of benefits is less than 60%, and that if the employee purchases coverage through an exchange and the employer is providing minimum essential coverage the employee will lose the benefit of the employer subsidy under the plan. New employees must receive this notice at their time of hire beginning March 1, 2013.
Taxation of Retiree Drug Subsidies (Medicare Part D)	Employers will be taxed on subsidies they receive for maintaining retiree drug coverage for Medicare-eligible employees. Employers will be required to report any subsidies they receive for providing creditable prescription drug plans for their retirees as gross income.
Taxes for High-Income Families	Families with annual gross income higher than \$250,000 will have additional 3.8% tax on all investment income and contribute higher amounts to Medicare through payroll taxes.

Effective 2014	
Guaranteed Coverage	Coverage must be available to everyone with no pre-existing conditions exclusions or recissions of coverage.
Essential Benefits	HHS will establish essential benefits and types of coverage required of all plans. Essential benefits must include at least: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, clinical trial participation, mental health and substance use disorder services including behavioral health treatment, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventative and wellness services and chronic disease management, and pediatric services including oral and vision care.
Employer-Sponsored Coverage	<ul style="list-style-type: none"> • Group health plans will be prohibited from setting rates or denying coverage based on pre-existing conditions, from placing excessive waiting periods on eligibility for benefits for new hires (90-day maximum), and from placing annual and lifetime dollar limits on benefits. Insurers will only be able to vary premiums based on geographic location, age, and tobacco use. • Employers that offer coverage must also provide a “free choice voucher” to any employees with incomes between 133% and 400% of the federal poverty level (currently about \$29,327 to \$88,000 for a family of four) if that employee’s share of the premium is between 8% and 9.8% of his or her income and the employee enrolls in an exchange. The amount of the voucher is the amount the employer would have paid for the employee under the employer’s group health plan. Employers providing free choice vouchers are exempt from the penalties for employees receiving premium credits for coverage purchased through the exchange. Free choice vouchers are not taxable income. • “Play or Pay” = Tax penalties will be assessed for companies with 50 or more FTE employees that do not provide health insurance of up to \$2,000 per employee, with the first 30 employees being exempt. • Any employer with more than 50 employees that does not offer coverage but has at least 1 full time employee receiving the premium assistance tax credit to purchase coverage through the exchange will be required to pay the lesser of \$3,000 for each employee receiving that credit or \$750 for each of their full time employees total.

Effective 2018	
Tax on Cadillac Health Plans	Employers will be taxed on high-end “Cadillac” health plans (those with premiums of \$10,200 or more for singles and \$27,500 for families) each year. The excess premium will be subject to a 40% tax. HSAs, HRAs and FSAs are included for purposes of calculating this tax. Free-standing dental and vision benefits are not taxable benefits for purposes of determining this tax.

In response to the Patient Protection and Affordable Care Act and the Health Care and Education Tax Credit Reconciliation Act, collectively known as Health Care Reform, Kistler Tiffany Benefits has formed a Health Care Reform committee to monitor legislation and provide guidance to our valued clients. Our team is creating user-friendly tools and resources, as well as establishing best practices for our clients in regards to the application of this legislation. For more information regarding our services, please contact us at reform@ktbenefits.com.