# #20 - A Review of Health Care Reform Patient Protection and Affordable Care Act© 3/23/2010 (for the years 2010, 2011, 2012, 2013)

## *"To Grandfather or not to Grandfather, that is the question."*

The impact of health care reform on the costs of health care plans is currently unknown. When a plan is grandfathered, you exchange the ability to make changes (within limits – II.D, #8-10) to your health care plan now, for more options in the future. You can wait and see the affect of health care reform before you jump in.

I. Summary of Health Care Reform Implementation

II. Grandfathering: Small, Large 100+, Insured or Self-Insured Groups – For Advantages see II. A & B, For Changes Allowed see II. C & D

III. Did you decide to Grandfather your plan? See III. Disclosure of Status Note:

A. If (since 3/23/2010) you have already made "large plan" changes – outside allowable limits (see II. D. below) you are not a Grandfathered plan. Your plan will be one of four levels of coverage in 2014 made up of "Essential Benefits" (not defined as of yet.)

B. One disadvantage of Grandfathering is that you must stay with the same insurer (see II. D. #4 below)

C. No matter what status you assume, make sure you review your D&O, EPL, EBL, and the Fiduciary Liability Coverage. "Your plan beneficiary's interest should be your prime concern."

Note: This is only a brief description of the subject. Please refer to insurance company materials or HHS for more details and Q&A.

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***~ Please call Dave or Jon Trapp at 784-5433 with your questions. ~***

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10/18/10

# "Past Updates or Publications for Clients of the A Companies"

1. *Brief summary for COBRA for the Employer*. (10/22/88)

2. *Structure and Rationale for Section 89(k) and Section 89*. (12/88)

3. Rose E. and Raymond A. Reader's, *Quick and Easy Reading Improvement Book*. (4/91) Read faster and better to really be in the technical age. 30 pages.

4. *52 COBRA Questions and Answers*. (2/92)

5. *Family Medical Leave Act (FMLA) – as it relates to Worker's Compensation and COBRA*. (2/1/96)

6. *Due Diligence Risk Evaluation for Mergers and Acquisitions*. (4/97)

7. HIPPA- *Your Health Insurance Reform Survival Kit*. (6/97) Federal effective 7/1/99 and WI #289 Effective 5/1/97.

8. *Your Facts 2000*-Compendium of Many Facts and All Other Tables of Any Possible Interest. (11/99) 140 pages of everything you need to know.

9. *Comparison of Defined Contribution Accounts – FSA, HRA and HSA*. (2/18/04)

10. *Helping you with HIPAA(PHI)©.* (3/29/04) The Law, Your Manual and all necessary forms. 36 pages

11. *Primer on Group Health Contracts – Different Types of Insuring* (12/14/05)

12. *Comparative Cost of a Similar Market Basket of Drugs and the PBM's that Distribute Them* ©. (1/23/06)

13. *Health Care Reform in the U.S. and Wisconsin: A Comparison of all Plans and Proposals*. Care Cooperative's proposal included. (2/07) 34 pages

14. *Pre-tax Plans that can Simplify Your Health Insurance* (7/6/09)

15. *Plans at a Glance: HRAs, HSAs and FSAs*. (8/06) Updated 7/6/09 for 2010 Plan Year

16. *How to Use your Health Insurance and Medical Services Wisely* (10/10/07) The problem of over treatment and employee instructions.

17. *Helping Employers and Employees Understand the Process of Applying for Medicare, Advantage Plans, Medicare Supplement Plans and Part D Plans* (4/22/08) Summary of Trigger Events and Dates of Enrollment in Medicare. 5th Edition (10/08/10)

18. *Brief Summary of What is Possible and Legal in Designing Employer Wellness Programs* (6/24/08)

19. *Summary of the Wisconsin Long Term Care Insurance Partnership Plan Act Effective 1/1/2009* (1/12/09) (rev. 9/22/10)

20. *A Review of Health Care Reform Patient Protection and Affordable Care Act and "Grandfathering" 3/23/2010* 9/23/2010 (rev. 10/18/10)


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# I. Health Care Reform Implementation Timeline

**Quick reference timeline** (**P** = affects plan design)
(**A** = applies to all plans – All Groups & Individuals)

| | | |
|---|---|---|
| Effective upon enactment (3/23/10) | 2010 | P Automatic Enrollment for 200+ employees – await regulations - employee can opt out<br><br>10% "vice" tax on indoor tanning<br><br>P 35% tax credit for businesses with 25 or fewer employees that offer health insurance (25% for tax exempt employers) |
| Effective 90 days following enactment (6/23/10) | | High Risk Pool – For individuals – HHS Application<br><br>P Temporary Health insurance and a drug subsidy for employers with Workers age 55 and older (and their family members) who retire early |
| Effective plan years or renewals beginning on or after September 23, 2010<br><br>*** Grandfathered plans exempt by disclosure. A=Applies to non-Grandfather plans.<br>All plans are not exempt.<br><br>(See attachment.) | | PA Adult Children Coverage to age 26 (Wis. Age 27)<br>***Grandfathered plans may exclude adult children covered under another group plan until 2014.<br><br>PA No restricted annual dollar limits in-network on "Essential Benefits" (to be defined).<br><br>PA No Lifetime Limits In-Network on "Essential Benefits" (to be defined)<br><br>PA No Group Preexisting Condition Exclusions for enrollees under age 19. No Individual or Group Exclusions after 1/1/2014.<br><br>PA No Rescissions (primarily individual and small group coverage)<br><br>PA First Dollar 100% Coverage (A&B Services) for more Preventive Care In-Network*** (6/14/10 – Patient Protection Act)<br><br>PA Revised Appeals Process (effective NAIC Model/HHS)***<br>(*See II.B.1.a-d/h-k below)<br><br>PA Non-discrimination Rules Extended to Insured Plans - May not favor the highly compensated***<br><br>PA All Emergency Services without prior authorization/treated as in-Network *** (6/14/10 Patient Protection Act)<br><br>PA Choice of Providers (pediatrician and OB-GYN)*** – All in-network – no preauthorization or referral |
| Effective 1/1/2011 | 2011 | 20% penalty for individuals under age 65 who take distributions from Health Savings Accounts or Archer Medical Savings Accounts for non-medical purposes.<br><br>Aggregate value of health coverage must be reported on employees' W-2 forms. 2011 values must be shown in 2012 reporting.<br><br>P Flexible Spending Accounts will no longer allow reimbursement for over-the-counter medications without a prescription (insulin excluded.)<br><br>Pharmaceutical manufacturing companies face a tax levy based on the entity's branded prescription drug or biological product sales. The first year revenue is set at $2.5 billion.<br><br>P "Class" Long Term Care effective<br>(per HHS not effective unti 10/1/2012) |

| | | |
|---|---|---|
| March 23, 2012 | 2012 | PA Uniform Explanation of Coverage<br><br>PA 4 page pre-enrollment coverage document sent outlining benefits and exclusions<br><br>PA 60-Day Notice in Advance of Material Modifications |
| January 1, 2013 | 2013 | Medicare Tax Increase for High-Earners<br><br>PA No Deduction for Retiree Drug Subsidy<br><br>Comparative Effectiveness Fee (policy years ending after November 30, 2012)<br><br>Patient-Centered Outcomes Research Trust Fund collects fees from medical insurers and self-insured plans at a rate of $1 per covered individual until 2013, increasing $2 in 2014, ending in 2019.<br><br>2.3% tax on medical devised, such as pacemakers and X-ray machines. Exclusions include eyeglasses, hearing aids and items purchased by the public at retail outlets.<br><br>P Flexible Spending Accounts will be limited to $2,500/an. and Indexed for inflation.<br><br>P Tax deduction ends for employers providing retirees with a Medicare Part D prescription drug benefit for employees that accept a 28% subsidy from the government.<br><br>3.8% surtax on investment income for wealthy Americans:<br>- Individuals who make more than $200,000 annually<br>- Couples making more than $250,000 annually<br><br>Itemized medical deductions threshold increases from 7.5% of income to 10% of income, for those younger than Age 65. Apples to those 65 and older starting in 2017.<br><br>The Medicare payroll tax will increase from 1.45% to 2.35% for:<br>- Individuals making over $200,000 annually<br>- Couples making in excess of $250,000 annually. |
| March 1, 2013 | | PA Employer Notification to Employees Regarding Exchanges – Effective 1/1/2014 |

## II. Grandfathering

### A. Brief Summary of Advantages of Grandfathering a Plan from Point I. Above ~You can wait and see how things workout ~

If you Grandfather your plan, you could cut costs in the future depending on how "Essential Benefits" are defined for all groups, individuals, insured or self-insured plans. You would reduce the number of adult dependents you could cover, copay some preventive services, reduce appeals, disclose duties and keep pregnancy treatment in-network.

1. You don't have to comply with covering adult children to age 26 if there is other group coverage.
2. You can define A and B preventive services – not First Dollar – and still have a copay.
3. You can discriminate in 105b fully insured medical reimbursement and keep a plan.
4. You can keep pediatrics and OB-GYN providers in-network.
5. Emergency services could be preauthorized or network restricted.
6. You can discriminate in payment to providers based on professional licenses.
7. You do not have to comply with new HHS reporting.
8. In 2014, you can have deductibles greater than $2,000. Deductibles higher than $2,000 will be penalized. (How?)
9. If the enforced community rates of 1/1/2014 are not as good as your Grandfathered plan rates you can keep your current rates.
10. You do not have to comply with revised "Appeals Process" or transparency to the public (II.E.)

There are benefits in declaring your plan Grandfathered as changes are allowed within ranges that still allow cost control. For large employers, a cost benefit analysis is needed and a definition of "Essential Benefits".

**Note: Put your notes in the margins as to how you value your advantages and disadvantages of Grandfathering.**

### B. More Details of Advantages of Grandfather Status (As we know today, without a definition of "Essential Benefits", Grandfathering could be avoiding whatever Essential Benefits are defined in the future.)

1. If Grandfathered, you don't have to comply with the revised appeal process (more detailed than ERISA) that must be met by a non-Grandfathered plan (fully insured or self-insured). This process includes:
   a. Have an internal claims and appeals process.
      i. Plans must follow state or federal appeals process.
      ii. A benefit determination subject to internal review includes:
         - Whether a service is a covered benefit.
         - Imposition of pre-existing condition or other benefit limits.
         - Medical necessity and experimental treatment determinations.
         - A determination to rescind coverage.
      iii. Plans must ensure that internal review processes are fair and impartial.

iv. Individuals must be notified of their rights to internal reviews and external appeals in a "culturally and linguistically appropriate manner."

b. Provide notice of an external appeals process.
c. Allow an enrollee to review his or her file, present evidence during the appeals process and continue to receive coverage pending outcome.
d. Implement an external review process (self insured only) that must be completed within 45 days.
e. For plan years before July 2, 2011, insurers in states with an existing external review process that complies with health care reform may follow that process. If the state external review process does not comply, or if there is no applicable state external review process, the federal standard (not yet published) must be followed. For self-insured plans, unless the state external review process applies, the federal standard (not yet published) must be followed.
f. All non-grandfathered fully insured and self-funded group health plans must meet the new consumer protection standards for internal and external review for plan years on and after September 23, 2010. (9/20/10 – No details)

## C. What changes are allowed for Grandfathered plans?

1. You can add new family members and employees.
2. Changes in premiums of a policy or plan.
3. Changes required complying with federal or state law (Mental Nervous Parity).
4. Changes to increase benefits or voluntarily comply with provisions of the Patient Protection and Affordable Care Act.
5. Changes to plan structure, for example, switching from a health reimbursement arrangement to major medical coverage or from insured to self-funded coverage.
6. Changes to a provider network.
7. Changes to accommodate mergers and acquisitions (as long as the merger or acquisition is not done solely to allow a group to move from one grandfathered plan to another when the plan change would reduce benefits or increase cost sharing in excess of that allowed by PPAC Act).
8. Changes to or of a Third Party Administrator or Stop Loss Carrier. (They are realizing how a "plan" is defined under ERISA.)

## D. What changes would cause a loss of grandfathered status after 3/23/10? Some changes are allowed in limits. See #8, #9 and #10 Below.

1. Basic Law - Increasing costs or reducing benefits to participants negates Grandfather status. But within limits you can make changes and stay Grandfathered.
2. A group that is not allowed or is not eligible to customize or change benefits cannot be Grandfathered. (A one plan carrier.)
3. Issuer or plan sponsor does not disclose to participants and beneficiaries that the plan or coverage is a grandfathered health plan.
4. **Change from one insurer to another.** (Insurance Company Lobby Gift.)
5. Increase coinsurance (or another percentage cost-sharing requirement) above the level that was set on March 23, 2010.
6. Eliminate all (or substantially all) benefits to diagnose or treat a particular condition.
7. Impose an annual limit on the dollar value of benefits if an annual or lifetime limit had not been previously imposed on all benefits or, for plans that previously imposed a

lifetime limit on all benefits, impose an overall annual dollar limit that is lower than the lifetime limit, or, for plans that previously imposed an annual limit on all benefits, decrease the dollar value of the annual limit.

8. Increase fixed-amount cost-sharing requirements other than co-payments, such as a deductible or an out-of-pocket limit, by a total percentage (measured from March 23, 2010) that is more than the sum of medical inflation plus 15%.
9. Increase copayments above the level in effect on March 23, 2010, by an amount that exceeds the greater of (a) the sum of medical inflation plus 15%, or (b) $5.00 increased by medical inflation ($5.00 plus medical inflation).

   Example of cost sharing or copay changes allowable as a percent increase.
   Example of #8 above in 2011: 4% + 15% = 19%
   Example of #9 above in 2011: 4% + 15% = 19% or $5.00 + 4% = ?
10. Reduce employer contributions (calculated by cost or formula, such as hours worked) toward any tier of group health insurance coverage or a group health plan by more than 5% below the contribution rate on March 23, 2010.

## E. To review Grandfathering into 2014 (the second time through to help you decide), these Health Care Reform provisions apply to non-Grandfathered plans (with comments about Grandfathered plans). Note: Depending on final regulations "preserving grandfathered status for a particular" benefit package option is also possible.

1. This chart applies to insured and self-insured plans, but because self-insured can be more customized, it applies more to self-insured plans. **(Please note your comments in the margin as they relate to your plans.)**
2. You could read this chart as "Grandfathered Plans don't have to . . . ."

| Issue | Description | Effective Date (plan year is calendar year) |
|---|---|---|
| Age 26 Exclusions | While all plans (Grandfathered and non-Grandfathered) must cover adult dependent children up to age 26, a Grandfathered plan need not offer such coverage if the child is eligible for another employer-sponsored health plan | 1/1/2011 through 1/1/2014 |
| First-Dollar Preventive Care | Non-Grandfathered plans must provide certain specified preventive-care services (e.g., immunizations, screenings) without cost sharing. Grandfathered plans can cost share. | 1/1/2011 |
| Appeals and External Review | Non-Grandfathered plans must establish internal and external claims appeals processes for appeals of benefit determinations and claims, allow participant to present evidence and testimony in appeal, provide notice to employees and allow participants to continue coverage during disputes. | 1/1/2011 |
| Provider Choice | Non-Grandfathered plans must allow participants to choose their primary care provider, including an OB-GYN for females and a pediatrician for children. | 1/1/2011 |
| Emergency Services | Non-Grandfathered plans must cover emergency services without prior authorization and without out-of-network surcharges. | 1/1/2011 |

| | | |
|---|---|---|
| Transparency in Coverage Reports | Non-Grandfathered plans must report to HHS, state commissioner and make available to the public, the following: financial data, claims payments and policies, claims denials, enrollment and disenrollment data, rating practices, cost sharing and payments for out-of-network coverage, and other information required by HHS. | 1/1/2011 |
| Quality of Care Reporting | Non-Grandfathered plans must report annually to HHS and enrollees regarding plan features that improve health outcomes, reduce hospital readmissions, improve patient safety and reduce medical errors, and implement wellness activities. HHS will make reports public. | 3/23/2012 at the latest |
| Non-Discrimination of Licensed Providers | Non-Grandfathered plans cannot discriminate against a provider who is acting within the scope of his or her license while providing services allowed under the plan. For example, if benefits are covered when performed by a surgeon, then must cover the same benefits when performed by a chiropractor (assuming within scope of license.) | 1/1/2014 (Chiropractic lobby gift) |
| Clinic Trials | Non-Grandfathered plans must cover clinical trials and routine expenses for clinical trials for cancer and other life-threatening diseases and cannot discriminate against individuals for participating in the trial. | 1/1/2014 |
| Maximum Cost Sharing | Cost-sharing, including deductibles, coinsurance, copayments or similar charges, cannot exceed the out-of-pocket maximum for high deductible health plans in 2014, indexed thereafter. | 1/1/2014 |

## III. If you decide to Grandfather your plan, you must disclose to your employees anytime after 3/23/2010. How? [Notices Follow] Remember, you can break that status anytime by your actions.

A. Prepare a cover letter of explanation (we recommend) to your eligible employees.
B. Preserve your "plan" as of this date. (Laminate/secure a copy)
C. Attach the appropriate HHS Disclosure to your Cover Letter
*"This [group health plan or health insurance issuer] believes this [plan or coverage type] is a 'grandfathered health plan' under the Patient Protection and Affordable Care Act."*
D. Model notices after current or next renewal for:
    1. Maintain Grandfathered Status Disclosure
    2. No Lifetime Limits
    3. Extension of Dependent Coverage to Age 26 – Not if Grandfathered
    4. Freedom to Choose Pediatrician/Ob-Gyn – Not if Grandfathered

Bibliography:

IBF 6/29/10
HHS.gov 6/14/10
NAIFA (6/23/10)
UNUM 7/10-MK2602
UHC-EW48434380-000/IBF 6/30/10
Anthem 8/2/10
Anthem 8/9/10

# CHOOSE TO MAINTAIN GRANDFATHERED STATUS

To maintain status as a grandfathered health plan, a 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 within the meaning of section 1251 of the Patient Protection and Affordable Care Act and must provide contact information for questions and complaints.

The following model language can be used to satisfy this disclosure requirement:

> This [group health plan or health insurance issuer] believes this [plan or coverage] is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act).
>
> As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your [plan or policy] may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.
>
> Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at [insert contact information]. [For ERISA plans, insert: You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.] [For individual market policies and nonfederal governmental plans, insert: You may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.]

# Model Language Notice Lifetime Limit No Longer Applies and Enrollment Opportunity

Plans and issuers are required to give written notice that the lifetime limit on the dollar value of all benefits no longer applies and that an individual, if covered, is once again eligible for benefits under the plan. Additionally, if the individual is not enrolled in the plan or health insurance coverage, or if an enrolled individual is eligible for but not enrolled in any benefit package under the plan or health insurance coverage, then the plan or issuer must also give such an individual an opportunity to enroll that continues for at least 30 days (including written notice of the opportunity to enroll). The notices and enrollment opportunity must be provided beginning not later than the first day of the first plan year beginning on or after September 23, 2010. For individuals who enroll under this opportunity, coverage must take effect not later than the first day of the first plan year beginning on or after September 23, 2010.

These notices may be provided to an employee on behalf of the employee's dependent. In addition, the notices may be included with other enrollment materials that a plan distributes to employees, provided the statement is prominent. For either notice, if a notice satisfying the requirements is provided to an individual, the obligation to provide the notice with respect to that individual is satisfied for both the plan and the issuer.

The following model language can be used to satisfy the notice requirement:

> The lifetime limit on the dollar value of benefits under [Insert name of group health plan or health insurance issuer] no longer applies. Individuals whose coverage ended by reason of reaching a lifetime limit under the plan are eligible to enroll in the plan. Individuals have 30 days from the date of this notice to request enrollment. For more information contact the [insert plan administrator or issuer] at [insert contact information].

# Model Language for Notice of Opportunity to Enroll in connection with Extension of Dependent Coverage to Age 26

The interim final regulations extending dependent coverage to age 26 provide transitional relief for a child whose coverage ended, or who was denied coverage (or was not eligible for coverage) under a group health plan or health insurance coverage because, under the terms of the plan or coverage, the availability of dependent coverage of children ended before the attainment of age 26. The regulations require a plan or issuer to give such a child an opportunity to enroll that continues for at least 30 days (including written notice of the opportunity to enroll), regardless of whether the plan or coverage offers an open enrollment period and regardless of when any open enrollment period might otherwise occur. This enrollment opportunity (including the written notice) must be provided not later than the first day of the first plan year beginning on or after September 23, 2010. The notice may be included with other enrollment materials that a plan distributes, provided the statement is prominent. Enrollment must be effective as of the first day of the first plan year beginning on or after September 23, 2010.

The following model language can be used to satisfy the notice requirement:

> Individuals whose coverage ended, or who were denied coverage (or were not eligible for coverage), because the availability of dependent coverage of children ended before attainment of age 26 are eligible to enroll in [Insert name of group health plan or health insurance coverage]. Individuals may request enrollment for such children for 30 days from the date of notice. Enrollment will be effective retroactively to [insert date that is the first day of the first plan year beginning on or after September 23, 2010.] For more information contact the [insert plan administrator or issuer] at [insert contact information].

# Patient Protection Model Disclosure

When applicable, it is important that individuals enrolled in a plan or health insurance coverage know of their rights to (1) choose a primary care provider or a pediatrician when a plan or issuer requires designation of a primary care physician; or (2) obtain obstetrical or gynecological care without prior authorization. Accordingly, the interim final regulations regarding patient protections under section 2719A of the Affordable Care Act require plans and issuers to provide notice to participants of these rights when applicable. The notice must be provided whenever the plan or issuer provides a participant with a summary plan description or other similar description of benefits under the plan or health insurance coverage. This notice must be provided no later than the first day of the first plan year beginning on or after September 23, 2010.

The following model language can be used to satisfy the notice requirement:

For plans and issuers that require or allow for the designation of primary care providers by participants or beneficiaries, insert:

> [Name of group health plan or health insurance issuer] generally [requires/allows] the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. [If the plan or health insurance coverage designates a primary care provider automatically, insert: Until you make this designation, [name of group health plan or health insurance issuer] designates one for you.] For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the [plan administrator or issuer] at [insert contact information].

For plans and issuers that require or allow for the designation of a primary care provider for a child, add:

> For children, you may designate a pediatrician as the primary care provider.

For plans and issuers that provide coverage for obstetric or gynecological care and require the designation by a participant or beneficiary of a primary care provider, add:

> You do not need prior authorization from [name of group health plan or issuer] or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the [plan administrator or issuer] at [insert contact information].

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# Grandfathering Discussion Card

## General concept:

The impact of health care reform on the costs of health care plans is currently unknown. When a plan is grandfathered, you exchange the ability to make changes to your health care plan now for more options in the future.

## Grandfathering and You:

| Do you... | Your Answer | Suited for/Needs Grandfathering? |
|---|---|---|
| Have a deductible over $2000?<br>*in 2014, deductibles over $2000 will be subject to penalties* | Yes | **Yes** |
| Plan to increase cost shares for certain health care benefits for your employees this year?<br>*Any changes along these lines could cancel grandfathered status* | Yes | No |
| Offer preventive care at 100%?<br>*Required for all non-grandfathered plans in 2011* | Yes | No |
| Plan to replace/remove/add a plan option?<br>*Any changes along these lines could cancel grandfathered status* | Yes | No |
| Feel you would benefit from community rating?<br>*In 2014, all non-grandfathered plans will have community rating* | N/A | N/A |
| Need to change contribution levels by more than 5% from their amount as of 3/23/2010?<br>*Grandfather requires contribution levels stay within 5% of 3/23/10* | Yes | No |
| Offer different benefits that favor "highly compensated" individuals?<br>*To continue this practice, you may need grandfathered status.* | No | No |
| Plan to switch insurance companies?<br>*Switching companies could cancel grandfathered status* | Yes | No |

## Advantage:

Grandfathering your health care plan allows you to see the effects of health care reform on the market before you switch over.

## Further Details:

While you may give up grandfathered status at any renewal, once given up, you cannot get the status back. Grandfathered plans must include a statement to all participants and beneficiaries that the plan believes it is a grandfathered plan.