



Overview

Many of the provisions in the new healthcare reform law will not take effect for several years. However, the first significant wave of provisions impact employer-sponsored health plans and will take effect Sept. 23, 2010. **Unless otherwise indicated below, these early provisions will not affect plans until they renew for the next plan year.**

Grandfathered plans

If you have a group health plan in effect before the healthcare reform law was enacted on March 23, 2010, it's considered a "grandfathered" plan and is exempt from some of the healthcare reform changes. To remain grandfathered, you cannot make benefit changes that significantly increase your employees' cost share for health coverage.

The following benefit changes **will not** cause loss of grandfathered status:

- Adding employees to your plan
- Complying with federal or state law
- Increasing employee contributions by 5 percent or less
- Voluntarily changing benefits to comply with healthcare reform

Examples of changes that **will** cause a plan to lose grandfathered status:

- Obtaining a new policy, certificate, or contract of insurance sold after March 23, 2010
- Eliminating benefits for a particular condition
- Adding or decreasing overall annual dollar limit
- Increasing coinsurance percentage
- Increasing deductible or out-of-pocket maximum by more than medical inflation, plus a one-time-only 15% increase
- Increasing copayments for any service by more than the annual rate of medical inflation, plus a one-time-only 15 percent or \$5 increase, whichever is greater
- Decreasing employer contribution rate by more than 5 percent
- Changing carriers (fully-insured plans only)

Remember:

In most cases, any group that made a plan change between March 23 and June 17, 2010, will be allowed (upon renewal) to change back to their original plan if they want to retain grandfathered status.

Changes that affect your business and the employees who depend upon you...

Dependent coverage changes

The federal healthcare reform law allows adult children to remain on their parents' plan until they reach age 26.



Benefit changes

Plans sold or renewed with an effective date on or after Sept. 23, 2010, will experience the following benefit changes:

- **Lifetime maximum.** Plans will have an unlimited lifetime maximum
- **Annual dollar limits.** No annual dollar limits on covered essential health benefits:
 - Prescription drugs
 - Emergency services
 - Hospitalization
 - Maternity and newborn care
 - Mental and substance use disorder, including behavioral health treatment
 - Ambulatory patient services
 - Rehabilitation and facilitative services and devices
 - Laboratory services
 - Preventive and wellness services and chronic disease management
 - Pediatric services, including dental and vision care
- **Emergency care.** Plans will cover services for emergency medical care administered in a hospital's emergency facility at the in-network benefit level.

New groups or plans no longer grandfathered on or after Sept. 23, 2010, will also include:

- **Preventive services.** Plans will cover in-network preventive care services at 100%. Members will not pay a copayment, coinsurance, or deductible.

Some preventive services covered by the regulation include:

- Immunizations
- Blood pressure screenings
- Cholesterol screenings
- Mammograms
- Colonoscopies
- Obesity screenings
- Type 2 diabetes screenings
- Diet counseling
- Obesity screenings and counseling
- Tobacco-use screenings

Pre-existing conditions

Pre-existing condition limitations will not apply to a covered person under age 19. This provision will apply to your benefit plan at your next renewal after Sept. 23, 2010, unless otherwise specified.



Appeals

Covered persons will have the right to an internal appeal and external claims review. This provision will apply to your benefit plan at your next renewal after Sept. 23, 2010, unless otherwise specified.

Early Retiree Reinsurance Program

The regulations create a new \$5 billion reinsurance program for employers that provide health insurance coverage to early retirees who are over age 55 but are not eligible for Medicare. This program began June 21, 2010, and continues until insurance exchanges become available on Jan. 1, 2014 or funding for the new program runs out.

Primary care physicians

If a plan requires designation of a primary care physician, a participating physician who specializes in pediatrics may be selected as the primary care physician for a covered dependent child.

Gynecological and obstetric services

If a plan provides coverage for gynecological or obstetric care, authorizations or referrals for such care are no longer required for such care, as long as the provider remains in your designated network. **This will be effective for all plans on Oct. 1, 2010.**

Non-discrimination rules

Groups may no longer restrict membership in a benefits program that favors highly compensated individuals, as defined by the federal government. The only exception for this provision is if the health plan has retained its grandfather status.