



This update is sent periodically to keep you informed of employee benefit plan issues that may impact your organization.



The following is a summary of the immediate impact of the newly signed healthcare reform legislation. We have also attached a Milliman Client Action Bulletin that provides a timeline of key provisions through 2018. Milliman, a national actuarial firm, partners with us to provide actuarial services for our clients.

We will be hosting a seminar in late April to present national healthcare reform and we hope you will join us. In addition, we will be meeting with each of you in the coming months to discuss the implications of the legislation on your programs specifically. We will be in touch soon with more information.

Because of the size and scope of the legislation, and the number of federal departments involved in issuing more detailed regulations for implementation, it will take time to fully analyze and digest the changes that will be effective beyond 2010. Therefore, it is our recommendation that clients avoid the temptation to digest the Act in its entirety, but rather, take steps over time to implement the various provisions as they become effective.

Health Care Reform – changes effective first of the plan year after 9/23/10 (plans renewing 10/1/10 or later)

On March 23, 2010, President Obama signed The Patient Protection and Affordability Care Act (the "Act"), and on March 30, 2010 he signed the reconciliation bill to "fix" the Act. The legislation contains over 2500 pages of changes to our health care system. Some changes go into effect this year, others in 2014, and others more than eight years from now.

The earliest meaningful provisions impacting employers that sponsor health plans will be effective on the first day of the plan year after six months of the signing of the Act. In other words, plans renewing October 1, 2010 or later will become subject to the Act at renewal.

The first step is for employers to categorize their plan as a "Grandfathered" or "Non-Grandfathered" plan. A Grandfathered plan is a health plan that was in existence on the date of enactment (March 23, 2010). A Non-Grandfathered plan was established after the date of enactment. It is unclear what changes to a Grandfathered plan could cause it to become a Non-Grandfathered plan. This is an important distinction because not all provisions under the Act apply to Grandfathered plans. As this distinction is clarified, we will let you know.

The following is a list of major provisions on the horizon, effective at renewal for plan years beginning October 1, 2010 and later.

All health plans (Grandfathered or Non-Grandfathered)

1. **Elimination of lifetime limits** and certain annual limits on benefits
 - Plans may not impose lifetime limits on benefits. Plans may not impose annual limits on certain essential benefits (if offered) as defined by the Department of Health and Human Services (HHS). HHS is required to develop a complete list of essential benefits. Until then, the following essential benefits will not be able to have annual limits:
 - Ambulatory patient services
 - Emergency services
 - Hospitalization
 - Maternity and newborn care
 - Prescription drugs
 - Preventive and wellness services
2. Plans **can no longer impose pre-existing condition exclusions for children under age 19**. (In 2014, this will also apply to adults.)
3. Plans **required to extend coverage to dependents through age 26**, regardless of marital status
 - For Grandfathered plans, this applies only if the child is not eligible for other employer-sponsored coverage.
4. **Small employers (under 25 employees) may receive a temporary sliding-scale tax credit**, depending on size of workforce and average pay, for tax years 2010 through 2013.
 - The maximum tax credit can be up to 35% of the employer's contribution, for employers with 10 or fewer employees and an average annual salary of less than \$25,000. The credit phases out as firm size and average wage increases.

Non-Grandfathered plans must comply with the above, plus:

5. **Preventive care must be covered at 100%** (no deductibles or copayments).
6. **Emergency services cannot require prior authorization**, and the plan cannot impose additional charges (e.g. copayments or coinsurance) if the emergency facility is out of the plan's network.
7. **Employer plans cannot discriminate in favor of highly-paid employees** in terms of benefits or eligibility. (This applied to self-funded plans already, but now also applies to fully insured plans.)
8. Health plans are required to spend at least **85% of premium dollars on medical expenses** (80% for small group plans under 100 employees).

We will continue to keep you informed as the legislation evolves.

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