

The most immediate aspect of the reform law will be:

## 1. **DEPENDENT COVERAGE EXTENDED TO AGE 26 ON MEDICAL PLANS**

BEGINNING WITH PLAN YEARS ON OR AFTER SEPTEMBER 23, 2010

Employees covered under a medical plan will be able to extended coverage to eligible dependents up until age 26 under the new reform law. This can be done upon the renewal of the group medical plan on or after September 23, 2010 (some carriers have indicated that they will implement it sooner). The definition of an “eligible” dependent has yet to be fully defined within the legislation. It is also unknown at this point if a dependent who “aged-off” of a current medical plan would be eligible to re-enroll once this provision goes into effect. In addition, some states may have their own laws that extended dependent coverage to an even older age. **The dependent coverage age extension applies only to medical plans.**

## 2. **NO LIFETIME LIMITS ON MEDICAL PLANS**

BEGINNING WITH PLAN YEARS ON OR AFTER SEPTEMBER 23, 2010

The health reform law eliminates Lifetime dollar limits on all medical plans, as of September 23, 2010. For existing medical plans, the reform law states that Lifetime Limit benefit changes can be made during the group’s renewal, so while this provision goes into effect on September 23, 2010, in-force groups may not receive this benefit change until their next scheduled renewal date. **The No Lifetime Limits provision applies only to medical.**

## 3. **NO PRE-EXISTING CONDITIONS ON MEDICAL PLANS**

BEGINNING WITH PLAN YEARS ON OR AFTER SEPTEMBER 23, 2010 FOR DEPENDENT CHILDREN AND IN 2014 FOR ADULTS.

Starting on September 23, 2010, medical plans can no longer impose pre-existing conditions for dependent children under the age 19. In 2014, the same pre-ex prohibition on medical plans take effect for adults. With the introduction of HIPAA in 1996, the usage of pre-ex to determine eligibility for a group medical plan was significantly reduced, so this reform provision will only have a slight impact to most carriers’ current pre-ex practices for group coverage. Pre-ex is primarily used as a determining factor when selling individual medical plans, so this provision will have a bigger impact to those plans. **The No Pre-Ex provision applies only to medical plans.**

Please note that these components of the Patient Protection and Affordable Care Act pertain to all individual medical plans and both fully and self-funded group medical plans.