* * * BULLETIN * * *

TO: ALL GROUP HEALTH CLIENTS

FROM: GREENBERG & ASSOCIATES INSURANCE

DATE: JULY 21, 2010

RE: HEALTHCARE REFORM UPDATES PREVENTIVE CARE & W-2 REPORTING REQUIREMENTS

The Departments of Labor, Treasury and Health and Human Services released their Interim Final Regulations relating to coverage for preventive services under the Patient Protection and Affordable Care Act on July 14, 2010. The Interim Final Regulations apply to group health plans for plan years beginning on or after September 23, 2010.

The Interim Final Regulations clarify the cost-sharing requirements when a recommended preventive service is provided during an office visit. A plan may impose cost-sharing for an office visit only if a recommended preventive service is billed separately from the office visit. If a recommended preventive service is not billed separately from an office visit and the primary purpose of the office visit is the delivery of these services, then a plan may not impose cost-sharing for that office visit.

The regulations also clarify that a plan is not required to provide coverage for recommended preventive services delivered by out-of-network providers. The plan may also impose cost-sharing requirements for the recommended preventive services delivered out-of-network. The Interim Final Regulations also allow that if a recommendation or guideline for preventive services does not specify the frequency, method, treatment, or setting for that service, the plan may rely on established techniques and the relevant evidence base to determine the frequency, method, treatment or setting for these services. Plans also have the option to cover preventive services in addition to those required by the Patient Protection and Affordable Care Act. If they do so, they may impose cost-sharing requirements for a treatment that is not a recommended preventive service, even if the treatment results from a recommended preventive service.

If you're interested in seeing a complete list of the recommendations and guidelines that are required to be covered without cost sharing go to: http://www.HealthCare.gov/center/regulations/prevention.html . Click on "Recommendations: Guidance for Insurers and Medical Professionals" at the center of the page.

We have also received additional information from the National Association of Health Underwriters regarding the new employer W-2 health insurance reporting requirements. The IRS has not yet issued guidance, but, NAHU has been researching this provision and have given us some insight into the upcoming requirements.

Employers will be required to calculate and report the aggregate cost of applicable employer-sponsored health insurance coverage on employees' Form W-2's for taxable years beginning after December 31, 2010. Even though this new reporting requirement applies for tax years beginning after December 31, 2010, because employees are entitled to request their W-2 early if they terminate employment during the year, payroll systems need to be updated for this change by January 2011. Therefore, while most W-2's for tax year 2011 will be issued in January 2012, employers must have the capacity to reflect this information no later than February 1, 2011 in the event that a terminating employee requests one.

The aggregate cost of an employee's health benefits will NOT be included in their taxable income. The reporting requirement is being used to track coverage values for the 40% excise tax on "high-cost" employer-based medical plans starting in 2018.

The coverage costs for both insured and self-insured plans that must be reported under the new W-2 requirement include:

- Medical Plans
- Prescription Drug Plans
- Dental and vision plans, unless they are "stand alone" plans (i.e. the employee may elect only dental or vision and is not required to also enroll in the medical coverage)
- Executive physicals
- On-site clinics if they provide more than de minimis care
- Medicare supplemental policies
- Employee assistance programs

If an employee enrolls in employer-sponsored health insurance coverage under a major medical plan, a dental plan and a vision plan, the employer is required to report the total value of the combination of all coverages. Employers will NOT have to provide a breakdown of the various types of coverage, but, must only report the aggregate cost.

At this time, it appears that determining the value of the employer-sponsored health coverage is to be done by using the COBRA continuation of coverage rules under IRC Sec. 4980B (f)(4). The employer is required to report the aggregate premium calculated under the COBRA rules, not the portion of the premium that the employee has to pay.

Once the final regulations are available, we will update you regarding the W-2 requirements. But, we wanted to give you a head's up that this will be something you will need to be doing for the upcoming year. Therefore, you might want to start working with your payroll vendors in the near future to provide them the necessary information they will need to deal with your W-2 requirements.

Sincerely,

Sharon Greenberg and Adrienne Hutchins

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