

October 2010 Client Health Care Reform Update

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This Health Care Reform Update provides important content to help you work with your Simplifi Account Manager in preparing your Plan to comply with the Patient Protection and Affordable Care Act (PPACA) requirements. This update includes the following:

1. IRS Announces Interim Relief from W-2 Health Care Coverage Reporting Requirement
2. Guidance on Coverage of Preventive Services
3. Essential Benefits Recommendations
4. Health Care Reform Plan Notice Language

1. IRS Announces Interim Relief from W-2 Health Care Coverage Reporting Requirement

On October 13, 2010, the Internal Revenue Service announced interim relief from the 2011 W-2 Form requirement to report on the cost of health care coverage of group health insurance. In IRS Notice 2010-69 the Treasury Department and the IRS specifically state that reporting of the cost of coverage will NOT be mandatory for W-2 Forms issued in 2011.

The Treasury Department and the IRS have determined that relief from the mandatory reporting that was part of the Patient Protection and Affordable Care Act (PPACA) is appropriate to provide employers with additional time to make any necessary changes to their payroll systems or procedures in preparation for compliance with the reporting requirement.

This particular provision of health care reform has been riddled with confusion from the outset. The health care reform language in the PPACA provides generally that the aggregate cost of applicable employer-sponsored coverage must be reported on employees' W-2 forms. It further provides that, for this purpose, the aggregate coverage cost to be reported is to be determined using similar rules to define the applicable premium to provide COBRA continuation of coverage. The health reform law was only to be a reporting change.

Earlier this year, however, a flurry of web based notices and information pieces on health care reform incorrectly asserted that the coverage amounts reported on an employee's W-2 Forms will be taxable to the employee beginning with the 2011 tax year. Since that time, the IRS has continued to emphasize to the public and industry leaders that the health care coverage amounts that will eventually be required on employee W-2 Forms are not taxable.

In the much welcomed notice of interim relief, the IRS and the Treasury Department further affirm that the reporting requirement is not mandatory for W-2 Forms issued for 2011. Accordingly, the notice provides that an employer will not be treated as failing to meet such requirements in the health reform law, and will not be subject to any penalties for failure to meet such reporting requirements, merely because it does not report the aggregate cost of employer-sponsored coverage.

The Treasury Department and the IRS anticipate issuing further guidance on the W-2 reporting requirement before the end of the year.

2. Guidance on Coverage of Preventive Services

On July 14, 2010, the Departments of Health and Human Services, Labor, and Treasury issued interim final regulations requiring Plans and to cover certain preventive services without any cost sharing for the individual, such as requiring co-pay, co-insurance, or meeting deductibles, when delivered by in-network providers. The mandate affects only non-grandfathered Plans and does not apply to grandfathered Plans until 2014. Accordingly, this health care reform mandate will apply to all Plans

beginning in 2014. Plans are still permitted to require cost-sharing for preventive services if they are performed by an out-of-network provider.

The interim final regulations provide that Plans covered by these rules must offer coverage of a comprehensive range of preventive services that are recommended by physicians and other experts without imposing any cost-sharing requirements. Specifically, these recommendations include the following categories:

Evidence-based preventive services: The U.S. Preventive Services Task Force, an independent panel of scientific experts, ranks preventive services based on the strength of the scientific evidence documenting their benefits. Preventive services with a "grade" of A or B, like breast and colon cancer screenings, screening for vitamin deficiencies during pregnancy, screenings for diabetes, high cholesterol and high blood pressure, and tobacco cessation counseling will be covered under these rules.

Routine vaccines: Health plans will cover a set of standard vaccines recommended by the Advisory Committee on Immunization Practices ranging from routine childhood immunizations to periodic tetanus shots for adults.

Prevention for children: Health plans will cover preventive care for children recommended under the Bright Futures guidelines, developed by the Health Resources and Services Administration with the American Academy of Pediatrics. These guidelines provide pediatricians and other health care professionals with recommendations on the services they should provide to children from birth to age 21 to keep them healthy and improve their chances of becoming healthy adults. The types of services that will be covered include regular pediatrician visits, vision and hearing screening, developmental assessments, immunizations, and screening and counseling to address obesity and help children maintain a healthy weight.

Prevention for women: Health plans will cover preventive care provided to women under both the Task Force recommendations and new guidelines being developed by doctors, nurses, and scientists, which are expected to be issued by August 1, 2011. (healthcare.gov)

The following is a list of the Grade A and B recommendations of the United States Preventive Services Task Force that are required under the interim final regulations to have first dollar coverage by non-grandfathered health plans; until 2014, at which time the regulations apply to all Plans:

Covered Preventive Services for Adults

- **Abdominal Aortic Aneurysm** one-time screening for men of specified ages who have ever smoked
- **Alcohol Misuse** screening and counseling
- **Aspirin** use for men and women of certain ages
- **Blood Pressure** screening for all adults
- **Cholesterol** screening for adults of certain ages or at higher risk
- **Colorectal Cancer** screening for adults over 50
- **Depression** screening for adults
- **Type 2 Diabetes** screening for adults with high blood pressure
- **Diet** counseling for adults at higher risk for chronic disease
- **HIV** screening for all adults at higher risk
- **Immunization** vaccines for adults--doses, recommended ages, and recommended populations vary:
 - Hepatitis A
 - Hepatitis B
 - Herpes Zoster

- Human Papillomavirus
- Influenza
- Measles, Mumps, Rubella
- Meningococcal
- Pneumococcal
- Tetanus, Diphtheria, Pertussis
- Varicella
- **Obesity** screening and counseling for all adults
- **Sexually Transmitted Infection** (STI) prevention counseling for adults at higher risk
- **Tobacco** Use screening for all adults and cessation interventions for tobacco users
- **Syphilis** screening for all adults at higher risk

Covered Preventive Services for Women, Including Pregnant Women

- **Anemia** screening on a routine basis for pregnant women
- **Bacteriuria** urinary tract or other infection screening for pregnant women
- **BRCA** counseling about genetic testing for women at higher risk
- **Breast Cancer Mammography** screenings every 1 to 2 years for women over 40
- **Breast Cancer Chemoprevention** counseling for women at higher risk
- **Breast Feeding** interventions to support and promote breast feeding
- **Cervical Cancer** screening for sexually active women
- **Chlamydia** Infection screening for younger women and other women at higher risk
- **Folic Acid** supplements for women who may become pregnant
- **Gonorrhea** screening for all women at higher risk
- **Hepatitis B** screening for pregnant women at their first prenatal visit
- **Osteoporosis** screening for women over age 60 depending on risk factors
- **Rh Incompatibility** screening for all pregnant women and follow-up testing for women at higher risk
- **Tobacco Use** screening and interventions for all women, and expanded counseling for pregnant tobacco users
- **Syphilis** screening for all pregnant women or other women at increased risk

Covered Preventive Services for Children

- **Alcohol and Drug Use** assessments for adolescents
- **Autism** screening for children at 18 and 24 months
- **Behavioral** assessments for children of all ages
- **Cervical Dysplasia** screening for sexually active females
- **Congenital Hypothyroidism** screening for newborns
- **Developmental** screening for children under age 3, and surveillance throughout childhood
- **Dyslipidemia** screening for children at higher risk of lipid disorders
- **Fluoride Chemoprevention** supplements for children without fluoride in their water source
- **Gonorrhea** preventive medication for the eyes of all newborns
- **Hearing** screening for all newborns
- **Height, Weight and Body Mass Index** measurements for children
- **Hematocrit or Hemoglobin** screening for children
- **Hemoglobinopathies** or sickle cell screening for newborns
- **HIV** screening for adolescents at higher risk
- **Immunization** vaccines for children from birth to age 18 —doses, recommended ages, and recommended populations vary:
 - Diphtheria, Tetanus, Pertussis
 - Haemophilus influenzae type b
 - Hepatitis A
 - Hepatitis B

- Human Papillomavirus
- Inactivated Poliovirus
- Influenza
- Measles, Mumps, Rubella
- Meningococcal
- Pneumococcal
- Rotavirus
- Varicella
- **Iron** supplements for children ages 6 to 12 months at risk for anemia
- **Lead** screening for children at risk of exposure
- **Medical History** for all children throughout development
- **Obesity** screening and counseling
- **Oral Health** risk assessment for young children
- **Phenylketonuria (PKU)** screening for this genetic disorder in newborns
- **Sexually Transmitted Infection (STI)** prevention counseling for adolescents at higher risk
- **Tuberculin** testing for children at higher risk of tuberculosis
- **Vision** screening for all children (healthcare.gov)

3. Essential Benefits Recommendations

Effective with plan years beginning after September 23, 2010, the Health Care Reform law mandates that self-insured Plans will have no lifetime maximum dollar limits on in-network “essential benefits” and they are only allowed to have restricted annual dollar limits on in-network essential benefits, to the extent these essential benefits are covered in the Plan.

Health Care Reform defines essential benefits as those benefits falling in the following general categories: Ambulatory Patient Services; Emergency Services; Hospitalization; Maternity and Newborn Care; Mental Health and Substance Use Disorder Services, including Behavioral Health Treatment; Prescription Drugs; Rehabilitative and Habilitative Services and Devices; Laboratory Services; Preventive and Wellness Services and Chronic Disease Management; and Pediatric Services, including Oral and Vision Care.

Until these essential benefits are more specifically defined by the government, health plans are expected to make “good faith efforts” to comply with the “reasonable interpretation” of these types of benefits as they administer their plans. Taking into consideration these guidelines and using our best efforts to reasonable interpret the intentions of the new Health Care Reform regulations; the Simplifi staff has worked to develop the following recommendations to help better define essential benefits for our clients:

Essential Benefits	Definition
Hospitalization	In-Patient Services rendered by a hospital facility; does NOT apply to professional fees
Ambulatory Services, including emergency department services	Out-Patient Services, including ER services, rendered by a hospital facility; does NOT apply to professional fees
Prescription Drugs	Drugs requiring a prescription for the patient to receive them; does NOT apply to OTC items
Rehabilitative and Habilitative Services and Devices	Health Services, both facility and professional based, and devices which are medically necessary for the rehabilitation of a patient as it relates to a disease, disorder, or injury
Laboratory Services	Lab services regardless where rendered, both facility and professional based fees

Essential Benefits	Definition
Mental Health and Substance Abuse Services	Health Services to specifically treat mental health and substance abuse conditions; both facility and professional based fees included
Preventative Services	See defined benefit listing above
Maternity Care and Newborn Care	All Health Services rendered for any expected mother (including a plan member's dependent child) and newborn infant up through 14 days old; both facility and professional based fees
Pediatric including oral and vision care	All Health Services rendered for a child up through age 21 years; both facility and professional based fees

4. Health Care Reform Plan Notice Language

Simplifi has developed the following Health Care Reform notices for use by Plans to inform participants to the changes coming to their Plan in the next year as a result of the new Health Care Reform law. The notices come in two versions; one for Grandfathered Plans and one for Non-Grandfathered Plans. Simplifi will be preparing each existing client with the applicable Notice for distribution to all Plan members on or around November 1, 2010.

Notice Language for Grandfathered Plans

FEDERAL HEALTH CARE REFORM: IMPACT TO YOUR PLAN

Dear _____ Employee/Associate/Team Member:

You are receiving this document in compliance with the Patient Protection and Affordable Care Act, the newly enacted federal health care reform law, ("Health Care Reform") and to educate you on the plan changes which are required under the new regulations and affect plan years beginning after September 23, 2010. There may be other changes to your plan which will be provided prior to the beginning of the plan year; however, Health Care Reform regulations do require your plan to make the following changes.

Your Plan believes that it is a "Grandfathered" health plan under Health Care Reform. As permitted by Health Care Reform regulations, 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 the Plan is not yet required to include certain consumer protections of Health Care Reform 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 under Health Care Reform such as 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 your human resource department or your plan administrator. 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.

The following are the changes to your grandfathered plan that are required under Health Care Reform for this coming plan year:

-Extension of Dependent Coverage - Adult children up to their 26th birthday, who are without access to

coverage through their own employer, are eligible to receive coverage under their parent's plan, regardless of the child's marital or student status, or whether they are supported by their parents.

-No Lifetime Limits and Restrictions on Annual Limits - There are no lifetime maximum dollar limits on in-network "essential benefits" and there are only restricted annual dollar limits on in-network essential benefits, to the extent these essential benefits are covered in the plan. Health Care Reform defines essential benefits as those benefits falling in the following general categories: Ambulatory Patient Services; Emergency Services; Hospitalization; Maternity and Newborn Care; Mental Health and Substance Use Disorder Services, including Behavioral Health Treatment; Prescription Drugs; Rehabilitative and Habilitative Services and Devices; Laboratory Services; Preventive and Wellness Services and Chronic Disease Management; and Pediatric Services, including Oral and Vision Care.

-No Preexisting Conditions Exclusions For Children - The plan will not impose preexisting condition exclusions on enrollee children under the age of 19.

-Limited Rescissions - The plan cannot rescind an individual's coverage unless the individual has committed an act of fraud against the plan or misrepresentation of material fact.

The above list of changes to your plan is the list of mandatory changes required under Health Care Reform. As is mentioned above, this is not intended to be a complete list of the changes to your plan. There may be other changes to your plan which will be provided prior to the beginning of the plan year. If you have any questions or want additional information regarding your plan, please contact your human resource department or your plan administrator.

Disclaimer: *The information contained herein is provided as information only and is not intended to be relied upon by any person or entity as legal advice. Any person or entity needing legal advice on these issues should seek legal counsel from an attorney.*

Notice Language for Non-Grandfathered Plans

FEDERAL HEALTH CARE REFORM: IMPACT TO YOUR PLAN

Dear _____ Employee/Associate/Team Member:

You are receiving this document in compliance with the Patient Protection and Affordable Care Act, the newly enacted federal health care reform law, ("Health Care Reform") and to educate you on the plan changes which are required under the new regulations and affect plan years beginning after September 23, 2010. There may be other changes to your plan which will be provided prior to the beginning of the plan year; however, Health Care Reform regulations do require your plan to make the following changes.

Your Plan believes that it is a "Non-Grandfathered" health plan under Health Care Reform. Companies can lose their grandfather status if they take certain steps such as reducing benefits, significantly raising copayment charges, significantly raising deductibles or changing insurance carriers.

Questions regarding which protections apply and which protections do not apply to a grandfathered or a non-grandfathered health plan, and what might cause a plan to change from grandfathered health plan status can be directed to your human resource department or your plan administrator. 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 or non-grandfathered health plans.

The following are the benefit changes to your non-grandfathered plan that are required under Health Care Reform for this coming plan year:

-Extension of Dependent Coverage - Adult children up to their 26th birthday are eligible to receive coverage under their parent's plan, regardless of the child's marital status, student status, whether they are supported by their parents, or have coverage available through their employer.

-No Lifetime Limits and Restrictions on Annual Limits - There are no lifetime maximum dollar limits on in-network "essential benefits" and there are only restricted annual dollar limits on in-network essential benefits, to the extent these essential benefits are covered in the plan. Health Care Reform defines essential benefits as those benefits falling in the following general categories: Ambulatory Patient Services; Emergency Services; Hospitalization; Maternity and Newborn Care; Mental Health and Substance Use Disorder Services, including Behavioral Health Treatment; Prescription Drugs; Rehabilitative and Habilitative Services and Devices; Laboratory Services; Preventive and Wellness Services and Chronic Disease Management; and Pediatric Services, including Oral and Vision Care.

-No Preexisting Conditions Exclusions For Children - The plan will not impose preexisting condition exclusions on enrollee children under the age of 19.

-Limited Rescissions - The plan cannot rescind an individual's coverage unless the individual has committed an act of fraud against the plan or misrepresentation of material fact.

-Primary Care Provider Designation - Where individuals are required to select a primary care provider under the plan, an individual may designate any available in-network primary care provider available to accept the individual. The primary care provider designated by an individual can now include in-network pediatricians, obstetricians, and gynecologists.

-Access to Obstetricians and Gynecologists - The plan will not require individuals to obtain a referral or prior authorization to receive coverage for in-network obstetricians and gynecologists.

-Coverage of Emergency Services - To the extent emergency services are covered in the plan, the plan will not require prior authorization for emergency services, regardless as to whether the service is performed in-network or out-of-network.

-Coverage of Preventive Services - The plan will not require deductibles, co-pays, or coinsurance for in-network Health Care Reform mandated preventive services, including in-network child preventive services. For more information on the coverage of preventive services as under Health Care Reform go to www.dol.gov/ebsa/healthreform.

The above list of changes to your plan is the list of mandatory changes required under Health Care Reform. As is mentioned above, this is not intended to be a complete list of the changes to your plan. There may be other changes to your plan which will be provided prior to the beginning of the plan year. If you have any questions or want additional information regarding your plan, please contact your human resource department or your plan administrator.

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If you have any questions regarding the content of this Health Care Reform Update, please feel free to contact your Simplifi Account Manager.

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Works Cited

"Background: The Affordable Care Act's New Rules on Preventive Care - Preventive Services | Featured Provisions | About the Law | Understand the New Law | HealthCare.gov." Health Care - HealthCare.gov. Web. 29 Oct. 2010. <<http://www.healthcare.gov/law/about/provisions/services/background.html>>.

"Preventive Services Covered under the Affordable Care Act - Preventive Services | Featured Provisions | About the Law | Understand the New Law | HealthCare.gov." Health Care - HealthCare.gov. Web. 29 Oct. 2010. <<http://www.healthcare.gov/law/about/provisions/services/lists.html>>.