

EBS FORAN
INSURANCE AND ADVISORY SERVICES
INCORPORATED

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As you know, the Patient Protection and Affordable Care Act (PPACA) was signed into law this past March

While we anticipate there may be changes to the law as now written, the PPACA as it stands now requires Employers to adhere to specific rules and regulations.

In previous correspondence from this office to you, we have overviewed the issue of "grandfathering" an Employer Sponsored Health Care Plan. We also released correspondence on the revisions to Flexible Spending Accounts with respect to "over-the-counter" drugs and supplies.

In this writing, we will present other topics of relevance to Employers. Should you have any questions on anything presented, please contact your EBS Foran/John P. Foran Insurance Agency (EBS Foran) Account Manager.

I. W-2 Reporting

On a "positive" note, on October 12, 2010, the Internal Revenue Service (IRS) released Notice 2010-69 which delays the mandatory reporting of the cost of Employer sponsored health insurance on Form W-2 for calendar year 2011. Reporting in 2011 will be voluntary, not mandatory, and Employers who do not report this amount will not be subject to any penalties. It is strongly recommended by this office that you begin to work with your payroll vendor (if you contract this service) or your in-house payroll systems department to be certain your year-end reporting will be able to handle this task.

Under the new requirement, Employers must report costs of participating in the following: medical plans; prescription drug plans; executive physicals; on-site clinics which provide more than a minimum of care; Medicare supplemental policies; Employee Assistance Programs; dental and vision plans, unless they are "stand-alone" plans; and, the cost of coverage under a HRA Plan.

When completing the Employee's W-2 Form, Employers must establish a dollar value for the coverage provided, including both the Employer's and Employee's portions of the costs, and report the total annually on their Employees' W-2 Form.

II. Benefit/Coverage Maximums

With the enactment of the PPACA, medical plans cannot set "lifetime" dollar limits for "essential" benefits.

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In response to this mandate, most insurance carriers will modify the way certain benefits are provided

Two of the more significant benefits impacted are durable medical equipment (DME) and prosthetic devices. Typically, DME benefits and prosthetic devices had a dollar maximum per insured per calendar year. As an example, DME oftentimes has a \$1,500.00 calendar year maximum.

It appears the insurance community will be addressing this mandate by eliminating the dollar maximum **but** implementing a large co-insurance benefit in its place.

As an example, Tufts Health Plan has stated it will eliminate the \$1,500/year DME maximum, and then replace it with a 30% patient co-insurance. (Fallon Community Health Plan has indicated it will be implementing a similar change.)

Employers are advised to work with your legal counsel to ensure your plan remains compliant and to discuss what impact, if any, the Employer may have with respect to this change on any existing or expiring Employee/union contracts.

We would also recommend you work with your EBS Foran Account Manager to ensure the benefit change is properly communicated and that your benefits literature is up-to-date and reflects this change.

III. Preventative Care Benefits

Also included in the PPACA is the requirement that specific preventative care benefits be covered in full, not subject to a co-pay, any deductible and/or co-insurance factor.

As a result, most insurance carriers are eliminating the co-pay, deductible and co-insurance factors on these benefits.

It is important to note that Managed Care Plans that offer "out-of-network" preventive services may still include the "cost-sharing" features noted above in claims with a non-network provider.

For those medical plans that have **not** accepted the "grandfathered" status, the above changes to "in-network" benefits becomes effective as of September 23, 2010 (see footnote #1).

Examples of services to be provided with no patient cost (for "in-network" benefits) are the following:

- . Routine adult exams
- . Routine GYN exams
- . Certain family planning services
- . Routine hearing exams
- . Routine vision exams
- . Certain prenatal services
- . Routine pediatric care

The above list is not to be construed as all encompassing and is subject to change if the Federal Government provides more specific guidance.

Again, we encourage you to speak to your EBS Foran Account Manager to address this benefit change specific to your particular carrier, claims administrator (self-funded) and benefits schedule

You will also need to update your Employee Benefits Literature in this regard as well

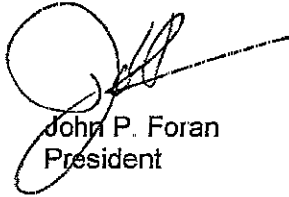
In summary, the enactment of the PPACA presents many challenges to Employers and Insurers alike

The EBS Foran Team is ready to provide whatever assistance we can to help you understand these changes and what they mean to you.

As always, the EBS Foran Team does not provide legal advice, and we recommend you review the above with your legal counsel. We would also be pleased to speak to your legal counsel on issues specific to your plan offering(s) as well

Thank you for allowing us to be of continued service to you.

Sincerely,



John P. Foran
President

Footnote #1: Certain insurers, such as Blue Cross Blue Shield of MA have indicated the plan changes with respect to the elimination of co-pays, etc. will be implemented beginning with Plan Years on or after September 23, 2010