



November 11, 2011

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As you know, the Patient Protection and Affordable Care Act (PPACA) was signed into law on March 23, 2010. Since that time SIHO has been sending periodic e-news regarding the provisions of the bill. In order to provide structure, the following timeline will be included with each newsletter; In addition, each newsletter will provide clear and pertinent information about a selected few topics from this timeline **and will be highlighted in red.**

Immediately

- Grandfather Status
- Small Business Health Insurance Tax Credit
- Reinsurance Program for Early Retiree Health Coverage (June 1, 2010)
- High-Risk Pool Coverage (July 1, 2010)
- Health Insurance Informational Portals (July 1, 2010)

Plan Years Starting on or after September 23, 2010

- Dependent Coverage through Age 26
- No Pre-Existing Condition Exclusions for Children
- No Lifetime Benefit Limits and "Restricted" Annual Limits
- No Rescissions (except Fraud)
- All Emergency Services Covered In-Network*
- No Cost Sharing for Specific Preventive Services*

Note: *Indicates provision does not immediately apply to Grandfathered Group Health Plans.

2011-2013

- Increased tax on HSA and MSA Withdrawals not used for Medical Expenses
- Public Long-Term Care Program
- Medical Loss Ratio (MLR) Requirements
- Comparative Effectiveness Studies Begin
- All Group Plans Must Report Benefits to HHS
- Additional Medicare Tax Levied onto High Income Individuals

2014 and Beyond

- Exchanges
- Annual Taxes on Private Health Insurers
- Monetary Penalties for any Individual Failing to Purchase Coverage
- Expanded Medicaid and Tax Credits for Low Income Individuals
- Employer Responsibility Requirements and Free Choice Vouchers
- Guarantee Issue and Guarantee Renewal
- Pre-Existing Exclusions, Annual Limits, and Lifetime Limits Eliminated
- Restricted Underwriting Factors
- Wellness Program Changes
- Excise Tax (2018)

W-2 Reporting of Aggregate Employer Cost of Health Care Coverage

The Patient Protection and Affordable Care Act will require employers to report the cost of coverage under employer-sponsored group health plans, according to the Internal Revenue Service (IRS). The IRS provided employers additional time to prepare for this requirement in 2011 by making the reporting optional. Smaller employers, which are defined as fewer than 250 employees, will not be required to report the cost of coverage to employees in 2012 either. All employers with 250 employees or more are required to report the cost of coverage for all plan participants in 2012.

The purpose for requiring employers to report the cost of coverage is to show employees the overall value of their health care benefits. According to the IRS, the amount reported does not affect tax liability.

The 2011 Form W-2 is available for viewing on www.irs.gov. The form includes the codes that employers may use to report the cost of coverage under an employer-sponsored group health plan.

Additional information is available by clicking on the link below.

[IRS Updates](#)

Summary of Benefits and Coverage and the Uniform Glossary

The Department of Health and Human Services (HHS) proposed a rule under the Patient Protection and Affordable Care Act that would provide access to clear, consistent and comparable information about each health benefit plan. These standardized tools, which must be provided to enrollees beginning on March 23, 2012, would assist employers in order to select the best coverage for their business and employees. The Summary of Benefits and Coverage (SBC) and the Uniform Glossary of Terms are intended to accurately describe the benefits and coverage under the applicable plan or coverage.

America's Health Insurance Plans (AHIP) conducted a survey to estimate the initial and ongoing costs for the requirement to provide these documents to plan participants. The study indicates that the initial estimates provided by HHS and the National Association of Insurance Commissioners (NAIC) were too low and stated that costs could be considerably higher than the estimates. Some of the reasons the costs could be higher include duplication of materials already delivered to group health plan participants, paper delivery of comparison materials, the requirement to provide SBCs to "shoppers" and the requirement to include premium information on the initial SBC, according to the study.

The proposed rule requires health insurers to issue SBCs to individuals and employers in the shopping phase for health insurance shoppers, at application, enrollment, renewal, when a policy is issued and upon request, according to the AHIP study.

More information is available at the link below.

[AHIP Research](#)

Please be advised that some regulations surrounding this legislation have not yet been finalized. The advice found within this newsletter should never be interpreted as legal advice.

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