Legislative Update for 2013

HEALTH & HUMAN SERVICES: Nelson, Chair, Deuell, Vice-Chair, Huffman, Nichols, Schwertner, Taylor, Uresti, West Zaffirini

CATEGORIES OF BILLS: Chapter 172, Healthcare Bills, Insurance Code Bills, Federal Healthcare

Committee Meetings:

Date	Location	Content

Bill Number	Date Filed	Brief Description	Effective Date	Applicable to Chapter 172	Comments
SB 84/Ellis		Relating to regulation of health benefit plan issuers in this State. A health benefit plan issuer may not, with respect to an individual younger than 19 years of age: (1) deny the individual's application for coverage due to a preexisting condition, (2) limit or deny coverage under the health benefit plan to the individual on the basis that the benefits requested are required to treat a preexisting condition or charge the individual a premium in an amount that is more than two times the premium charged by the health benefit plan issuer to an individual younger than 19 years of age who does not have a preexisting condition, if the individual enrolls in a health benefit plan described by Section 1521.006 during an enrollment period described by Section 1521.006. 1521.005 coverage for certain dependents required if a health benefit plan includes dependent coverage, the health benefit plan issuer shall approve the enrollment of an individual who is the minor child of an enrollee in the health benefit plan. Enrollment of an individual health benefit plan under a section on a guaranteed issue basis during a period other than an open enrollment period under Subsection © if the applicant or a parent, managing conservator, or legal guardian of the applicant experiences a qualifying event under the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. Section 1320d et seq.).		Applicable	
TX83HB 170/Alonzo, Roberto	11.13.12	Relating to the coverage by certain health benefit plans of mammograms performed by certain health care providers to a female who is 35 years of age or older must include coverage for an annual screening by low-dose mammography for the presence of occult breast cancer. Must be subject to the same dollar limits, deductibles, and coinsurance factors as coverage for other radiological examinations under the plan. A health benefit plan may require an enrollee to receive prior approval before having a covered mammogram performed by a physician or provider other than the enrollee's primary care physician or primary care provider.	September 1, 2013	N/A	

Bill Number	Date Filed	Brief Description	Effective Date	Applicable to Chapter 172	Comments
TX83HB 197/Farias, Joe	11.15.12	Relating to an obesity and wellness information portal on comptroller's Internet website. The comptroller may consult with the Health and Human Services Commission and the Department of State Health Services in establishing the content for the portal.	September 1, 2013	N/A	
HB 226 companion SB 73		Coverage for Children < 19 years of age; preexisting conditions, enrollment in plans, no cost share allowed on preventive care and screenings	September 1, 2013	Attempt to remove reference to Chapter 172	
HB 459/Gullen	1.16.13	Relating to the creation of a navigator program as described by the Patient Protection and Affordable Care Act, adopt rules governing the certification of a navigator, provide training to navigators,	September 1, 2013	PPACA navigator no impact today for TML IEBP	
HB 495/Hernandez Luna	1.16.13	Relating to the requirement that certain health benefit plans provide coverage for supplemental breast cancer screening. Mammography and other Breast Cancer Screening	September 1, 2013	Applicable	Evidence based screening
HB 522/Kuempel	1.16.13	Relating to direct payment by a health insurer to physicians and health care providers. Provider means a person who provides health care services or ambulance services under a license, certificate, registration or other similar evidence of regulation issued by this or another state of the U.S. Must provide assignment of Benefits options so covered individual can assign benefits to provider. Direct payment to preferred providers required.	September 1, 2013	N/A	Evidence based plan eligible benefits
HB 542/Zerwas	1.16.13	Relating to the prescription and pharmaceutical substitution of biological/biosimilar products. A pharmacy ma not substitute a biosimilar biological product for a prescribed reference product unless the US Food and Drug Administration has determined that the prescribed reference product for the specified indicated use. Before delivery of a prescription for an interchangeable biosimilar biological product, a pharmacist must personally, or through the pharmacist's agent or employee inform the patient or the patient's agent that a less expensive interchangeable biosimilar biological product is available for the reference product prescribed. Refills do not require same education.	January 1, 2014	N/A	Evidenced based eligible prescriptions.
Naishtat, Elliott/HB 593	1.18.13	Relating to the expansion of eligibility for medical assistance to certain persons under the federal Patient Protection and Affordable Care Act. The department shall provide medical assistance to all persons who apply for that assistance and for whom federal matching funds are available under the Patient Protection and Affordable Care Act as amended by the Health Care and Education Reconciliation Act of 2012. Executive commissioner of the Health and Human Services Commission shall take all necessary actions to expand eligibility for medical assistance under Chapter 32, Human Resource Code	September 1, 2013	N/A	
Ellis/SB 84		Relating to regulation of health benefit plan issuers in this state. Chapter 1509 Texas Health Insurance Exchange Definition of Health Benefit Plan (a) in this chapter, "health benefit plan" means an insurance policy, insurance agreement, evidence of coverage, or other similar coverage document that	September 1, 2013	Applicable	Texas is not supporting an exchange at this moment, but I think we should begin

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		provides coverage for medical or surgical expenses incurred as a result of a health condition, accident or sickness that is issued by: an insurance company; a group hospital service corporation operating under Chapter 842, a fraternal benefit society operating under Chapter 885; a stipulated premium company operating under Chapter 884, an exchange operating under Chapter 942, a health maintenance organization operating under Chapter 883, a multiple employer welfare arrangement that holds a certificate of authority under Chapter 846 or an approved nonprofit health corporation that holds a certificate of authority under Chapter 844.			working on inclusion as a definition of a Health Plan. Defines certification of health benefit plan as a qualified health plan if the plan provides the essential health benefits package described by Section 1302(a)
Burnam/HB 59		Relating to participation by political subdivisions in federal healthcare programs. If the state does not authorize the expansion of Medicaid as provided under the federal Patient Protection and Affordable Care Act then local hospital districts, counties and other units of local government created under state law may apply directly to the federal government to expand Medicaid contingent on their ability to provide local tax funds for the state share of the match.	September 1, 2013	N/A	
White/H.J.R. 48		Proposing a constitutional amendment relating to the rights of individuals to choose or decline to choose to purchase health insurance coverage. Each individual in this state has the right to choose or decline to choose to purchase health insurance coverage without penalty or sanction or threat of penalty or sanction.	Submitted to voters at an election to be held November 5, 2103	N/A	Does not support Supreme Court Decision
Creighton/H.J.R. 59		Proposing a constitutional amendment relating to the rights of individuals to choose or decline health insurance coverage. Each individual in this state has the right to choose or decline to choose health insurance coverage without penalty or sanction or threat of penalty or sanction.	Submitted to voters at an election to be held November 5, 2103	N/A	Does not support Supreme Court Decision
Ellis/S.J.R. 8		Proposing a constitutional amendment requiring the state to expand eligibility for the Medicaid program to certain persons. The state shall provide medical assistance under the federal Medicaid program to all persons who apply for that assistance and for whom federal matching funds are available under the Patient Protection and Affordable Care Act (Pub. L. No. 111-148) as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. No. 111-152) to the state to provide that assistance.	Submitted to voters at an election to be held November 5, 2103	N/A	
Larson/HB 119		Relating to citizenship information reported by persons who receive local or state money to provide services to individuals in this State to provide a health care, educational, welfare, correctional, or other service to an individual in this state shall: identify the individual's country of citizenship before providing services to the individual	September 1, 2013	N/A	

Bill Number	Date Filed	Brief Description	Effective Date	Applicable to Chapter 172	Comments
Raymond/HB 128		Relating to the creation of childhood health program grant. The department shall develop and implement a grant program to support programs related to childhood health, fitness, and obesity prevention.	September 1, 2013	N/A	
Alonzo/HB 170		Relating to the coverage by certain health benefit plans of mammograms performed by certain health care providers.	September 1, 2013	N/A	
Farias/HB 197		Relating to an obesity and wellness information portal on the comptroller's Internet website. The portal must serve as a clearinghouse for information relating to obesity and wellness	September 1, 2013	N/A	
Thompson of Harris/226		Relating to prohibition of certain insurance discrimination. A person may not refuse to insure or provide coverage to an individual, refuse to continue to insure or provide coverage to an individual, limit the amount, extent, or kind of coverage to an individual, or charge an individual a rate that is different from the rate charged to other individuals for the same coverage because of the individual's race, color, religion, or national origin, age, gender, marital status, or geographic location, disability or partial disability or sexual orientation or gender identify or expression.	September 1, 2013	N/A	
Eiland/HB 620	1.23.13	Relating to the regulation of certain health care provider network contract arrangements. Registration Required unless the person holds a certificate of authority issued by the department to engage in the business of insurance in this state or operates a health maintenance organization under Chapter 843, a person must register with the department not later than the 30th day after the date on which the person begins acting as a contracting entity in this state.	September 1, 2013	Registration and notice requirements for provider networks. TML IEBP accesses the UnitedHealth Choice Network	
Deuell/SB 253		Relating to newborn screening for congenital heart defects, pulse oximetry screening test means a noninvasive test that estimates the percentage of hemoglobin in blood that is saturated with oxygen, birthing facility means an inpatient or ambulatory health care facility that offers obstetrical and newborn care services. The term includes: a hospital licensed under Chapter 241 that offers obstetrical services; a birthing center licensed under Chapter 244, a children's hospital licensed by the department or a facility maintained and operated by the department.	September 1, 2013	N/A	Similar to HB 392 filed 1.8.13, similar to HB 740
J/HB 522	1.15.13	Relating to direct payment by a health insurer to physicians and health care providers. A payment to a physician or health care provider under an assignment of benefits may not be more than the amount the insurer would have paid in the absence of an assignment of benefits.	September 1, 2013	N/A	
Zerwas/HB 542	1.15.13	Relating to the prescription and pharmaceutical substitution of biological products. Interchangeable biosimilar biological product authorized. A pharmacy may not substitute a biosimilar biological product for a prescribed reference product unless	September 1, 2013 Subchater F Chapter 562 Occupations Code as added by this Act takes effect	N/A	

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		the US Food and Drug Administration has determined that the biosimilar biological product is interchangeable with the prescribed reference product for the specified indicated use.	January 1, 2014		
/HB 495	1.14.13	Relating to the requirement that certain health benefit plans provide coverage for supplemental breast cancer screening and other breast cancer screenings.	September 1, 2013	N/A	
/HB 473	1.11.13	Relating to the provision under the medical assistance program of certain medications to children younger than five years of age. Prior authorization for certain medications for Children. To the extent allowed by federal law, the commission shall ensure that a managed care organization providing prescription drug benefits under the Medicaid program requires prior authorization for the provision of an antipsychotic or neuroleptic medication to a child who is younger than five years of age.	September 1, 2013	Medicaid Program	
/HB 446	1.10.13	Relating to information about fetal alcohol syndrome to be provided to pregnant patients. Counsel the patient about the risks of drinking alcohol while pregnant, including fetal alcohol syndrome.	September 1, 2013	N/A	Expansion of Wellness Benefits at no Cost Share for Educational Counseling Services
/HB 395	1.8.13	Relating to the use by certain health care providers of electronically readable information from a driver's license or personal identification certificate.	September 1, 2013	N/A	
/HB 226	11.29.12	Relating to prohibition of certain insurance discrimination. Sexual orientation or gender identify or expression.	September 1, 2013	N/A	
Fletcher/HB 309	12.19.12	Relating to prohibiting abortion when based on the sex of the unborn child, creating an offense. Sex selected abortion.	September 1, 2013	N/A	
/HB 365	1.7.13	Relating to certain disease or illnesses suffered by firefighters and emergency medical technicians. Certain Contagious disease. Presumption under Section 607.053, 607.054, 607.055, 607.056 or 607.0565	September 1, 2013	N/A-IRP	
/HB 361	1.7.13	Relating to group health benefits coverage for dependents and family members of persons wrongfully imprisoned. Eligible to obtain group health benefit plan coverage through the Texas Department of Criminal Justice as if the person were an employee of the department	September 1, 2013	N/A	
/HB 219	11.27.12	Relating to the provision of certain public benefits and services to persons not lawfully present in the US and reimbursement from the federal government for those benefits and services. Request for Reimbursement not later than March 31 of each year based on the information obtained under Section 2351.003, the comptroller shall make a written request to the US Congress for reimbursement of the cost of providing to persons not lawfully present in the US education and health benefits and services required by federal law during the previous fiscal year.	September 1, 2013	N/A	

Bill Number	Date Filed	Brief Description	Effective Date	Applicable to Chapter 172	Comments
/HB 592	1.18.13	Relating to the definition of serious mental illness for purposes of certain group health benefit plans. Addition is posttraumatic stress disorder to bi-polar disorders (hypomanic, manic, depressive, and mixed, depression in childhood and adolescence, major depressive disorders (single episode or recurrent), obsessive-compulsive disorders, paranoid and other psychotic disorders, schizo-affective disorders (bipolar or depressive and shizophrenia	September 1, 2013	Applicable	
/HB 649	1.23.13	Relating to tax reimbursement for businesses that refuse to comply with certain federal health care coverage requirements based solely on the religious convictions of the owners of the businesses, authorizing tax refunds and credits.	9.1.13	N/A	
/HB 771	1.28.13	Relating to information maintained in the immunization registry after an individual becomes an adult.	9.1.13	N/A	
Nelson/SB 62		Relating to the vaccination against bacterial meningitis or entering students at public and private or independent institutions of higher education.	10.1.13	N/A	
Nelson/ SB 63		Relating to consent to the immunization of certain children.	9.1.13	N/A	
Nelson/SB 8		Relating to the provision and delivery of certain health and human services in this state, including the provision of those services through the Medicaid program and the prevention of fraud, waste, and abuse in the program and other programs. Eligibility determination for services provided through the commission or a health and human services agency related to: child health plan program, financial assistance, medical assistance, nutritional assistance, long-term care services, community-based support services, other health and human services programs	9.1.13	Medicaid	
/HB 624	1.23.13	Relating to the payment for services provided by certain types of health care practitioners under contracts between the practitioners and managed care benefit plans	9.1.13	Applicable	
Zaffirini/SB 40		Relating to the immunization data included in and excluded from the immunization registry.	9.1.13	N/A	
Nelson/SB 7		Relating to improving the delivery and quality of certain health and human services, including the delivery and quality of Medicaid acute care services and long-term care services and support.	9.1.13	N/A	
/HB 739	1.29.13	Relating to the creation of a voluntary consumer-directed health plan for certain individuals eligible to participate in the group benefits program provided under the Texas Employees Group Benefits Act and their qualified dependents.	9.1.13	N/A	
Howard/HB 772	1.28.13	Relating to the immunization data included in and excluded from the immunization registry.	9.1.13	N/A	
Nelson/SB 57		Relating to improving the delivery and quality of certain health and human services, including the delivery and quality of Medicaid acute care services and long term care services and support	9.1.13	N/A	

Bill Number	Date Filed	Brief Description	Effective Date	Applicable to Chapter 172	Comments
/SB 255		Relating to the creation of a voluntary consumer-directed health plan for certain individuals eligible to participate in the group benefits program provided under the Texas Employee Group Benefits Act and their qualified dependents.	9.1.13	N/A	
/SB 294		Relating to extending a local behavioral health intervention pilot project. Not later than December 1, of each even-number year, the local mental health authority involved in the pilot project shall submit a report to the department regarding the local behavioral health intervention pilot project including: comprehensive analysis of the efficacy of the project, the local authority's findings and recommendations. Act expires 9.1.23	Takes effect immediately if it receives a vote of 2/3 of all members elected to each house, as provided by Section 39, Article III, Texas Constitution.	N/A	
Zaffirini/SB 41		Relating to the administration and provision of consumer-directed services under certain health and human services program.	9.1.13	N/A	
Zaffirini/ SB 53		Relating to life support services provided by certain emergency medical services personnel	9.1.13	N/A	
/SB 97		Relating to distributing or prescribing abortion-inducing drugs providing penalties	9.1.13	N/A	
/SB 166		Relating to the use by certain health care providers of electronically readable information from a driver's license or personal identification certificate.	9.1.13	N/A	
Ellis/SB 85		Relating to prior approval of certain insurance rates. This chapter applies only to a health benefit plan that provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including an individual, groups, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract or an individual or group evidence of coverage or similar coverage document that is offered.	9.1.13	N/A	
/HB 595	1.18.13	Relating to the repeal of certain health programs and councils, to the review of certain health programs, panels, councils, systems, foundations, centers, committees, and divisions under the Texas Sunset Act, and to the transfer of certain functions to the Department of State Health Services, providing penalties. The commission shall: plan and direct the Medicaid program in each agency that operates a portion of the Medicaid program including the management of the Medicaid managed care system and the development, procurement, management, and monitoring of contracts necessary to implement the Medicaid managed care system.	9.1.13	N/A	
/HB 746	1.28.13	Relating to allowing health care providers to provide services across state lines in catastrophic circumstances.	9.1.13	N/A	
Deuell/SB 303	1.31.13	Relating to advance directives and health care and treatment decisions. Nutrition and hydration means the provision of nutrients or fluids by a tube inserted in a vein, under the skin in the subcutaneous tissues, or in the stomach (gastrointenstinal tract), life sustaining treatment, advance directive, ethics committee meeting if	9.1.13	N/A	

Bill Number	Date Filed	Brief Description	Effective Date	Applicable to Chapter 172	Comments
		physician recommends against life sustaining treatment and patient readmitted within six months.			
Davis/HB 865	1.31.13	Relating to removing the single nonprofit trust requirement for certain insurance premium tax exemptions; affecting certain taxes.	9.1.13	Applicable	
Villarreal/HB 868	1.31.13	Relating to exceptions to mental health information disclosure prohibitions.	9.1.13	applicable	
Gonzales/HB 831	1.30.13	Relating to consent to the administration of certain medications provided to foster children.	9.1.13	N/A	
Smithee/HB 997	2.5.13	Relating to health plan and health benefit plan coverage for abortions. Extent that the abortion of her pregnancy is necessary to prevent her death or a serious risk of substantial and irreversible physical impairment of a major bodily function of the enrollee, other than a psychological or emotional condition.		applicable	
Johnson/HB 996	2.6.13	Relating to the expansion of eligibility for medical assistance to certain persons under the federal Patient Protection and Affordable Care Act. The department shall provide medical assistance to all persons who apply for that assistance and for whom federal matching funds are available under the Patient Protection and Affordable Care Act.	9.1.13	N/A	
Johnson/HB 1001	2.6.13	Relating to the expansion of eligibility for Medicaid in certain counties under the federal patient Protection and Affordable Care Act.	9.1.13	N/A	Medicaid 1115 waiver is discussed with many counties. Grant Money Available
Johnson/HB 1002	2..6.13	Relating to creation of the Texas Health Insurance Exchange.	9.1.13	N/A No movement on Exchange in Texas by the State	"Seeks to enroll qualified health plans"
Zerwas/HB 1032	2.6.13	Relating to the creation of a standard request form for prior authorization of prescription drug benefits. Prescribe a single, standard from for requesting prior authorizations of prescriptions drug benefits	9.1.13	applicable	
Eiland/HB 1036	2.6.13	Relating to the regulation of pharmacy benefit managers; imposing penalties; imposing and authorizing fees. A pharmacy benefit manager may not charge a transaction fee for a claim submitted electronically to the pharmacy benefit manager by a retail pharmacy. A pharmacy benefit manager may not require that a retail pharmacy by a member of a network managed by the pharmacy benefit manager as a condition for the retail pharmacy to participate in another network managed by the pharmacy benefit manager. A pharmacy benefit manager may not exclude a retail pharmacy from participation in a network if the pharmacy accept the terms, conditions, and reimbursement rates of the pharmacy benefit manager, meets all applicable federal and state licensure and permit requirements; and has not been excluded from participation as a provider in any federal state program.	9.1.13	applicable	

Bill Number	Date Filed	Brief Description	Effective Date	Applicable to Chapter 172	Comments
Nelson/SB 406	2.6.13	Relating to the delegation and supervision of prescriptive authority by physicians to certain advance practice registered nurses and physician assistants.	9.1.13	N/A	

Topic to Track:

1. How will minimum essential coverage and essential health benefits be interrelated in the upcoming regulatory guidance? Treasury has indicated that the minimum essential coverage regulations are expected to encompass self-insured plans. The expectation is that Treasury is going to provide some type of parameters on what benefits a self-insured plan must cover in order for a self-insured plan to constitute minimum essential coverage. One logical parameter would be that a self-insured plan provides minimum essential coverage if the plan covers essential health benefits. But, as always, until we actually see the regulations, we won't know exactly how everything will play out.
2. Surgical Contraception (tubal ligation)

PPACA Table

Year Implemented	PPACA Benefits
2018	▪ Imposing 40% excise tax on Cadillac plans: $10,200 for individuals; $27,500 for families; $11,850 for retirees; and $30,950 for employees in high risk professions, such as police and fire (Delayed) ▪ Discussion Item: Prohibition of physician owned hospitals (Delayed)
2014 August 28, 2012, from 1:00 PM - 3:00 PM Austin Mtg	▪ HITECH Conversion to ICD 10 October 2014 and from 4010 to 5010 June 2012 ▪ Group health plans may only impose, restricted annual limits on the dollar value of essential benefits, and for plan years beginning on or after January 1, 2014, annual limits must be eliminated. Essential Benefits include: ambulatory patient service, emergency services, hospitalization, maternity and newborn care, mental health and substance abuse disorders (including behavioral health treatment), prescription drugs, Rehabilitative and habilitative (creates skills and functions) services and devices, laboratory services, preventative and wellness services and chronic disease management, pediatric services (including oral and vision care) Pediatric Oral and Vision Care: CCIIO suggest looking to the state's Children's Health Insurance Program (CHIP) or the Federal Employees Dental and Vision Insurance Program to ascertain essential benefits. It appears the following would fit the guidelines: preventive and basic dental services: cleanings, and fillings, more advanced dental services root canals, crowns and medically necessary orthodontia and routine eye examinations with refraction, corrective lenses and contact lenses. ▪ Proposed that the "treatment limitations" have the meaning found in 146.136 which includes both quantitative and non quantitative limits on benefits. Quantitative includes limits based on the frequency of treatment, days of coverage, or other similar limits on the scope and duration of teams. Non quantitative limits include prior authorizations, step therapy type of restrictions. ▪ Development of accrediting organization, possibly URAC-standards to include consumer access, utilization management, quality assurance, provider credentialing, compliance with appeals, network adequacy, patient information ▪ Permissive essential benefits for annual limits before 2014 are: » 2010: $750.00, 2011: $1,250.00,2012: $2,000.00, 2014: None Permitted ▪ Limitation of waiting period 90 days ▪ Reinsurance Contribution January 1, 2014 (from fully insured and self insured plans); State-based transition reinsurance program to help stabilize the premium coverage for the individual health insurance market during the first three years of operation of the ExchangeBy December 31, 2014 notice of the use it or lose it guidance will be defined for Section 125 Plans. ▪ Independent Payment Advisory Board (IPAB) issues first report to Congress if Medicare spending exceeds growth target ▪ Wellness Incentives increase from 20% to 30% ▪ Quality Reporting requirements through improved health outcomes January 1, 2014 » Standardization Web Portals » Standardization of Benefit Plans » Standardization of Coordination of Benefits ▪ Participation in clinical trials for eligible services ▪ Ban on dollar limits, Qualitative and Quantitative Discussion

Year Implemented	PPACA Benefits
	▪ >19 pre-existing condition exclusions ▪ Solo drug manufacturers will notify FDA 6 months prior to discontinuation of Rx ▪ Law implements an age band so that the amount on older people will be no more than three times what a younger individual pays. Guaranteed issue and rating variation bands on age, family composition, tobacco use, guaranteed renewability, and availability of coverage, Prohibition of discrimination based on health status, No differentiation based on a person's health status when coverage is first purchased. Known as "community rating" ▪ **Full Time/Part Time benefit coverage: definition of part time employee: 30/25/20 hours a week, seasonal labor >120 days/year ▪ Non tax deductible penalties Pay or Play Mandate: $2,000 per full-time worker with 50 or more employees ▪ Inadequate Coverage Free Voucher Program: 100%-400% of Federal Poverty level and premium is more than 8.4%-9% of household income. Inadequate Coverage: Penalty $3,000 (# of employees receiving a premium tax credit or cost subsidy) » Offering Small Employer Tax Credits that provide coverage; Premium Tax Credit: marriage, divorce, and mid-year changes; Small Business Health Options Program (SHOP); 25/50 or fewer employees with $50,000/$40,000 maximum average wage: Tax Credit for tax exempt employers maximum of 35%/tax exempt 25% » By December 31, 2014 notice of the use it or lose it guidance will be defined for Section 125 Plans. ▪ Independent Payment Advisory Board (IPAB) issues first report to Congress if Medicare spending exceeds growth target
2013	▪ Health Identification Number Application ▪ Increasing the Medicare payroll tax by 0.9% on upper income Americans » 4.17.12 - Obama's Buffet Rule minimum 30% tax for millionaires » Impose a 3.8% tax on net investment income of high income individuals ▪ The Unreimbursed Healthcare Spending Account unreimbursed healthcare spending amount limit to a standard maximum of $2,500 per plan year January 2013 and thereafter. The dependent care flex benefit will remain at $5,000 (or $2,500 in married and filing separately). ▪ Medicare reduction in payment for select hospital readmissions if occurs within 30 days 1% of Medicare payment (recouping $280M in payments from about 2,200 hospitals beginning in October 1, 2012: 9.10.12 state 2/3 of hospitals will be hit: Arkansas, Kentucky, Mississippi, Illinois, and Mass. will be hit the hardest—causal factors could be socioeconomic factors ▪ Expanded coverage of preventive services ▪ Authorizations of Data Sharing by Accrediting Entities to the Exchange ▪ Sustainable Growth Rate (SGR)/Doc Fix » Physicians will not incur Medicare payment cut of 27.4% until 12.31.12 but Burgess is requesting a delay for another year estimating a 28% cut in Medicare Reimbursement—estimating cost would be offset by the overseas contingency fund. This will require about $10B in offsets. » Comments are being collected in eliminated the SGR and begin the transition to a better payment system » Sequestration Report published on 9.14.12 1.2trillion dollars 2% Medicare, $11 billion reduction, 8.2% or $319 million in FDA spending and 8.2% or $2.52billion in Natl Health Institute ▪ W-2 Form reporting for Health care Coverage ▪ Exchange Notice to employees establishing state health insurance exchanges/HHS Notification 11.16.12, Exchanges will be certified for operations Jan 1, 2013. States may allow employers with more than 50/100 employees to purchase coverage in Exchange; possibility of multiple Exchanges within each state and across state lines. (Texas: Zerwas) » Large Employers, 2017 » Certify Qualified Health Plans Statute » Does not authorize tax credits in federal health insurance exchanges, it authorized them solely through state health insurance exchanges » Operate 24/7 web portal and toll-free number » Health plans rating system/enrollee satisfaction » Subsidy eligibility and electronic cost calculate » Rate Increase Review » Navigator to facilitate enrollment » Communication information to Department of Treasury » Determine exemption from individual mandates » Connect employer and public programs for eligibility/enrollment » No individual underwriting

Year Implemented	PPACA Benefits
2012	▪ Plans after September 23, 2012 compliant with standardization of information - Summary of Benefits Coverage (SBC); midyear changes require 60 day notice for material changes to SBC Content ▪ Women's Reproductive Health Act (Plans July 1, 2012 thereafter) ▪ Medicare hospital value-based purchasing program ▪ Increase in physician quality reporting requirements in Medicare ▪ Additional Medicare pilot programs on alternative payment methodologies e.g., accountable care organizations ▪ Proposed Rule on Affordable Care Act's Comparative Effectiveness Research Fees » Two new sections in the Internal Revenue Code (IRC) require insurers and self-insured plans to pay comparative effectiveness research fees. One section applies to health insurance policies, with the fees paid by the issuers of the policies. The other section applies to self insured health plans, including self-insured state and local governmental plans, with the fees paid by the plan sponsor. » Calendar plans will pay the fees for the 2012 through 2018 plan years (for a total of seven years). For plans that do not operate on a calendar-year basis, the fee would apply to the first plan year that ends on or after October 1, 2012. The fees do not apply to plan years ending after September 30, 2019. » In the first year it applies, the fee will be **$1/PMPY** multiplied by the average number of lives covered under the plan (including dependents). In subsequent years, the multiplier is **$2/PMPY** times the average number of covered lives but this number will be reviewed annually and could change. » Plan sponsors will have three options for calculating average number of covered lives. Actual Count ee & dep each day of plan year/number of days in plan year; Snapshot add total covered lives on one date each quarter of plan year dividing sum by number of days in plan year, or Form 5500 Reported Employees by adding number of employees covered at the beginning of plan year to the number of employees at the end of the plan year and dividing by two. » Types of Coverage Not Subject to the Fees: dental and vision benefits would be exempt only if they are "limited-scope" benefits (separate coverage from medical with an additional premium/contribution if they elect coverage); Flexible Spending Accounts (FSAs) that qualify as excepted benefits under HIPAA are exempt from fees. H.S.A.s are not subject to the fees. HRAs and Retiree Coverage are subject generally subject to fees.

Federal Government

A. Patient Protection Affordable Care Act

1. Comparative Research Committee $1.00 PPPY Revised IRS form 720 to remit. Calendar-year plans will pay the fees for the 2012 through 2018 plan years (for a total of seven years). For plans that do not operate on calendar-year basis, the fee would apply to the first plan year that ends on or after October 1, 2012. The fees continue to apply through the plan year ending before October 1, 2019.
2. Patient-Centered Outcomes Research Institute (PCORI) will conduct research evaluating and comparing health outcomes and assess the clinical effectiveness, risks and benefits of medical treatments.
3. First Year
    a. $1.00 PPPY (average)
4. Subsequent Years
    a. Multiplier is $2.00 average number of covered lives, retirees and their families count as covered lives, whether benefits are provided through a plan with actives or a retiree-only plan.
    b. COBRA Coverage Participants are subject to the fees
5. This number will be reviewed annually and could change

B. Transitional Reinsurance Program (insurance coverage to "high-risk individuals" in the individual health insurance market)

1. Beginning 2014 and ending 2016 (Applies for Limited Time –fee begins November 15, 2014)
2. Plan sponsors of a self-funded plan will submit plan enrollment information to HHS. This number will describe the average number of covered lives for the 2014 benefit year. Generally within 15 days of that submission, HHS will notify the employer of the amount which must be paid as a Reinsurance Fee.
3. $5.25 Per covered life for each month in 2014 (could increase if insufficient)/Pre-Existing Subsidy Cost $63-per-head fee to cushion the cost of covering people with pre-existing conditions labeled as the "sleeper issue"
4. If the State chooses not to establish a reinsurance program, the Department of Health and Human Services (HHS) will establish a reinsurance program for the State. (Compensation for "high risk individual" in the individual health insurance market)

5. Beginning 2014 and ending 2016. Reinsurance Program will be funded through "contributions" made by (1) insurance companies that sell health plans in the fully-insured individual and group health insurance market and (2) TPAs on behalf of self insured plans. Administrative expenses may be added to the overall annual contribution amount and States are permitted to collect more than the amount specified in the law if the State believes that such amounts are not sufficient to cover its reinsurance payments or administrative costs. The proposed regulations confirm that the plan is liable and do not impose any affirmative obligations on TPAs. Contributions are based on major medical health insurance coverage only.

C. Proposed rule stipulates the rate will be $5.25 per covered life for each month in 2014. Plan sponsors will have three options for calculating average number of covered lives. **Actual Count** employee & dependent each day of plan year/number of days in plan year; **Snap Shot** add total covered lives on one date each quarter of plan year dividing sum by number of days in plan year, or **Form 5500** Reported Employees by adding number of employees covered at the beginning of plan year to the number of employees at the end of the plan year and dividing by two.

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