Stephens Insurance, LLC

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Health Insurance Reforms That Will Impact Private Health Insurance

Plan-Related Health Insurance Reform Provisions

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UBA United Benefit Advisors

Plan-Related Health Insurance Reform Provisions

Topic	Provisions	Effective Date
	INSURER RELATED PROVISIONS	
Minimum Loss Ratios	Minimum loss ratio requirements will be established for insurers in all markets (self-insured plans are exempt). The Minimum Loss Ratio is: o 85% for large group plans (101 employees or more) o 80% for small group plans (100 and below) o 80% for individual plans The calculation is independent of: o Federal taxes o State taxes o Any payments as a result of the risk adjustment provisions o Any payments as a result of the reinsurance provisions Starting in 2011, carriers will have to issue a pro rata **premium rebate to individuals** for plans that fail to meet the Minimum Loss Ratio requirements. Allows the Secretary of DHHS to make adjustments to the percentage if it proves to be destabilizing to the individual or small group markets. The National Association of Insurance Commissioners (NAIC) is required to establish uniform definitions regarding the Minimum Loss Ratio and how the rebate is calculated by December 31, 2010.	Plan years beginning on or after September 23, 2010 The standards and any potential rebates to policy-holders being applied to the 2011 plan year.
Quality Information Reporting by Group Health Plans	Requires the Secretary of DHHS to develop quality reporting requirements for use by group health plans and group and individual health plans about their coverage benefits and health care provider reimbursement structures that: o Improve health outcomes o Prevent hospital readmissions o Improve patient safety o Reduce medical errors o Implement wellness and health promotion activities All group health plans (including **self-insured** plans) and group and individual health insurance carriers must annually submit to: o the Secretary of DHHS o to plan enrollees during the annual open enrollment period a report on whether the benefits under the plan or coverage include the specified components.	Plan years beginning on or after September 23, 2010 (Grandfather rules apply)

Plan-Related Health Insurance Reform Provisions

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	The Secretary of DHHS will make the reports available to the public through an Internet website and can develop and impose appropriate penalties on employer groups and health plans for non-compliance.	
Modified Community Rating Requirements	Strict modified community rating standards must be adhered to by: o All individual health insurance policies o All fully insured group policies of 100 lives and under o Larger groups purchasing coverage through the exchanges Premium variations would only be allowed for: o Age (3:1) o Tobacco use (1.5:1) o Family composition o Geographic regions to be defined by the states Experience rating would be prohibited. Wellness discounts are allowed for group plans under specific circumstances.	Plan years beginning on or after January 1, 2014. (Grandfather rules apply)
	PLAN COVERAGE RELATED PROVISIONS	
Coverage of Preventive Care	Mandates coverage of specific preventive services with **no** cost-sharing (if provided in-network) for: o Fully-insured individual health plans o Fully-insured group plans o **Self-insured** group health plans The services that must be covered at minimum include: o Evidence-based items or services with a rating of `A' or `B' in the current recommendations of the United States Preventive Services Task Force o Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved o For infants, children, and adolescents: evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration. o For women, additional preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration. o For women, the recommendations issued by the United States Preventive Service Task Force regarding breast cancer screening, mammography, and prevention shall be considered the most current other than those issued in or around November 2009.	Plan years beginning on or after September 23, 2010 (Grandfather rules apply)

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Varying Health Plan Rules Based on Salary	Requires group health plans (other than a self-insured plan) to comply with the Internal Revenue Section 105(h) rules that prohibit discrimination in favor of highly compensated individuals (which currently apply to self-insured plans). **Note: The effective date has been delayed until the IRS provides additional guidance (1/1/14?)**	Plan years beginning on or after September 23, 2010 (Grandfather rules apply)
Policy Rescissions	Prohibits rescissions of health plan coverage in all insurance markets and **self-insured** group health plans, except for cases of fraud or for enrollees making an intentional misrepresentation of material fact as prohibited by the terms of the plan or coverage. Coverage may not be cancelled without prior notice to the enrollee.	Plan years beginning on or after September 23, 2010
Lifetime Benefit Limits	Prohibits lifetime limits on the dollar value of "essential" benefits for any participant or beneficiary of: o Fully-insured individual health plans o Fully-insured group plans o **Self-insured** group health plans	Plan years beginning on or after September 23, 2010
Annual Benefit Limits	Annual benefit limits on DHHS-defined "non-essential" benefits for: o Fully-insured individual health plans o Fully-insured group plans o **Self-insured** group health plans Must be no less than: o $750,000 for plan years beginning between September 23, 2010 and September 22, 2011 o $1,250,000 for plan years beginning between September 23, 2011 and September 22, 2012 o $2,000,000 for plan years beginning between September 23, 2012 and December 31, 2013 o Unlimited for plan years beginning on or after January 1, 2014	Plan years beginning on or after September 23, 2010 (Grandfather rules apply for individual policies only)
Coverage of Emergency Services	Mandates coverage of emergency services at in-network level regardless of provider for: o Fully-insured individual health plans o Fully-insured group plans o **Self-insured** group health plans	Plan years beginning on or after September 23, 2010 (Grandfather rules apply)
Designating a Primary Care Physician	Allows enrollees to designate any in-network allopathic or osteopathic doctor as their primary care physician (including OB/GYN and pediatrician) for: o Fully-insured individual health plans o Fully-insured group plans o **Self-insured** group health plans	Plan years beginning on or after September 23, 2010 (Grandfather rules apply)

Plan-Related Health Insurance Reform Provisions

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Extended Dependent Coverage	Increases the age of a dependent (including married and/or non-student dependents) for health plan coverage to age 26 for: o Fully-insured individual health plans o Fully-insured group plans o **Self-insured** group health plans o COBRA coverage For grandfathered group plans until 2014, the coverage to age 26 provisions would only apply to those dependents that do not have another source of employer-sponsored health insurance.	Plan years beginning on or after September 23, 2010 (Limited grandfathering applies as noted)
Coverage and Claims Appeals Process	Requires plans to have an internal and external coverage appeals process for: o Fully-insured individual health plans o Fully-insured group plans o **Self-insured** group health plans At a minimum, plans and issuers must: o have an internal claims process in effect, which process must initially incorporate the current claims procedure regulations issued by the Department of Labor in 2001 o provide notice to enrollees, in a culturally and linguistically appropriate manner, of available internal and external appeals processes, and the availability of any applicable office of health insurance consumer assistance or ombudsman to assist them with the appeals processes o allow enrollees to review their files, to present evidence and testimony as part of the appeals process, and to receive continued coverage pending the outcome of the appeals process o implement an external review process that meets applicable state requirements and guidance that is to be issued by HHS	Plan years beginning on or after September 23, 2010 (Grandfather rules apply)
OB/GYN Non-Referral Provision	Where the plan provides obstetrical and gynecological coverage, and requires designation of a primary care physician, the plan must allow covered females to obtain obstetrical or gynecological care from an in-network provider without authorization or referral from the primary care physician.	Plan years beginning on or after September 23, 2010 (Grandfather rules apply)
Penalties for Non compliance with Benefit Mandates	Penalties for non-compliance with any mandated benefit provision is $100 per day per violation per affected participant.	Plan years beginning on or after September 23, 2010
Non-retaliation Provisions	An employer may not discriminate or retaliate against an individual on account of the fact the individual: o qualifies for federal insurance subsidies or tax credits o notifies the government of the employer's violation of the health reform laws o etc.	March 23, 2010 (Grandfather rules apply)

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Cafeteria Plan Safe Harbor for Small Employers	Small employers (generally those with an average of 100 or fewer employees during either of the prior two years) will be allowed to adopt new “simple" cafeteria plans. In exchange for satisfying minimum participation and contribution requirements, these plans will be treated as meeting the non-discrimination requirements that would otherwise apply to the cafeteria plan. Minimum contribution requirements: o At least 2% of pay **or** o Lesser of: o 6% of pay o 200% of employee contributions	Taxable years beginning on or after January 1, 2011.
Pre-existing Conditions	Coverage must be offered on a guarantee issue basis in all markets and be guaranteed renewable. (Grandfather rules apply). Exclusions based on pre-existing conditions would be prohibited in all markets. o **For enrollees under age 19, pre-existing conditions are prohibited beginning in plan years beginning September 23, 2010.**	Plan years beginning on or after January 1, 2014. (Grandfather rules apply for individual policies only)
Employee Waiting Period for Coverage	An employer that requires a waiting period before an employee can enroll in health care may not impose a waiting period in excess of 90 days.	Effective plan years beginning on or after January 1, 2014.
Employer Wellness Plans	Codifies and improves upon the HIPAA bona fide wellness program rules: o Increases the value of workplace wellness incentives to 30% of single premiums o With agency discretion to increase the cap on incentives to 50%.	Plan years beginning on or after January 1, 2014.
Coverage of Clinical Trials	Group plans must provide coverage for participation in clinical trials for the treatment of cancer or other life-threatening diseases. o Plans cannot carve out different coverage levels for routine patient costs due to participation in the trial o Plan cannot deny coverage on out-of-network grounds, if the trial is conducted out-of-state, but it appears that routine patient costs can be paid at OON levels Rule kicks in if: o the individual is eligible to participate in the trial per the trial’s protocol **and** o a participating provider says the individual is an appropriate candidate, or o insured provides evidence proving his participation is appropriate	Plan years beginning on or after January 1, 2014. (Grandfather rules apply)

Plan-Related Health Insurance Reform Provisions

Topic	Provisions	Effective Date
	EMPLOYER NOTICE AND REPORTING REQUIREMENTS	
Reporting on W-2s	Requires all employers to include on W-2s the aggregate cost (COBRA -2%) of employer-sponsored health benefits. If employee receives health insurance coverage under multiple plans, the employer must disclose the aggregate value of all such health coverage, but exclude: o All contributions to HSAs o All contributions to Archer MSAs o Salary reduction contributions to FSAs	Benefits payable during taxable years beginning on or after January 1, 2012.
Summary of Benefits	Requires that all: o group health plans (including **self-insured** plans) o group health insurers o individual health insurers provide a summary of benefits and a coverage explanation to: o All applicants at the time of application o To all enrollees prior to the time of enrollment or re-enrollment o All policyholders or certificate holder at the time of issuance of the policy or delivery of the certificate. The summary must include specific information to be determined by the Secretary of DHHS in consultation with the National Association of Insurance Commissioners. It may not exceed four pages (DHHS will provide a template) and must be linguistically appropriate. The summary can be provided in paper or electronic form. Employers and health plans that willfully fail to provide the information required can be fined up to $1,000 for each such failure. Each failure to provide information to an enrollee constitutes a separate offense.	DHHS and NAIC must develop the summary of benefits standards on or after March 23, 2011. Health Plans and employer groups must begin notifying enrollees on or before March 23, 2012.
Material Modification of Plan Provision	If a group health plan or health insurance issuer makes any material modification in any of the terms of the plan or coverage involved that is not reflected in the most recently provided summary of benefits and coverage, the plan or issuer shall provide notice of such modification to enrollees not later than 60 days prior to the date on which such modification will become effective.	Health Plans and employer groups must begin notifying enrollees on or before March 23, 2012.

Plan-Related Health Insurance Reform Provisions

Topic	Provisions	Effective Date
Business Tax Reporting (1099 Forms)	Expands obligation of persons engaged in a trade or business to report on payments of other fixed and determinable income or compensation. Extends reporting to include payments made to corporations other than corporations exempt from income tax under section 501(a). Also expands the kinds of payments subject to reporting to include reporting of the amount of gross proceeds paid in consideration for property or services. Generally, businesses that pay any amount greater than $600 during the year to corporate and non-corporate providers of property and services will be required to file an information report with each provider and with the IRS.	Effective for payments made on or after January 1, 2012.
New Employer Disclosure Obligation re: Exchanges	Employers subject to the FLSA ($500,000+ in sales or engaged in interstate commerce) must supply employees with written notice regarding: o the existence of the insurance Exchange(s) o the services supplied by the Exchange o how the employee may contact the Exchange o if the employer is not supplying qualifying coverage, that the employee might qualify for subsidies in the Exchange for the purchase of insurance	At the time of hire, or with respect to current employees, on or before March 1, 2013.
New Employer Reporting Obligation re: "Minimum Essential Coverage"	Health plans, including **self-insured** employer plans and public programs, must provide an annual statement (Form 1099-HC) reflecting the months during the calendar year for which the individual had "minimum essential coverage" (to avoid the individual mandate penalty for those months) to both: o Covered individuals o The IRS Penalty for noncompliance: $50 for each missed statement to an employee, to max. of $100,000.	January 1, 2014.
New Employer Reporting Obligation re: Furnishing of Qualifying and Affordable Coverage	To allow the IRS to determine if surcharges apply, employers potentially subject to the "free rider surcharge" must annually, by January 31, report the details of: o the employer's coverage o eligibility o premium requirements o employer contributions o health plan enrollees The report must be delivered to both: o Covered individuals o The IRS . Penalty for noncompliance: $50 for each missed statement to an employee, to max. of $100,000.	January 1, 2014.

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	EMPLOYER COVERAGE REQUIREMENTS	
Employer Mandate	An employer does NOT have to offer coverage. **If** they do not offer "qualified" and "affordable" coverage and both: o Employ more than 50 "full-time equivalent" employees during the preceding year AND o One or more employees receives a premium assistance tax credit to buy coverage through an Exchange the employer must pay a fine: o If no coverage is offered, $2,000 per year (calculated monthly) times the number of full-time employees; however: o the first 30 employees are exempted from the calculation o the surcharge does not apply to employees who get vouchers o If you offer coverage but it is not "qualified" AND "affordable", $3,000 for each of those employees receiving a premium assistance tax credit (penalty capped at $2,000 times the number of FTEs; the first 30 employees are again disregarded in this calculation.) Penalty amounts are indexed annually to average per capita premium increases (rounded down to the next lowest $10) measured after 2014 (as determined by HHS). "Full-time equivalent employees" - total part-time hours for the month divided by 120 (plus number of "normal" FTEs - 30 hours per week or more) o Part-time employees are considered solely for the purpose of determining if an employer has an average of 50 or more full-time employees and is therefore subject to the employer responsibility and penalty provisions. o However, any penalties would be assessed only on behalf of full-time employees who work, on average, 30 or more hours per week with respect to the month. "Qualified" coverage - Plan design is expected to pay at least 60% of allowed charges and meet minimum benefit standards. "Affordable" coverage - Employee contributions to the plan must not exceed 9.5% of employee's household income. An employer is not subject to the fine if: o The workforce exceeded 50 full-time equivalent employees due to seasonal employees working for 120 days or fewer during the calendar year o Seasonal worker means a worker who performs labor or service on a seasonal basis as defined by DOL (includes retail workers employed exclusively during the holiday seasons)..	January 1, 2014.

Plan-Related Health Insurance Reform Provisions

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Employee Free Choice Requirements	An employer that provides and contributes to health coverage for employees must provide free choice vouchers to each employee who is required to contribute more than 8.0% and not more than 9.8% of the employee's household income toward the cost of coverage, if: o Such employee's household income is not greater than 400% of FPL and o The employee does not enroll in a health plan sponsored by the employer. The 8.0% and 9.8% factors are to be indexed to the rate of premium growth. The amount of the voucher must be equal to the amount the employer would have provided toward such employee's coverage (individual vs. family based on the coverage the employee elects through the Exchange) with respect to the plan to which the employer pays the largest portion of the cost. The value of vouchers would be adjusted for age, and the vouchers would be used in the exchanges to purchase coverage that would otherwise be unsubsidized. The employee can keep amounts of the voucher in excess of the cost of coverage elected in an exchange without being taxed on the excess amount	January 1, 2014.
Auto-Enrollment by Employers	Requires employers with more than 200 employees to auto-enroll all new employees (and re-enroll existing employees) into any available employer-sponsored health insurance plan. Waiting periods in existing law can apply. Employees may opt out if they have another source of coverage.	Effective once DOL regulations are issued. (Target date: January 1, 2014)
	STATE GOVERNMENT RELATED PROVISIONS	
Group Size	Redefines small group coverage as 1-100 employees. States may also elect to reduce this number to 50 for plan years prior to January 1, 2016.	January 1, 2014.
Premium Assistance for Employer-Sponsored Coverage	Requires **states** to offer premium assistance and Medicaid wrap-around benefits to Medicaid beneficiaries who are offered employer-sponsored coverage, if cost-effective to do so, under terms outlined already in current law.	January 1, 2014. (The effectiveness requirement is retroactive to February 4, 2009)

Plan-Related Health Insurance Reform Provisions

Topic	Provisions	Effective Date
State-Based Exchanges	Requires each state to create an Exchange to facilitate the sale of qualified benefit plans to individuals, including: o The federally-administered multi-state plans o Non-profit co-operative plans. Levels of coverage to be offered through the Exchange: o Bronze Plan - provides 60% of actuarial value of minimum qualifying coverage o Silver Plan - provides 70% of actuarial value of minimum qualifying coverage o Gold Plan - provides 80% of actuarial value of minimum qualifying coverage o Platinum Plan - provides 90% of actuarial value of minimum qualifying coverage o A catastrophic-only policy would be available for those 30 and younger. "Actuarial value" - the anticipated amount of all eligible expenses (including deductibles, co-pays, etc.) that will be paid by the plan. Deductible limits of $2,000 individual and $4,000 family, unless contributions are offered that offset excess deductibles. Out-of-Pocket limits for all Exchange plans must be no more than OOP limits for HSA-compatible HDHPs ($5,950 single; $11,900 family) The states must create “SHOP Exchanges” to help small employers purchase such coverage. The states can establish regional Exchanges. The state can either: o Create one exchange to serve both the individual and group market o Create a separate individual market exchange and group SHOP exchange. States can also apply for a modification waiver from DHHS. U. S. territories would: o Be allowed to create Exchanges o Be treated like a state for funding purposes, if they establish an Exchange Exchanges must: o Maintain a call center o Provide consumer information (including open enrollment) o Maintain a website o Submit financial reports o Comply with oversight investigations	January 1, 2014

Plan-Related Health Insurance Reform Provisions

Topic	Provisions	Effective Date
	Health plans are required to submit a justification for any premium increase in advance. Exchanges may reject bids by insurance companies with "excessive" (undefined) premium increases.	
Minimum Essential Benefits for Exchange Plans	Establishes standards for qualified coverage, including: o Mandated benefits o Cost-sharing requirements o Out-of-pocket limits (tied to HSA limits) o A minimum actuarial value of 60%. "Essential benefits" - All the major categories of a comprehensive medical coverage, and the items and services included within those broad categories: o Ambulatory patient services o Emergency services o Hospitalization o Maternity and newborn care o Mental health and substance abuse o Prescription drugs o Rehabilitative services, habilitative services, and devices o Laboratory services o Preventive and wellness services o Pediatric services, including oral and vision care	January 1, 2014.
Health Care Choice Compacts	Permits states to form health care choice compacts and allows insurers to sell policies to individuals in any state participating in the compact. Insurers selling policies through a compact would only be subject to the laws and regulations of the state where the policy is written or issued (with exceptions.) Regulations will be issued by July 1, 2013.	January 1, 2016
Large Groups in Exchanges	States may choose to allow large groups (over 100) to purchase coverage through the exchanges.	January 1, 2017.

Plan-Related Health Insurance Reform Provisions

Topic	Provisions	Effective Date
State Opt-Out Provisions	Provided that they create their own programs meeting specified standards, states are allowed to apply for a waiver (for up to 5 years) of requirements relating to: o qualified health plans o Exchanges o cost-sharing reductions o tax credits o the individual responsibility requirement o shared responsibility for employers This provision does not apply to waivers of ERISA.	Plan years beginning on or after January 1, 2017.
	FEDERAL GOVERNMENT RELATED PROVISIONS	
Health Insurance Premium Rate Review	Establishes **federal** review of health insurance premium rates. The Secretary of DHHS, in conjunction with the states, will have new authority to monitor health insurance carrier premium increases beginning in 2010 to: o prevent unreasonable increases o publicly disclose such information. Carriers that have a pattern of unreasonable increases may be barred from participating in the Exchange.	March 23, 2010
"Fannie Med" Co-Operatives	Establishes a Consumer Operated and Oriented Plan (CO-OP) program to provide grants or loans for the establishment of non-profit insurance cooperatives to be offered through the Exchange. Authorizes $6 billion in appropriations for start-up loans or grants to help meet state solvency requirements. Does not require states to establish such cooperatives.	March 23, 2010
Pre-existing Condition Coverage for Individual Market via High Risk Pool	Creates high-risk pool coverage for people who cannot obtain current individual coverage due to pre-existing conditions. It will be financed by a $5 billion appropriation. This national program can work with existing state high-risk pools and will end on January 1, 2014, once the Exchanges become operational and the other pre-existing condition and guarantee issue provisions take effect.	On or before June 21, 2010

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Topic	Provisions	Effective Date
Early Retiree Reinsurance Program	Creates a temporary reinsurance program for employers providing health insurance coverage (including self-funded coverage) to retirees age 55 or older who are not eligible for Medicare. This program would reimburse employers retrospectively 80% of claims between $15,000 - $90,000, which will be indexed for inflation. The employer is required to use any reimbursement to lower the cost to plan enrollees. It will be financed by a $5 billion appropriation. The program will end either when the appropriation has been exhausted or on January 1, 2014.	March 23, 2010
Definition of Qualified Medical Expenses	Changes the definition of qualified medical expenses for HSAs, MSAs, FSAs, and HRAs to the definition used for the itemized deduction. An exception to this rule is included so that amounts paid for over-the-counter medicine with a prescription still qualify as medical expenses.	January 1, 2011.
CLASS Act	Creates a new voluntary public long-term care program, Community Living Assisted Services and Support (CLASS) for adults who become functionally limited. Requires all employers to enroll employees, unless the employee elects to opt out. Requires employers to collect premiums through payroll deduction (employers without a payroll deduction program are NOT required to establish one.	January 1, 2011. (CLASS plans estimated to be effective January 1, 2013)
Federal Study on Large-Group Plans	Mandates a federal study on the impact the market reforms in the bill will have on the large group market, particularly on whether or not they have encouraged groups to self-fund.	Report due on or before March 23, 2011
Federal Study on Self-insured Plans	Mandates annual studies by the federal Department of Labor on self-insured plans using data collected from the Annual Return/Report of Employee Benefit Plan (Department of Labor Form 5500) begin. The studies will include general information on self-insured group health plans, including: o Plan type o Number of participants o Benefits offered o Funding arrangements o Benefit arrangements	Report due on or before March 23, 2011

Plan-Related Health Insurance Reform Provisions

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	The studies will also use data from the financial filings of self-insured employers, including information on: o Assets o Liabilities o Contributions o Investments o Expenses	
Medicare Reimbursements to Providers	Reduce annual market basket updates for inpatient hospital, home health, skilled nursing and hospice. Reduce Medicare payments that would otherwise be made to hospitals by specified percentages to account for excess hospital admissions. Effective fiscal year 2014, reduces Medicare Disproportionate Share Hospital payments initially by 75%,and subsequently increase payments based on amount of uncompensated care.	Effective fiscal years 2010 - 2014.
	TAX-RELATED PROVISIONS	
BCBS Plans	Limits the special deduction for Blue Cross Blue Shield organizations of 25% of the amount by which certain claims, liabilities, and expenses incurred on cost-plus contracts exceed the organizations' adjusted surplus. The special deduction will be available only to those otherwise qualifying BCBSA plans that expend at least 85% of their total premium on reimbursement for clinical services provided to enrollees.	Tax years beginning on or after January 1, 2010.
OTC Drug Exclusion from Account-Based Plans	Changes the definition of medical expense for purposes of employer-provided health coverage (including reimbursements under employer-sponsored health plans, HRAs, and Health FSAs, HSAs, and MSAs) to the definition for purposes of the itemized deduction for medical expenses. Account-based plans cannot provide non-taxable reimbursements of over-the-counter medications unless the over-the-counter medications are prescribed by a doctor. Prescribed medicines, drugs, and insulin still qualify for non-taxable reimbursements from those accounts.	Applies to expenses incurred on or after January 1, 2011.

Plan-Related Health Insurance Reform Provisions

Topic	Provisions	Effective Date
Tax on Brand-Name Prescription Drug Manufacturers	Imposes a new annual non-deductible fee on pharmaceutical manufacturers and importers of branded prescription drugs (including certain biological products). The aggregate annual fees, based on market share, to be imposed on covered entities will be: o $2.5 billion in 2011 o $2.8 billion in 2012-2013 o $3.0 billion in 2014-2016 o $4.0 billion in 2017 o $4.1 billion in 2018 o $2.8 billion annually thereafter	Payable in 2011 with respect to sales in 2010.
HSA and Archer MSA Distribution Tax Increases	Increases the tax on distributions from a health savings account or an Archer MSA that are not used for qualified medical expenses to 20%.	Distributions made on or after January 1, 2011.
Medicare Premium Changes	Freezes the threshold for income-related Part B premiums for 2011 through 2019. Increases Medicare Part D premiums (via subsidy reduction) for those with incomes above $85,000 per individual and $170,000 per family.	January 1, 2011.
Tax on Group Health Plans to Fund Comparative Effectiveness Research	New federal premium tax on fully-insured and **self-insured** group health plans to fund comparative effectiveness research program begins. As financing mechanism to fund Patient Centered Outcome Research, imposes a fee on private insurance plans equal to $2 for each individual covered under a specified individual or group health insurance policy $1 in 2013 only).	First plan year ending on or after October 1, 2012 No longer applies to policy years ending after September 30, 2019.
Employer Subsidies of Medicare Part D Premiums	Elimination of employer deductible 28% subsidy under Medicare Part D. The employer deduction for prescription drug claims will be reduced by the retiree drug subsidy (RDS) amount payable to the employer. FAS 109 requires employers to immediately take a charge against current earnings to reflect the higher anticipated tax costs and higher FAS 106 liability. Under ASC 740, the expense or benefit related to adjusting deferred tax liabilities and assets as a result of a change in tax laws must be recognized in income from continuing operations for the period that includes the enactment date. Therefore, the expense resulting from this change will be recognized in the first quarter of 2010 even though the change in law may not be effective until later years.	Applies to taxable years beginning on or after January 1, 2013.

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FSA Limit	Limits FSA contributions for medical expenses to $2,500 per year. Indexes the cap for inflation. Prescriptions qualify for reimbursement only if physician-prescribed or if insulin.	Applies to taxable years beginning on or after January 1, 2013.
Tax on Medical Devices	New (non-deductible) annual excise taxes imposed on medical device manufacturers and importers, according to market share, in the amount of 2.3% of the price for which the medical device is sold. The tax would not apply to: o Eyeglasses o Contact lenses o Hearing aids o Any other device deemed by the Secretary to be of the type generally purchased by the public at retail for individual use.	Applies to sales made on or after January 1, 2013.
Medical Expense Tax Deduction Limitation	The threshold for the itemized deduction for unreimbursed medical expenses would be increased to 10% of AGI for regular tax purposes. The increase would be waived for individuals age 65 and older for tax years 2013 through 2016.	Taxable years beginning on or after January 1, 2013.
Medicare Payroll Tax Increase	Beginning in 2013, an additional 0.9% Medicare Hospital Insurance (HI) tax is imposed on: o self-employed individuals o employees with respect to earnings and wages received during the year: o Above $200,000 for individuals o Above $250,000 for joint filers (not indexed) o Above $125,000 for married taxpayers filing separately These earnings and wages thresholds are not indexed for inflation. Self-employed individuals are not permitted to deduct any portion of the additional tax. The new taxes do not change employer HI tax obligations. Also levies a new 3.8% Medicare contribution on the lesser of: o Net investment income (income from interest, dividends, non-qualified annuities, royalties, rents, dispositions of properties, and similar passive activities) or o The excess of the taxpayer's modified AGI over the thresholds described above. The tax does not apply to distributions from qualified retirement plans, including IRAs, 410(a) money purchase plans, 403(b) plans, and 457(b) plans.	Taxable years beginning on or after January 1, 2013.

Plan-Related Health Insurance Reform Provisions

Topic	Provisions	Effective Date
Tax on Private Health Insurance Premiums	Imposes annual taxes on private health insurers whose annual net premiums written exceed $25 million, based on: o Net premiums written after December 31, 2011 o Third-party agreement fees received after December 31, 2011. The tax is phased in at: o $8.0 billion in 2014 o $11.3 billion in 2015 and 2016 o $13.9 billion in 2017 o $14.3 billion in 2018 o After 2018, fee is indexed to the annual amount of premium growth in subsequent years. Reduces the tax for certain tax-exempt health plans (CO-OPs) by allowing them to calculate the fee based on only 50% of their premiums. The tax does NOT apply to: o **Self-insured plans** o Governmental entities (other than those providing insurance through the Act's community health insurance option) o Certain non-profit insurers of last resort o Certain non-profit insurers with a medical loss ratio of 90 percent or more o Non-profit insurers that receive over 80% of their gross revenues from government programs like Medicare, Medicaid, and CHIP o Voluntary employee benefit associations that are established by non-employers	January 1, 2014, based on net premiums written on or after January 1, 2013 and third-party agreement fees received on or after January 1, 2013.
Tax on "Cadillac" Plans	The 40% excise tax on insurers of employer-sponsored health plans for active and/or retirees (both fully-insured and self-insured) with aggregate values that exceed: o $10,200 for individual coverage o $27,500 for family coverage Higher thresholds for retirees over age 55 and for employees in certain high-risk professions: o $11,850 for individual coverage o $30,950 for family coverage The tax would be indexed for inflation by: o CPI-U plus 1% in 2019 o CPI-U in 2020 and therafter Aggregate values of health plans include: o Reimbursements from FSAs and HRAs o Employer contributions to HSAs or MSAs o Coverage for dental, vision, and other supplementary health insurance coverage	Taxable years beginning on or after January 1, 2018.

Plan-Related Health Insurance Reform Provisions

Topic	Provisions	Effective Date
	Plans would be allowed to increase thresholds for plan costs higher than national pool, based on: o age o gender Excise tax does not apply to: o Stand-alone dental plans o Stand-alone vision plans o Accident o Disability o Long-term care o After-tax indemnity coverage o After-tax specified disease coverage	
	GRANTS OR TAX CREDIT PROGRAMS	
Rebates for Medicare Part D "Donut Hole"	There is a gap in Medicare prescription drug coverage (Medicare Part D) between $2,830 and $6,440 in total drug spending. The health care reform bill provides a $250 rebate check for all Medicare Part D enrollees who enter this "donut hole." Beginning in 2011, a 50 percent discount on brand-name drugs will be instituted **and** generic drug coverage will be provided in the donut hole. The donut hole gap will be filled by 2020. Beginning in 2011, the beneficiary co-insurance rate in the Medicare Part D coverage gap will gradually reduce from the current 100% to 25% in 2020 with 50% discounts on brand and generic drugs.	January 1, 2010 for rebate. Other measures noted begin January 1, 2011.
Therapeutic Discovery Tax Credit	Creates a federal tax credit for businesses with 250 or fewer employees that make a "qualified investment" in acute and chronic disease research during 2009 or 2010.	Based on investments paid in taxable years beginning in 2009 or 2010.
Indian Health Benefits	Native Americans may exclude from gross income the value of qualified health benefits received directly or indirectly from the Indian Health Service or from and Indian tribe or tribal organization.	For health benefits and coverage provided after March 23, 2010

Plan-Related Health Insurance Reform Provisions

Topic	Provisions	Effective Date
Small Employer Tax Credits	Makes available tax credits for qualified small employer contributions to purchase coverage for employees. In order to qualify, the business must ; o have no more than 25 full-time equivalent employees o pay average annual wages of less than $50,000 o provide qualifying coverage. In 2011-2013, the full amount of the credit (35%) will be available to employers with o 10 or fewer employees o average annual wages of less than $25,000 o will phase out when those thresholds are exceeded. The average wage threshold for determining the phase-out of credits will be adjusted for inflation after 2013. Beginning in 2014, small employers who purchase coverage through an Exchange will receive a maximum credit of up to 50% of premiums for up to 2 years **if** the employer contributes at least 50% of the total premium cost. Employers will not be eligible to use the credit for certain employees, including: o defined seasonal workers o self-employed individuals o 2% shareholders of an S corporation (as defined by section 1372(b) o 5% owners of a small business (as defined by section 416(i)(1)(B)(i) o dependents or other household members. However, leased employees **are** eligible employees for the credit. Employers receiving credits are denied any deduction for health insurance costs equal to the credit.	March 23, 2010. Retroactive for premiums paid in taxable years beginning on or after January 1, 2010.
Small Group Wellness Program Grants	Small employers that develop wellness programs would be eligible for grants. Appropriates $200 million in funding from fiscal years 2011-2015.	October 1, 2010

Plan-Related Health Insurance Reform Provisions

<table>
<tr><th>Topic</th><th>Provisions</th><th>Effective Date</th></tr>
<tr><td>Plan Design Cost-Sharing Subsidies in the Exchanges</td><td>Individuals with household incomes between 100% and 400% of the Federal Poverty Level (FPL) may purchase subsidized coverage in the health insurance Exchanges IF:
they are not enrolled in employer (or certain other coverage) coverage AND
do not have access to employer-based coverage that
pays at least 60% of covered medical costs AND
is priced to the individual at 9.5% or less of the individual's household income.
100% - 400% of Federal Poverty Level for FY 2009-10:
$10,830 - $43,320 (individual)
$22,050 - $88,200 (family of four)
"Household income" - gross income of the employee plus gross income of other family members on whom the employee takes the tax exemption, and who were required to file a tax return for the year.
Cost-sharing subsidies apply as follows:<table><tr><th>Household income as a percent of FPL</th><th>Plan cost-sharing subsidy results in coverage of % of plan’s benefits</th></tr><tr><td>100% - 150%</td><td>94%</td></tr><tr><td>>150% - 200%</td><td>87%</td></tr><tr><td>>200% - 250%</td><td>73%</td></tr><tr><td>>250% - 400%</td><td>70%</td></tr></table></td><td>January 1, 2014</td></tr>
<tr><td>Premium Tax Credits for Lower Income Individuals Purchasing Coverage via an Exchange</td><td>Individuals with household modified adjusted gross incomes (AGI) of at least 100% and not exceeding 400% of the Federal Poverty Level (FPL) may purchase subsidized coverage in the insurance Exchanges IF:
they are not enrolled in employer (or certain other coverage) coverage AND
do not have access to employer-based coverage that
pays at least 60% of covered medical costs AND
is priced to the individual at 9.5% or less of the individual's household income.
100% - 400% of Federal Poverty Level for FY 2009-10:
$10,830 - $43,320 (individual)
$22,050 - $88,200 (family of four)
Premium purchase tax credit:
"Annual credit" is the sum of "monthly credits", for each month a credit-eligible individual begins the month enrolled in qualifying Exchange-based coverage.</td><td>Tax years beginning on or after January 1, 2014</td></tr>
</table>

Plan-Related Health Insurance Reform Provisions

<table>
<tr><th>Topic</th><th>Provisions</th><th>Effective Date</th></tr>
<tr><td></td><td>"Monthly credit" is lesser of:
monthly premium for an Exchange-based plan covering the employee, spouse or dependent.
The amount by which the "Adjusted Monthly Premium" for the month for the Silver Plan available to the employee through the Exchange EXCEEDS 1/12th of the employee's Household Income for the year multiplied by his "Applicable Percentage"
"Adjusted Monthly Premium" is the age-adjusted premium the employee would pay for the Silver Plan for himself / family, less the premium cost for benefits judged non-essential benefits.
"Applicable Percentage" is based on the following table (a sliding scale applies between the minimum and maximum %):<table><tr><th>Household income as a percent of FPL</th><th>Minimum %</th><th>Maximum %</th></tr><tr><td>Up to 133%</td><td>2.0%</td><td>2.0%</td></tr><tr><td>133% - 150%</td><td>3.0%</td><td>4.0%</td></tr><tr><td>150% - 200%</td><td>4.0%</td><td>6.3%</td></tr><tr><td>200% - 250%</td><td>6.3%</td><td>8.05%</td></tr><tr><td>250% - 300%</td><td>8.05%</td><td>9.5%</td></tr><tr><td>300% - 400%</td><td>9.5%</td><td>9.5%</td></tr></table>Beginning in 2019, a fail-safe mechanism would be applied that reduces overall premium subsidies if the aggregate amount exceeds 0.504% of GDP.
The IRS would be responsible for determining eligibility for the tax credit.</td><td></td></tr>
<tr><td></td><td>MISCELLANEOUS PROVISIONS</td><td></td></tr>
<tr><td>Economic Substance Doctrine</td><td>A transaction would have economic substance only if:
the taxpayer’s economic position (other than its federal tax position) changed in a meaningful way AND
the taxpayer had a substantial purpose (other than a federal tax purpose) for engaging in the transaction.</td><td>Applies to transactions entered into after March 23, 2010.</td></tr>
</table>

Plan-Related Health Insurance Reform Provisions

Topic	Provisions	Effective Date
Grandfathered Health Plans	Individuals and employer group plans that wish to keep their current policy on a grandfathered basis would only be able to do so **if** the only plan changes made were to add or delete new employees and any new dependents. In addition, an exception is made for employers that have scheduled plan changes as a result of a collective bargaining agreement.	Grandfathered status is available for certain plan provisions in effect March 23, 2010.
Individual Mandate	Requires all American citizens and legal residents to purchase qualified health insurance. Coverage considered qualifying for this purpose includes: o Qualified Exchange plans o Grandfathered individual and group health plans o Medicare and Medicaid plans o Military and veterans' benefits o Any employer-sponsored plan Existing policies could remain in effect - but only so long as an individual does not: o Move o Change jobs o Experience any other material change in life status Violators are subject to an excise tax penalty. The penalty structure would be the higher of: o A flat dollar amount per person or o A percentage of the individual's income The fixed dollar amount phases in beginning with: o $95 per person in 2014 o $325 per person in 2015 o $695 per person in 2016 The percentage of taxable gross household income used in determining the fine amount would be: o 1.0% in 2014 o 2.0% in 2015 o 2.5% in 2016, capped at the average bronze-level insurance premium (60% actuarial) rate for the person's family Families will pay half the amount for children, with a cap of $2,250 for the entire family. After 2016, dollar amounts will be increased by the cost-of-living adjustment.	January 1, 2014.

Plan-Related Health Insurance Reform Provisions

Topic	Provisions	Effective Date
	No penalty is assessed if: o Coverage lapse is for 3 months or less o The lowest cost plan available to the individual exceeds 8.0% of AGI o The individual has income below the tax filing threshold Exceptions are provided for: o Religious objectors o Individuals not lawfully present o Individuals who are incarcerated o Members of Native American tribes o Those who cannot afford coverage (cost is more than 8% of modified gross income) o Those with incomes below the federal tax filing threshold ($9,350 individual; $18,700 joint) o Those who have received a hardship waiver o Those who were not covered for a period of less than three months during the year.	
	This information is not intended, and should not be considered exhaustive, nor should it be considered legal advice. Please contact legal counsel for any required legal advice.	

Stephens Insurance, LLC

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Health Insurance Reforms That Will Impact Private Health Insurance

Non Plan-Related Health Insurance Reform Provisions

January 11, 2011

UBA United Benefit Advisors

Non Plan-Related Health Insurance Reform Provisions

Topic	Provisions	Effective Date
	INSURER RELATED PROVISIONS	
Administrative Simplification	Health plans must adopt and implement uniform standards and business rules for the electronic exchange of health information.	March 23, 2010
Qualifications for Health Plan Participation in Exchanges	In order to qualify to participate in a state Exchange, health plans must: o Provide an adequate network of providers o Contract with essential community providers o Be accredited with respect to quality measures o Use a uniform enrollment form o Meet reporting requirements o Present data in a standard format o Meet marketing requirements o Contract with "navigators" to conduct outreach and enrollment services	January 1, 2014.
	STATE GOVERNMENT RELATED PROVISIONS	
Tort Reform	States are eligible for grants to test alternative mechanisms for liability reform.	Fiscal year 2011
Web-Based Information Portals	Requires the states and the Secretary of DHHS to develop information portal options (including an internet site) for state residents to obtain uniform information on sources of affordable coverage. Information must be provided on: o private health coverage options o Medicaid o CHIP o the new high-risk pool coverage o existing state high-risk pool options.	By July 1, 2010.
State-Level Subsidy Programs	Gives states the option of establishing a federally-funded, non-Medicaid state plan for people whose income exceeds 133% but does not exceed 200% of FPL who: o Do not have access to affordable employer-sponsored coverage o Would otherwise be eligible for subsidized coverage through a state-based Exchange. The funding for this program will come from the subsidy dollars.	January 1, 2014.

Non Plan-Related Health Insurance Reform Provisions

Topic	Provisions	Effective Date
Medicaid Expansion	Medicaid eligibility level is increased to 133% of FPL ($29,327 for a family of four). Permits states an income disregard of 5% of income with respect to determining Medicaid eligibility. The federal government will pay 100% of the cost of the new Medicaid expansion population until 2016. Starting in 2017, all non-expansion states would pay a phased-in amount (beginning at 95% in 2017) of the cost of covering the expansion population, so that the federal government's match would be 90% in 2020 and the out-years. For expansion states (states already covering childless adults through their Medicaid programs), it would: o Reduce the amount they are currently paying to cover this population by 50% in 2014 o Gradually increase the amount of the federal share, so that by 2019, all states would be paying the same amount for the non-pregnant adult Medicaid population.	January 1, 2014.
	FEDERAL GOVERNMENT RELATED PROVISIONS	
Health Reform Implementation Fund	Establishes a $1 billion Health Insurance Reform Implementation Fund within HHS to implement health reform policies.	March 23, 2010
Primary Care Workforce	Expands funding for scholarships and loan repayments for primary care practitioners working in underserved areas.	March 23, 2010
Public Health Prevention Efforts	Creates an interagency council to promote healthy policies at the federal level. Establishes a prevention and public health investment fund to provide an expanded and sustained national investment in prevention and public health programs.	March 23, 2010
Quality Infrastructure Programs	Additional resources provided to HHS to develop a national quality strategy and support quality measure development and endorsement for the Medicare, Medicaid and CHIP quality improvement programs.	January 1, 2011
Extending Payment Protections for Rural Providers	Extends Medicare payment protections for small rural hospitals, including: o hospital outpatient services o lab services o facilities that have a low volume of Medicare patients but play an important role in their communities.	March 23, 2010

Non Plan-Related Health Insurance Reform Provisions

Topic	Provisions	Effective Date
Tax Relief for Health Professionals	Excludes from gross income payments made under any State loan repayment or loan forgiveness program that is intended to provide for the increased availability of health care services in underserved or health professional shortage areas. This provision is effective for amounts received by an individual in taxable years beginning on or after January 1, 2009.	March 23, 2010.
National Health Care Workforce Commission	Establishes an independent National Commission to provide comprehensive, non-biased information and recommendations to Congress and the Administration for aligning federal health care workforce resources with national needs.	March 23, 2010.
Health Care Workforce Programs	Expands and improves low interest student loan programs, scholarships, and loan repayments for health students and professionals to increase and enhance the capacity of the workforce to meet patients' health care needs.	March 23, 2010.
Community Health Centers	Increases mandatory funding for community health centers by $2.5 billion.	Beginning 2010 fiscal year.
Identifying Affordable Coverage	The Secretary of Health and Human Services is required to establish an internet website through which residents of any state may identify affordable health insurance coverage options in that state. The website will also include information for small businesses about: o available coverage options o reinsurance for early retirees o small business tax credits o other information of interest to small businesses	On or before July 1, 2010.
Enhancing Primary Care Delivery	Provides a 10 percent Medicare bonus payment for primary care physicians and general surgeons. Establishes a Graduate Medical Education policy allowing unused training slots to be re-distributed for purposes of increasing primary care training at other sites.	January 1, 2011.
Center for Medicare & Medicaid Innovation	Establishes a new Center for Medicare & Medicaid Innovation to test innovative payment and service delivery models to reduce health care costs and enhance the quality of care provided to individuals.	March 23, 2010.

Non Plan-Related Health Insurance Reform Provisions

Topic	Provisions	Effective Date
Preventive Health Coverage	Provides a free, annual wellness visit and personalized prevention plan services for Medicare beneficiaries Creates incentives for State Medicaid programs to cover evidence-based preventive services with no cost-sharing Requires Medicaid coverage of tobacco cessation services for pregnant women (Effective October 1, 2010).	January 1, 2011.
Community Care Transitions Program	Establishes the Community Care Transitions Program to provide transition services to high-risk Medicare beneficiaries.	January 1, 2011.
Expanding Health Care Provider Workforce	Increases access to primary care by adjusting the Medicare Graduate Medical Education program. Primary care and nurse training programs are also expanded to increase the size of the primary care and nursing workforce.	January 1, 2011.
Hospital Value-Based Purchasing Program	Establishes a hospital value-based purchasing program to incentivize enhanced quality outcomes for acute care hospitals. Requires the Secretary to submit a plan to Congress by 2012 on how to move home health and nursing home providers into a value-based purchasing payment system.	For hospital discharges occurring on or after October 1, 2012.
Community First Choice Option	The new Community First Choice Option, which allows States to offer home and community-based services to disabled individuals through Medicaid rather than institutional care.	October 1, 2011.
Accountable Care Organizations	Implements physician payment reforms that: o enhance payment for primary care services o encourage physicians to join together to form “accountable care organizations” to gain efficiencies and improve quality.	January 1, 2012
Hospital Re-Admission Rates	Directs CMS to track hospital readmission rates for certain high-volume or high-cost conditions. Uses new financial incentives to encourage hospitals to undertake reforms needed to reduce preventable readmissions.	Applies to hospital admissions on or after October 1, 2012.

Non Plan-Related Health Insurance Reform Provisions

Topic	Provisions	Effective Date
Medicare Advantage Plans	Freeze 2011 Medicare Advantage payment benchmarks at 2010 levels. Then restructure payments to Medicare Advantage plans over a 4 or 6 year period, depending on the level of payment change: o higher payments for areas with low FFS rates (up to 107.5% of traditional Medicare spending) o lower payments for areas with high FFS rates (down to 97.5% of traditional Medicare spending) Prevents Medicare Advantage plans from imposing higher cost-sharing requirements for some Medicare covered benefits than is required under the traditional FFS program. Establishes a new mechanism to increase payments to "high-quality" Medicare Advantage plans, even though traditional Medicare does not base its payments on quality measures. Requires Medicare Advantage plans to spend at least 85 percent of their premium costs on medical claims. Directs rebates from plans not meeting that threshold into a management account at CMS. Imposes an arbitrary adjustment on Medicare Advantage payment benchmarks as part of the competitive bidding process. Traditional Medicare would not be required to compete head-to-head against private health plans in Medicare Advantage "competitive bidding" Gives the Secretary blanket authority to reject "any or every bid by a Medicare Advantage organization" Gives the Secretary blanket authority to reject "any bid by a carrier offering private Part D Medicare prescription drug coverage.	January 1, 2011
Payment Bundling	Establishes a five-year national pilot program on payment bundling to encourage hospitals, doctors, and post-acute care providers to work together to achieve savings for Medicare through increased collaboration and improved coordination of patient care.	January 1, 2013.
Patient Centered Outcomes Research	Establishes a private non-profit Patient-Centered Outcomes Research Institute governed by a private-public board to identify research priorities and conduct research that compares the clinical effectiveness of medical treatments.	March 23, 2010.

Non Plan-Related Health Insurance Reform Provisions

Topic	Provisions	Effective Date
Quality Reporting	Requires the Secretary to implement quality measure reporting programs for certain providers, including: o ambulatory surgical centers o long-term care hospitals o inpatient rehabilitation facilities o inpatient psychiatric facilities o PPS-exempt cancer hospitals o hospice providers Requires the Secretary to pilot test value-based purchasing for each of these providers in subsequent years.	Fiscal year 2014.
Medicaid Funding	Reduces Medicaid disproportionate share hospital (DSH) payments. Establishes a payment methodology whereby the largest DSH reductions would be imposed on the states with the largest reduction in the number of uninsured individuals. Directs the Secretary to develop a methodology for reducing federal DHS allotments to all states in order to achieve the mandated reductions. Increases DSH allotments for Tennessee for FY 2012 and 2013.	Reductions begin in fiscal year 2014.
Independent Payment Advisory Board (IPAB)	Creates a new Independent Payment Advisory Board (IPAB) to develop and submit recommendations to Congress to: o implement Medicare payment changes o keep Medicare spending below targeted levels o improve health outcomes for patients o promote quality and efficiency o expand access to evidence-based care Board recommendations would be legally binding absent legislative action by Congress Board also has authority to make recommendations regarding total health system costs but does not have authority to make changes beyond Medicare. If IPAB fails to submit a legislative proposal to reduce Medicare spending by the target amount, the Secretary of HHS has authority to cut payments to providers proportionally based on their share of total Medicare spend.	Funding effective beginning with fiscal year 2012.

Non Plan-Related Health Insurance Reform Provisions

Topic	Provisions	Effective Date
Physician Value-Based Payment	Creates a value-based payment program for physicians providing services to Medicare beneficiaries.	January 1, 2015.
CHIP	Children's Health Insurance Program was extended through September 30, 2015, but then must be reauthorized.	March 23, 2010.
	TAX RELATED PROVISIONS	
Excise Tax on Indoor Tanning	10% excise tax on amounts paid for indoor tanning services, whether or not an individual's insurance policy covers the service. Service provider to assess tax on customer.	Services performed on or after July 1, 2010.
Health Insurer Executive Compensation Limits	$500,000 **deduction limitation** on taxable year remuneration to officers, **employees**, directors, and service providers of covered health insurance providers **if** at least 25 percent of the premium income to the insurer does not meet minimum essential coverage requirements under the Act. Will apply to deferred compensation earned in the taxable year beginning on or after January 1, 2010.	Applies to current compensation paid during taxable years beginning on or after January 1, 2013.
	GRANTS OR TAX CREDIT PROGRAMS	
Grants for State Insurance Ombudsman Programs	Allows the Secretary of DHHS to award grants to States (or the Exchanges operating in such States) to establish, expand, or provide support for offices of health insurance consumer assistance or health insurance ombudsman programs. The new program, in coordination with State health insurance regulators and consumer assistance organizations, will receive and respond to inquiries and complaints concerning health insurance coverage with respect to Federal health insurance requirements and under State law. $30 million is appropriated to fund these grants in FY 2010, but the Secretary of DHHS will have to request additional appropriations to fund the grant program in the out-years.	March 23, 2010.
State Health Insurance Premium Rate Review	$250 million is appropriated for state grants to increase their review and approval process of health insurance carrier renewal rate increases.	March 23, 2010. (for 2010 Plan Year)

Non Plan-Related Health Insurance Reform Provisions

Topic	Provisions	Effective Date
Adoptions	The Patient Protection Act: o makes the adoption credit refundable o raises the dollar limitation for the credit to $13,170 and o extends the credit through 2011 o enhances the incentives for adopting children with special needs.	Applies to taxable years beginning on or after January 1, 2010.
	MISCELLANEOUS PROVISIONS	
Physician Self-referral	Extends the implementation of a ban on new physician-owned hospitals to December 31, 2010. Adds a limited exception to growth caps on existing physician-owned facilities for those hospitals that treat the largest number of Medicaid patients in their county.	March 23, 2010.
Non-Profit Hospitals	Non-profit hospitals must meet new requirements, including conducting periodic community health needs assessments and adopting written financial assistance policies, to satisfy tax-exempt status. The IRS is required to review a non-profit hospital's community benefit activities at least once every three years.	Generally, requirements apply to taxable years beginning after March 23, 2010. The community health needs assessment requirement applies to taxable years beginning after December 31, 2012.
Wellness Plans for the Individual Market	Applies the HIPAA bona fide wellness program rules to the individual market via: o A ten state pilot program in 2014- 2017 o With potential expansion to all states after July 1, 2017. It also calls for a new federal study on wellness program effectiveness and cost savings.	No later than July 1, 2014.
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