Federal Health Reform: Key Insurance Reforms in 2010
Insurance Committee
Pennsylvania House of Representatives

Joy Johnson Wilson, Health Policy Director
National Conference of State Legislatures

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The Laws

- The Patient Protection and Affordable Care Act (P.L. 111-148, PPACA) was signed into law on March 23, 2010.
- The Health Care and Education Reconciliation Act of 2010 (P.L. 111-152) was signed into law on March 31, 2010 and amended some of the provisions of P.L. 111-148.
- The package is now referred to as..."The Affordable Care Act"

Some Notes.....

- Because the reconciliation process was used, many technical and perfecting amendments were not in order. As a result, in part because the legislation was drafted assuming a Fall 2009 enactment.....
  - Some effective dates occur prior to enactment
  - Some drafting errors could not be addressed
  - Many effective dates will require very aggressive action to implement
  - Technical corrections could not be made because they were not in order and were subject to a point of order

Access - Overview

- Maintains an employer-based health care system
  - Imposes a penalty on employers that fail to provide coverage or whose employees go to the health insurance exchange for coverage
- Expands and modifies the Medicaid to become the foundation for the reformed health care system
  - All individuals with incomes at or below 133% of the federal poverty level (FPL) are eligible
- Requires individuals to obtain qualified coverage
  - Imposes a tax on individuals who fail to comply
- Establishes subsidies for premiums and cost-sharing for individuals with incomes between 133% and 400% of the federal poverty level (FPL)

Access – Overview cont.

- Establishes health care exchanges to help individuals and small businesses (initially) to purchase qualified coverage

Health Insurance Reforms – Now

- Temporary high-risk pools
- Prohibition on rescissions (exception for fraud)
- Extension of dependent coverage for young adults (expires at the 26th birthday)
- Limits preexisting condition exclusions for children
- Limits lifetime and/or annual caps
- Reinsurance for early retirees (applies to state and local government plans)

Health Insurance Reforms – Later

- Prohibition on preexisting condition exclusions
- Guaranteed issue/Guaranteed renewal
- Premium rating rules
- Non-discrimination in benefits
- Mental health and substance abuse services parity
- Prohibits discrimination based on health status
- Prohibits annual and lifetime caps

States and Insurance Reforms

- Authorize the state insurance commissioner to enforce new federal insurance laws.
- Review existing state insurance laws
  - Revise/Eliminate
  - Keep
- Review state employee health benefits programs for compliance.

Reforms Effective upon Enactment

- **State Grants** ---HHS awarded grants to states to establish or to expand existing "ombudsman" programs.
- **Federal Rate Review** - HHS Secretary is directed to establish a federal insurance rate review process.

Temporary High Risk Pools

- Appropriates $5 billion (2010 - 2014) to establish programs in the 50 states and DC, effective June 21, 2010. Funds will be available beginning July 1, 2010.
- Eligible individuals (citizens or legally present, uninsured for at least 6 months, has a preexisting medical condition)
- Rules-- (1) no preexisting condition exclusions; (2) limits out-of-pocket amounts to $11, 900-families and $5,950-individuals; (3) standard premium rate; (4) rates may vary on the basis of age by a factor of 4-1.
- State maintenance of effort (MOE) at 2009 levels.

Temporary Risk Pool Program - Status

- 19 states - HHS Administration; 28 states and DC - State Administration (includes Pennsylvania); 3 states (Kentucky, Rhode Island and Utah) are undecided
- To Be Decided
  - Definition of "preexisting condition"
  - Premium subsidies (in or out)
  - Liability (who has it?)
  - State flexibility (how far does it go?)
  - Flow of Funds (administration v. claims)
  - Citizenship verification process
- Interim Final Rule expected to be published soon.

Early Retiree Reinsurance Program

- Establishes a $5 billion temporary program to reimburse employers for the cost of providing health care coverage to early retirees (ages 55-64) and their spouses, surviving spouses, and dependents.
- Effective for plan years beginning on or after October 1, 2011. Program ends January 1, 2014.
- State and local governments are eligible to participate.
- **Interim Final Rule** published in the May 5, 2010 *Federal Register*. Effective June 1, 2010. Comments accepted until COB June 4, 2010.

(See handout for additional detail)

Dependent Coverage for Young Adults

- Requires plans, for plan years beginning on or after September 23, 2010 to extend coverage to adult children, up to age 26, on their parent's health insurance plan, if the parents want them to do so.
- State laws that provide additional protection are saved unless they prevent the application of the new federal law.
- Additional coverage is available for young adults who have parents that have access to cafeteria plans to offset health costs with pretax dollars. *(See handout for additional detail)*

Prohibition on Rescissions

- Prohibits plans from rescinding coverage, except in cases involving fraud (intentional misrepresentation of material fact).
- Effective for plan years beginning on or after September 23, 2010.

Limits on Preexisting Exclusions for Children

- Prohibits the imposition of preexisting condition exclusions on children under age 19 (Insurers have agreed to this interpretation of the law).
- Preexisting exclusion provisions are prohibited after January 1, 2014 for all individuals. After that time health insurers cannot use any of the following factors to determine or deny eligibility: health status, claims experience, rate of utilization of benefits, domestic violence, disability, or genetic information.

Limits on Lifetime/Annual Caps

- Prohibits the establishment of lifetime or *unreasonable* annual limits on the dollar value of "Essential Health Benefits" (EHBs).
  - Definition of EHBs will be determined by the HHS Secretary by administrative rule. General guidance is provided in the law.
- Effective for plan years beginning on or after September 23, 2010.
- For plan years beginning before January 1, 2014, the Secretary will define "reasonable" annual limits.
- Annual limits are prohibited after January 1, 2014.

Grandfathered Plan Requirements

- Effective for plan years beginning on or after September 23, 2010---
  - Prohibits lifetime limits
  - Prohibits rescissions
  - Requires dependent coverage up to age 26
  - Prohibits preexisting condition exclusions for dependents
  - Allows restricted annual limits (as determined by the HHS Secretary)

Health Insurance Exchanges

- State Planning Grants
  - Requires the Secretary to award grants, available 3/23/2011 until 2015, to states for planning and establishment of American Health Benefit Exchanges.
- States must declare intention to administer the exchange or to permit the federal fall-back by the end of 2012.

Health Insurance Exchanges

- American Health Benefit Exchanges
  - Requires states, by 2014, to establish an American Health Benefit Exchange that facilitates the purchase of qualified health plans and includes a Exchange for small businesses.
  - Requires the Secretary to:
    - Establish certification criteria for qualified health plans, requiring such plans to meet marketing requirements, ensure a sufficient choice of providers, include essential community providers in their networks, be accredited on quality, implement a quality improvement strategy, use a uniform enrollment form, present plan information in a standard format, and provide data on quality measures.
    - Develop a rating system for qualified health plans, including information on enrollee satisfaction, and a model template for an Exchange's Internet portal.
    - Determine an initial and annual open enrollment period, as well as special enrollment periods for certain circumstances.

Exchange Benefit Plans

- For the individual and small group markets, requires one of the following levels of coverage, under which the plan pays for the specified percentage of costs:

- Pla

	Percent of Plan Costs
Bronze	60
Silver	70
Gold	80
Platinum	90

- Child-Only Plan
  - If an insurer offers a qualified health plan, it must offer a child-only plan at the same level of coverage.

Exchange Benefit Plans

- Catastrophic Coverage Plan
  - In the individual market, a catastrophic plan may be offered to individuals who are under the age of 30 or who are exempt from the individual responsibility requirement because coverage is unaffordable to them or they meet the requirements for a hardship exemption.
  - A catastrophic plan must cover essential health benefits and at least 3 primary care visits, and must require cost-sharing up to the HSA out-of-pocket limits.

HSA Out-of-Pocket Limits

- Out-of-Pocket Spending Limits for 2010 and 2011
  - The maximum annual out-of-pocket amount for self-coverage is $5,950 and the maximum annual out-of-pocket amount for family coverage is twice that, $11,900.
    - 2011 limits will be officially published in the *Internal Revenue Bulletin 2010-23* on June 7, 2010.

Exchange Benefits

- Defines an essential health benefits package that covers essential health benefits, limits cost-sharing, and has a specified actuarial value (pays for a specified percentage of costs), as follows:
  - For the individual and small group markets, requires the Secretary to define essential health benefits, which must be equal in scope to the benefits of a typical employer plan.
  - For all plans in all markets, prohibits out-of-pocket limits that are greater than the limits for Health Savings Accounts.
  - For the small group market, prohibits deductibles that are greater than $2,000 for individuals and $4,000 for families. Indexes the limits and deductible amounts by the percentage increase in average per capita premiums.

Key Issues – Health Insurance Exchange

- State Options
  - Interstate Compacts
  - Basic Health Plan
  - Waiver (available in 2017)
- Creating a seamless Exchange/Medicaid connection
  - Financing
  - Technical Assistance
  - Staff Recruitment/Training
- Essential benefits/Affordability
  - Treatment of state mandated benefits
    - States must pay (individuals or plans) for mandated benefits not included in the essential benefit package.

Issue:

The Early Retiree Reinsurance Program

Citation:

Title I, Subtitle B, Section 1102 of the Patient Protection and Affordable Care Act.

Statutory Directive:

Requires the Department of Health and Human Services (HHS) to establish a temporary program within 90 days of enactment (June 1, 2010) for the purpose of providing reimbursement to participating employment-based plans for a portion of the cost of health benefits for early retirees, individuals 55 and over, and their spouses, surviving spouses, and dependents. Beginning with plan years on or after October 1, 2011, HHS will reimburse certain claims between $15,000 and $90,000.

Program Duration:

June 1, 2010 through January 1, 2014.

Funding:

$5 billion in financial assistance to eligible employers

Definitions:

Definition in Statute

Employee-based Health Plan–a group benefit plan providing health benefits that is maintained by private employers, state or local governments, employee organizations, voluntary employees' beneficiary association, a committee or board of individuals appointed to administer such plans, or a multiemployer plan.

Definition in Rule

Sponsor is a plan sponsor as defined in section 3(16)(B) of the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. 1002(16)(B), except that, in the case of a plan maintained jointly by one employer and an employee organization and or which the employer is the primary source of financing, the term means the employer.

The term **"plan sponsor"** means
(i) the employer in the case of an employee benefit plan established or maintained by a single employer,
(ii) the employee organization in the case of a plan established or maintained by an employee organization, or
(iii) in the case of a plan established or maintained by two or more employers or jointly by one or more employers and one or more employee organizations, the association, committee, joint board of trustees, or, other similar group of representatives of the parties who establish or maintain the plan.

Interim Final Rule:
Released in the Federal Register May 5, 2010, and effective June 1, 2010, comments will be accepted until 5 p.m. EST June 4, 2010.

- **Requirements to Participate:**
  1. Plans must have in place programs and procedures to generate cost-savings for participants with chronic and high-cost conditions. Plan sponsors must take a reasonable approach in identifying which conditions must be addressed. Chronic and high-cost conditions are defined as meaning a condition for which $15,000 or more in applicable claims are likely to be incurred during a plan year by one participant.
  2. Plan sponsors must have an agreement in place with health insurance issuers requiring disclosure of information on behalf of the sponsor to HHS. Section 1102 (d) requires HHS to conduct audits of claims data to ensure plan compliance requiring disclosure of private health information (PHI). The disclosure of PHI within this context will not require specific authorization from individuals as the disclosure is pursuant to "the required law."
  3. Section 1102 (d) also requires HHS to establish procedures to protect against fraud, waste, and abuse. **Sponsors must have policies and procedures in place to detect and reduce fraud, and attest that they are in place in the application.**
- **Application—a sponsor must submit the following:**
  1. One application must be filed for each plan and will be processed in the order they are received.
  2. A description of all benefit options under the employment-based plan.
  3. Applicants must submit a complete application the first time to be considered. All incomplete applications will be denied.
  4. Applicants must include a summary of how they will use the reimbursement to reduce costs and their plans to implement programs and procedures to generate savings for plan participants with chronic conditions.
  5. **Maintenance of Effort Requirement**—participating sponsors must agree to maintain funding levels to support their applicable plan or plans. The statute requires that funds dispersed under this program not be used as general revenue. The sponsors' plan for use must include how the funding received will be applied to maintain their level of effort in supporting the plan.
  6. Applicants must provide a projection of their reimbursement amounts for the first two plan-year cycles in their application.
- **Benefits Eligible for Reimbursement**
  1. Benefits are defined as medical, surgical, hospital, prescription drug, and such other benefits as determined by the secretary,
  2. The regulatory definition of "health benefits" clarifies that these benefits include benefits for diagnosis, cure, mitigation, or prevention of physical or mental disease or condition with respect to any structure or function of the body.
  3. Health benefits do not include benefits specified at 45 CFR 146.145(c) (2) as follows:
     i. Coverage only for accident (including accidental death and dismemberment),
     ii. Disability income coverage,
     iii. Liability insurance, including general liability insurance and auto mobile liability insurance,
     iv. Coverage issued as a supplement to liability insurance,
     v. Workers compensation or similar coverage,
     vi. Automobile medical payment insurance,
     vii. Credit-only insurance (for example, mortgage insurance),
     viii. Coverage for on-site medical clinics,
     ix. Limited scope dental and vision or long-term care provided under a separate policy or contract,
     x. Benefits provided under a health flexible spending arrangement, or

xi. Benefits provided under coverage for only a specified disease, i.e. a cancer policy.

- **Consequences of Non-compliance, Fraud or Similar Fault**

1. Failure to comply with the requirements of this part, or if fraud, waste and abuse or similar faults are found, the secretary may recoup or withhold funds, terminate or deny an application.

- **Amount of Reimbursement**

1. Claims submitted will be reimbursed at **80 percent of the health benefit costs for claims between $15,000 and $90,000** while funding is available.
2. Negotiated price concessions must be reflected on claims submitted for program reimbursement.

- **Reimbursement Method**

1. Claims for an early retiree may not be submitted until they have reached the required threshold in any given plan year. When that the threshold has been reached all claims below the applicable cost must be submitted in order to verify the cost threshold has been met.
2. Once the early retiree has reach $90,000 for a plan year, claims submission should cease.
3. In the case of a plan year that begins prior to June 1, 2010 and ends after, the plan sponsor may count claims that occurred prior June 1, 2010, but within the current plan year, toward the required claims threshold of $15,000. However, claims occurring prior to the June 1 effective date will not be tallied toward the $90,000 claim limit. Claims occurring prior to the effective date of June 1, 2010 are not reimbursable.

- **Maintenance of Records**

1. Specified records must be maintained for six years after expiration of the associated plan year.

- **Appeals**

1. The rule establishes a one-step appeals process.
2. Sponsors may appeal within 15 days of receipt of a determination at issue.

NCSL Fact Sheets on Health Reform

Issue: **Extension of dependent health coverage up to the age of 26.**

Citation:

Title I, Part A, Subpart II, Sec. 2714

Statutory Requirement:

Extension of health coverage for young adult children under their parent's health plan up to the age of 26.

Effective Date:

Group Coverage—Effective the first plan-year on or after September 23, 2010.

Individual Market—*See policy year definition on page two, as defined in rule.*

Grandfathered Plans—defined as an existing group health plan or health insurance coverage (including coverage from the individual health insurance market) in which a person was enrolled on the date of enactment. Grandfathered plans must comply and allow young adults to enroll under their parent's coverage in plan years beginning six months on or after date of enactment (September 23, 2010). Prior to 2014, a child may enroll for dependent coverage in a grandfathered plan only if the individual is not eligible for employment-based health benefits.

State Regulated Plans—state laws that impose stricter requirements on state regulated health issuers than those required by federal law will not be superseded. States may continue to impose their current policies upon state regulated health plans, or to conform their laws to the newly enacted health reform provisions.

Premium Rate & Payment:

The law is silent regarding the mechanism by which premiums for an adult dependent are paid. The health plan may exclude coverage for pre-existing conditions for a period of time depending on prevailing state and existing federal law if the dependent is 19 years of age or older and until the prohibition on pre-existing condition exclusions takes effect in 2014.

Interim Final Rules

The Departments of Health and Human Services (HHS), Labor, and Treasury issued new regulations May 10, 2010, which will take effect 60 days after their publication (July 10, 2010).

- **Rule Effective Date**—July 10, 2010, comments will be accepted until August 10, 2010.
- **HHS—45 CFR Subtitle A, Parts 144, 146 and 147**
  Jurisdiction—Amends laws in Part 146, 147, and 148 of the Public Health Service Act (PHS Act) pertaining to group health plans, group health insurance issuers, and health insurance issuers in the group and individual markets.

  Revises the definition of ***policy year*** in the individual market to mean the 12-month period that is designated as the policy year in the policy documents of the individual health insurance coverage. If no policy year has been designated, then the policy year is the deductible or limit year used under the coverage. If deductibles or other limits are not imposed on a yearly basis, the policy year is the calendar year.
- **DOL—Employee Benefits Security Administration—29 CFR Chapter 2590**
  Jurisdiction—Amends Part 2590 Rules and Regulations for Health Insurance Portability and Renewability for Group Health Plans.
- **DOT—Internal Revenue Service—26 CFR Parts 54 and 602**

Regulatory Requirements:

- **Applicability**—group health plans; group health insurance issuers.
- Requires group and individual health insurance plans that provides coverage to dependent children to extend coverage for these dependents until they reach their 26 birthday.
- Prohibits a plan from defining a dependent in any other way other that a relationship between a child and the participant.
- Prohibits a plan from denying or restricting coverage for a child who has not yet reached their 26th birthday based on the following:
    1. Financial dependency,
    2. Residency with participant,
    3. Student status,
    4. Employment,
    5. Marital status, or
    6. Combination of these factors.
- Prohibits coverage provided to dependents to vary based on age, except for children who are age 26 or older.
- Coverage must be offered to the dependent by the plan no later than the first day of the first plan year beginning on or after September 23, 2010.
- **Provides transitional relief for children whose coverage ended** or was denied coverage under a group health plan or other health insurance coverage before reaching their 26th birthday. The enrollment opportunity must be provided during the initial plan year beginning on or after September 23, 2110 and thereafter. Dependents must be offered full benefits, and pay no more for coverage than similarly situated individuals who did not lose coverage by reason of dependent cessation.
- **Special rule for grandfathered group health plans.** For plan years beginning before January 1, 2014, grandfathered plans may exclude an adult child who is not 26 years old from coverage if they are enrolled in an eligible employer-sponsored health plan.
- Defines a grandfathered health plan as being an existing group health plan or health insurance coverage (including coverage from the individual health insurance market) in which a person was enrolled on the date of enactment of health reform legislation. Therefore, as long as a person was enrolled in a health insurance plan on March 23, 2010, that plan has been grandfathered.
- Specifies that children who are eligible for coverage and are currently covered under a COBRA continuation provision must be given the opportunity to enroll as a dependent of an active employee. If a child in this case loses eligibility for coverage due to a qualifying event, such as aging out of coverage, they will have an opportunity to elect COBRA continuation coverage for another 36 months.
- Provides that if a plan has more than one benefit package option it must provide the individual the opportunity to enroll in any of these benefit package options for which they are eligible.
- Permits an employer to deduct from an employees' income the value of employer provided health coverage for an employee's child for an entire taxable year during which the child turns 26, if the coverage continues until the end of that taxable year.
- **Effective date of coverage** is the first day of the first plan year beginning on or after September 23, 2010.

Tax Treatment of Health Care Benefits Provided with Respect to Children Under Age 27

- IRS Notice 2010-38 provides guidance on the Affordable Care Act's (the Act) amendment of Section 105(b) of the Code, effective March 30, 2010, to extend the general exclusion from gross income for the reimbursements for medical care under an employer provided accident or health plan to any employee's child who has attained age 27 as of the end of the taxable year.
- The Act also makes parallel amendments that are effective March 30, 2010 to Section 401 (h) for retiree health accounts in pension plans, to Section 501 (c) (9) for voluntary employees' beneficiary associations (VEBAs), and to Section 162(l) for deductions by self-employed individuals for medical care insurance.
- A child is an individual who is a son, daughter, stepson, or stepdaughter of the employee, and a child include both a legally adopted individual of the employee and an individual who is lawfully placed with the employee for legal adoption by the employee. The term also includes an "eligible foster child" who has been placed with the employee by an authorized placement agency or by judgment, decree, or other order of any court.
- Beginning March 30, 2010, employers with cafeteria plans that allow employees to choose from a menu of tax-free benefit options and cash or taxable benefits are allowed to permit employees to begin making pre-tax contributions to pay for health coverage provided for an employee's children who are under 27 years of age.
- Plan sponsors then have until the end of 2010 to amend their cafeteria plan language to incorporate this change.

State Issues

- States may continue to apply state law requirements except to the extent that the requirements prevent the application of the Affordable Care Act requirements.
- State insurance laws that are more stringent than the federal requirement are unlikely to "prevent the application of" the Affordable Care Act, and be preempted.
- State and local governments as sponsors will be required to provide notice of an enrollment opportunity to individuals whose coverage has ended, or who was denied coverage under their plans before the attainment of age 26. HHS estimates that 126,000 state and local governmental plans will have to send approximately 19,627,000 notices to eligible employees in the individual market, 490 will have to send approximately 5,444,000 notices to individuals with policies covering dependents. The associated equivalent cost is estimated at $6,791,000 to prepare and distribute 25,071,000 notices; distribution of notices will be approximately $777,000 excluding postage cost.

Additional Information &Resources:

Effective March 30, 2010, employers may permit employees to begin making pre-tax contributions under a cafeteria plan (see description above) to provide coverage for children under age 27.

IRS Notice 2010-38 —Tax Treatment of Health Care Benefits Provided with Respect to Children Under Age 27—describes how employers with cafeteria plans are required to permit employees to begin making pre-tax contributions to pay for expanded benefits to adult dependents. [http://www.irs.gov/pub/irs-drop/n-10-38.pdf]

National Conference of State Legislatures Office of State-Federal Relations
444 North Capitol Street, NW, Suite 515, Washington, D.C. 20001
202-624-5400

NCSL HEALTH REFORM FACT SHEET

KEY PROVISIONS THAT TAKE EFFECT IMMEDIATELY

UNDER SENATE BILL (HR 3590) AS AMENDED BY RECONCILIATION BILL (HR 4872)

INSURANCE REFORMS

PROHIBITS PLANS FROM IMPOSING PRE-EXISTING CONDITION EXCLUSIONS ON CHILDREN—Prohibits health insurers from denying coverage to children with pre-existing conditions. *Effective 6 months after enactment.* (Beginning in 2014, this prohibition would apply to all persons.)

PROHIBITS PLANS FROM IMPOSING LIFETIME LIMITS ON COVERAGE—Prohibits health insurance companies from placing lifetime caps on coverage. *Effective 6 months after enactment.*

PROHIBITS THE IMPOSITION OF RESTRICTIVE ANNUAL LIMITS ON COVERAGE—Tightly restricts new plans' use of annual limits to ensure access to needed care. These tight restrictions will be defined by HHS. *Effective 6 months after enactment.* (Beginning in 2014, the use of annual limits would be prohibited for all plans.)

ELIMINATES CO-PAYMENTS AND DEDUCTIBLES FOR PREVENTIVE CARE UNDER NEW PRIVATE PLANS—Requires new private plans to cover preventive services with no co-payments and with preventive services being exempt from deductibles. *Effective 6 months after enactment.* (Beginning in 2018, this requirement applies to all plans.)

ESTABLISHES A TEMPORARY REINSURANCE PROGRAM FOR EARLY RETIREES—Creates a temporary re-insurance program (until the Exchanges are available) to help offset the costs of expensive health claims for employers that provide health benefits for retirees age 55-64. *Effective 90 days after enactment*

ESTABLISHES A NEW, INDEPENDENT APPEALS PROCESS—Ensures that consumers in new plans have access to an effective internal and external appeals process to appeal decisions by their health insurance plan. *Effective 6 months after enactment.*

ENSURES VALUE FOR PREMIUM PAYMENTS (Medical Loss Ratio)—Requires plans in the individual and small group market to spend 80 percent of premium dollars on medical services, and plans in the large group market to spend 85 percent. Insurers that do not meet these thresholds must provide rebates to policyholders. *Effective January 1, 2011.*

ESTABLISHES AN INTERIM HIGH RISK POOL PROGRAM —Provides immediate access to insurance for Americans who are uninsured because of a pre-existing condition - through a temporary high-risk pool. This program will end when the Health Insurance Exchanges become effective in 2014. *Effective 90 days after enactment.*

EXTENDS COVERAGE FOR YOUNG PEOPLE UP TO 26TH YEAR THROUGH PARENTS' INSURANCE – Requires health plans to allow young people up to their 26th year to remain on their parents' insurance policy, at the parents' choice **regardless of marital status. Note:** Language in H.R. 4872 Reconciliation Act of 2010 amends provisions in H.R. 3590 by adding a provision to clarify dependent coverage as it relates to the income definition under the Internal Revenue Code of 1986. This language defines an adult dependent as any child of the taxpayer who as of the

end of the taxable year has not attained age 27. NCSL has requested clarification of the congressional intent due to the differences in the language of the two bills. *Effective 6 months after enactment.*

PROHIBITS DISCRIMINATION BASED ON SALARY—Prohibits new group health plans from establishing any eligibility rules for health care coverage that have the effect of discriminating in favor of higher wage employees. *Effective 6 months after enactment.*

ASSISTANCE TO STATES TO PROVIDE HEALTH INSURANCE CONSUMER INFORMATION—Provides aid to states in establishing offices of health insurance consumer assistance in order to help individuals with the filing of complaints and appeals. *Effective beginning in FY 2010.*

TAX CREDITS

SMALL BUSINESS TAX CREDITS—Offers tax credits to small businesses to make employee coverage more affordable. Tax credits of up to 35 percent of premiums will be immediately available to firms that choose to offer coverage. *Effective beginning calendar year 2010.* (Beginning in 2014, the small business tax credits will cover 50 percent of premiums.)

MEDICARE

BEGINS TO PHASE-OUT THE MEDICARE PART D DONUT HOLE—Provides a $250 rebate to Medicare beneficiaries who hit the donut hole in 2010. *Effective calendar year 2010.* (Beginning in 2011, institutes a 50% discount on brand-name drugs in the donut hole; also completely closes the donut hole by 2020.)

ELIMINATES CO-PAYMENTS AND DEDUCTIBLES FOR PREVENTIVE CARE UNDER MEDICARE—Eliminates co-payments for preventive services and exempts preventive services from deductibles under the Medicare program. *Effective January 1, 2011.*

HEALTH CARE INFRASTRUCTURE AND WORKFORCE

COMMUNITY HEALTH CENTERS—Increases funding for Community Health Centers to allow for nearly a doubling of the number of patients seen by the centers over the next 5 years. *Effective beginning in fiscal year 2010.*

INCREASING NUMBER OF PRIMARY CARE DOCTORS—Provides new investment in training programs to increase the number of primary care doctors, nurses, and public health professionals. *Effective beginning in fiscal year 2010.*

LONG TERM CARE

CREATES NEW, VOLUNTARY, PUBLIC LONG-TERM CARE INSURANCE PROGRAM— Establishes a national voluntary insurance program for purchasing Community Living Assistance Services and Support (CLASS program), a long-term care insurance program to be financed by voluntary payroll deductions to provide benefits to adults who are actively employed and become functionally disabled. The program allows for an opt-out by employees, and a five year vesting period. *Effective on January 1, 2011.*

NCSL Staff Contacts:
Joy Johnson Wilson, Health Policy Director (Joy.Wilson@ncsl.org)
Rachel Morgan, Senior Policy Specialist (Rachel.Morgan@ncsl.org)