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MEMORANDUM

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August 24, 2010

TO: Interested Persons

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SUBJECT: State Implementation of Federal Health Care Reform Legislation

This memorandum responds to your request for information on federal health care reform legislation, including the federal Patient Protection and Affordable Care Act, and the Health Care and Education Reconciliation Act of 2010, which were signed into law in March of 2010 and are referred to throughout this memo as the "act." Specifically, you asked:

- What items within the act require state implementation and on what timeline?
- What items within the act allow for state variation?
- What resources will be available to the states for implementation of the act, and which resources has Colorado applied for?

Table 1 summarizes the provisions of the act, organized by specific topics described on page 2. The table provides a description of specific requirements of the law, information on the state actions that are required to implement the provision, and funding available to states for implementation. When available, the table also includes information on the funds for which the state has applied or is planning to apply.

Table 1 provides information on the portions of the act that require or allow for state involvement in implementation, and does not summarize the provisions of the act for which there is little to no state role. For instance, Table 1 does not summarize the provisions of the act that affect Medicare, as that program is administered entirely by the federal government. However, for your information and overall understanding of the act, Table 1 does provide information in a few specific areas, including taxation and grants for healthcare workforce development, in which there is little state involvement in implementation.

Table 1 contains summaries of the act's provisions related to the following topics.

Health insurance. Health insurance provisions of the act include changes to coverage requirements for health plans, oversight of health insurance rates, and required reporting related to health insurance plan premiums and expenses. The act also requires the creation of Health Insurance Exchanges, which allow consumers to shop for plans that offer federally acceptable benefits and coverage levels.

Medicaid and Children's Basic Health Plan (CHP+). The act implements a number of changes that affect the eligibility of low-income adults for the Medicaid program. In addition, the act makes specific changes to the programs and benefits that may be offered to Medicaid enrollees, processes for enrollment of adults and children in the Medicaid and CHP+ programs, and payments to states for the costs of these changes.

Funding for providers that serve the uninsured. The act provides direct funds and grants to providers, such as community health centers, that primarily serve individuals who are uninsured or who are enrolled in public health care programs. In general, these funds are provided directly to health care professionals and facilities rather than to the state.

Workforce. The act provides direct funding and grants to health care providers, academic institutions, and health care facilities to increase the number of health care providers. In general, these funds pass directly to individuals and health care and academic institutions rather than to the state.

Long-term care. A number of provisions of the act affect long-term care services for older adults. The act creates a program to fund community living assistance services and supports through payroll contributions. The act also makes a number of changes to long-term care services provided through Medicaid.

Public health. The act provides funds to state and local public health agencies to support epidemiology research, vaccination, and other public health activities.

Other. The act creates a number of grant programs to fund various health-related purposes.

Taxation and fees. Tax provisions of the act include credits to offset some of the costs of health care coverage for low income individuals and small businesses. Provisions also include tax and fee increases, which are intended to offset the costs of expanding coverage. According to estimates from the Congressional Budget Office, the net impact of these changes will raise $525 billion in revenue to the federal government between 2010 and 2019. All taxes and fees will be implemented at the federal level and do not require any state administration. Because state taxes are based on federal taxable income, state tax revenue is expected to increase as a result of the changes in tax policy.

Table 1
Summary of the Federal Health Care Reform Legislation

Provision	Description	State Action Required	Funding Available to States
	Health Insurance		

Requirements for Health Plans	The act makes the following changes to requirements for group and individual health insurance plans:
	
	• beginning September 23, 2010:
	  • prohibits plans from establishing lifetime or annual limits on the dollar value of benefits. Annual limits may be placed on benefits that are not "essential;"
	  • prohibits an insurer from rescinding coverage except in the case of fraud;
	  • requires insurers to provide coverage, without any cost sharing, for immunizations and other specified preventative health services;
	  • requires health plans that offer coverage for dependent children to continue coverage for an adult child until the child turns 26 years of age; and
	  • prohibits pre-existing coverage limitations for dependents under 19 years of age;
	
	• beginning in 2014:
	  • requires the Secretary of the Federal Department of Health and Human Services (Secretary) to develop a single set of operating rules to process insurance transactions;
	  • prohibits plans from applying pre-existing coverage limitations;
	  • specifies that rates may only vary based on the following factors:
	
	  ▸ family size;
	  ▸ geographic area;
	  ▸ age; and
	  ▸ tobacco use.
	
	  • requires health insurers to offer coverage to any individual or group that applies;
	  • requires health insurers to renew coverage at the option of the plan sponsor or the covered individual;
		Colorado may need to conform its existing laws regulating insurers to comply with federal legislation.	None specified.

Table 1
Summary of the Federal Health Care Reform Legislation (Cont.)

Provision	Description	State Action Required	Funding Available to States
Health Insurance (Cont.)			
Requirements for Health Plans (Cont.)	• prohibits plans from establishing any rules for eligibility based on any of the following factors: ▸ health status; ▸ medical condition; ▸ claims experience ▸ receipt of medical care; ▸ genetic information; ▸ evidence of insurability; ▸ disability; and ▸ any other health status-related factor; and • prohibits a plan from applying a waiting period for coverage longer than 90 days.		
Oversight of Rates	The act requires the Secretary to implement an annual review process of insurance premiums to determine if increases in rates are unreasonable.	Grants will be awarded to states to provide information and recommendations on rate reviews and to establish centers to collect, analyze and organize medical reimbursement information. As a condition of receiving a grant, states must provide the Secretary with information regarding trends in rating and premium increases.	Over a five-year period beginning in 2010, $250 million is available to fund grants to states. The Department of Regulatory Agencies (DORA) applied for a $1 million grant through the Grants to States for Health Insurance Premium Review Cycle I program. Future funding may be awarded on an annual basis.
Medical Loss Ratios and Rebates	The act requires insurers to: • submit a report to the Secretary on the insurer's premium/loss ratio; and • beginning January 11, 2011, provide an annual rebate to each plan enrollee if the premium/loss ratio is less than 85% for large group markets or 80% for small group markets.	None specified or unknown at this point.	None specified.

Table 1
Summary of the Federal Health Care Reform Legislation (Cont.)

Provision	Description	State Action Required	Funding Available to States
Health Insurance (Cont.)			
Consumer Assistance and Protection	The act requires: • insurers to implement an effective process through which enrolles can appeal coverage determinations and claims; • the Secretary, in conjunction with the state, to establish a website to allow residents of a state to identify affordable coverage options in the state; • insurers to provide uniform summary of benefit forms, developed from standards issued by the Secretary, to enrolles; and • the Secretary to distribute grants to states to establish or expand offices or ombudsmen to assist consumers with insurance-related issues.	In order to receive a grant for consumer assistance, states must comply with specific criteria and collect and report data to the federal government on the types and volumes of complaints submitted by consumers.	For 2014, $30 million is available for grants to states that establish or expand consumer assistance offices. DORA plans to apply for a portion of the total funding. A total of 56 awards are anticipated, ranging from $120,000 to $3.4 million.
High Risk Pool	The act requires the Secretary to establish, or contract with states or nonprofit entities to establish, high risk pools to provide health insurance coverage to individuals with pre-existing conditions. The high risk pool will be in place until 2014, when state health insurance exchanges are established.	In July 2010, Colorado formed a high-risk pool to comply with the provisions of the act called GettingUsCovered. The pool is jointly administered by Rocky Mountain Health Plans and CoverColorado. In order to qualify for coverage through the pool, individuals must be U.S. and Colorado residents, have been uninsured for at least six months, and have a pre-existing condition that has prevented them from obtaining commercial health insurance in the past.	A total of $5 billion across all states is available to subsidize premiums in the high risk pool. DORA applied for and received $90 million over a three-year period.
Wellness Programs	The act defines "wellness programs" as programs of health promotion or disease prevention offered by an employer. The act establishes the certain conditions for the operation of wellness programs. Wellness programs that were established prior to the enactment of the act may continue to operate. No later than July 1, 2014, the Secretary, along with the Treasury Secretary, are to establish a 10-state pilot program for wellness programs in the individual insurance market.	States must apply to participate in the pilot program. In order to participate, a state must demonstrate that the project is designed in a manner that: • will not result in any decrease in coverage; and • will not increase the costs to the federal government.	None specified.

Table 1
Summary of the Federal Health Care Reform Legislation (Cont.)

Provision	Description	State Action Required	Funding Available to States
	Health Insurance (Cont.)		
Qualified Health Plans and Essential Benefits Package	***Qualified health plans.*** As defined in the act, qualified plans: • have a certification that the plans may be offered through an exchange; • provide the essential health benefit package (described below); and • are offered by a health insurer in good standing that agrees to offer a plan in the silver and gold levels of the exchange, agrees to charge the same rates for plans offered inside and outside of an exchange, and complies with any additional rules issued by the Secretary. Qualified plans must meet specific marketing requirements and ensure a sufficient choice of providers, including essential community providers such as community health centers. Qualified plans are subject to a rating system, to be developed by the Secretary, and an enrollee satisfaction system. States may require that qualified plans offer benefits in addition to the essential health benefits package described below. States must assume the costs of these additional benefits. ***Essential health benefits package.*** The essential health benefits package is defined in the act as plans that provide coverage for certain essential health benefits, specified in the act, and limit cost-sharing. Essential health benefits include: • emergency services; • hospitalization; • maternity and newborn care; • mental health and substance abuse treatment; • prescription drugs; • preventative and wellness services; and • pediatric services, including oral and vision care.	States may pass a law to prohibit coverage of abortions in qualified health plans offered through the exchange. States may add addition benefits to qualified health plans above those required by federal law.	None specified.

Table 1
Summary of the Federal Health Care Reform Legislation (Cont.)

Provision	Description	State Action Required	Funding Available to States
	Health Insurance (Cont.)		
Qualified Health Plans and Essential Benefits Package (Cont.)	Beginning in 2014, plans are subject to an annual limit on cost-sharing, and the deductibles of plans offered in the small group market are limited to $2,000 for an individual and $4,000 for a family. The act establishes four benefit categories, equal to a specified percentage of the full value of benefits provided under the essential health benefits package: • bronze, 60%; • silver, 70%; • gold, 80%; and • premium, 90%. Health insurers may also offer catastrophic plans to individuals under the age of 30 in the individual market. States may pass laws to prohibit abortion coverage in qualified plans. Federal funds may not be used to provide voluntary abortions, and funds for abortion coverage must be segregated.		
Health Insurance Exchanges	***Establishment of state health insurance exchange.*** The act requires states to establish, by January 1, 2014: • a health insurance exchange through which individuals may purchase qualified health plans; and • a Small Business Health Options Program (SHOP exchange), designed to assist a qualified small employers in enrolling their in employees in qualified health plans offered in the state's small group market. States may combine the individual and SHOP exchanges into one exchange. States that do not establish an operational exchange by 2014 will have one established in the state by the Secretary.	States must determine: • whether to operate an exchange or allow the federal government to set up the exchange within the state; • whether to operate separate exchanges for individuals and small businesses, or to combine these exchanges; • whether to operate a regional exchange with other states, or to operate multiple exchanges within geographically distinct regions of the state; • whether to permit large employers to purchase coverage through the exchanges in 2017; and	By September 1, 2010, the Secretary must award Planning and Establishment Grants to states to establish an exchange. Each state's amount is to be determined on an annual basis through 2015, at which time the exchanges must be self-sustaining. DORA and HCPF will apply for the Colorado's planning grants. Grants are expected to be up to $1 million each year.

Table 1
Summary of the Federal Health Care Reform Legislation (Cont.)

Provision	Description	State Action Required	Funding Available to States
Health Insurance (Cont.)			
Health Insurance Exchanges	Exchanges must: • either be a governmental agency or a nonprofit entity that is established by the state; • only offer qualified health plans;. • develop procedures for the certification of plans as qualified health plans; • maintain telephone lines and websites where consumers can access information about the plans in the exchange; • provide information to individuals about their eligibility for public programs, such as Medicaid, and grant certifications for individuals who are exempt from the mandate for coverage; and • require plans seeking to continue to participate in the exchange to submit a justification of any increase in premiums prior to the implementation of the increase. States may operate regional exchanges. States may also establish multiple exchanges in one state if each exchange operates in a geographically distinct areas of the state. Employers may select a level of coverage to be made available to employees through an exchange. Employees may enroll in any qualified plan that meets the level of coverage selected by the employer. ***Health insurance markets.*** The act specifies that health insurers must consider all individuals who are enrolled in individual plans offered by the insurer in the exchange a single individual risk pool. Similar provisions apply to small group pools. A state may require the individual and small group markets to be merged. Health insurers may continue to offer plans outside of the exchange. ***Eligibility for exchange.*** Individuals must not be incarcerated and must be a lawful resident of the United States in order to purchase an exchange plan. Employers must make all full-time employee eligible for coverage. Initially, participation in the exchange is limited to small employers. Beginning in 2017, states may allow large employers to participate in the exchange.	• a funding mechanism for the exchanges when federal funding ends in 2015. Department of Health Care Policy and Financing (HCPF) and the State Health Care Reform Implementation Board are currently hosting a series of forums around the state to gain input from stakeholders regarding how the exchange should be structured in Colorado.	

Table 1
Summary of the Federal Health Care Reform Legislation (Cont.)

Provision	Description	State Action Required	Funding Available to States
	Health Insurance (Cont.)		
Consumer Operated and Oriented (CO-OP) Plan	The Secretary must create a program to facilitate the creation of nonprofit health insurers through loans and grants.	None specified or unknown at this point.	None specified.
Authority to Establish Alternative Programs	***Standard Health Plans.*** The act allows states to enter into contracts to offer 1 or more standard health plans providing at least the essential health benefits to eligible individuals in lieu of offering such individuals coverage through an exchange. Individuals who have a household income that exceeds 133%, but is below 200%, of the Federal Poverty Level (FPL) and who do not have access to an employer-sponsored plan are eligible for this coverage. ***Waivers.*** Beginning January 1, 2017, states may apply for waivers of specific requirements of the act, including the requirement to establish and operate an exchange. ***Health Care Choice Compacts.*** The act allows for the creation of Health Care Choice Compacts under which two or more states may enter into agreements. Under the agreements, individual health insurance plans may be sold in each state that enters into an agreement and be subject only to the laws of the state in which the plan was issued, with certain exceptions.	States must determine whether to avail themselves of any of the options to develop alternative programs.	***Standard Health Plans.*** Approved programs may receive federal funding in an amount equal to 85% of tax credits and cost-sharing subsidies that would have been provided to eligible individuals had they enrolled in an exchange plan. ***Waivers.*** The Secretary must develop an alternative means to transfer funds to the state that otherwise would have been paid to participants in the exchange.
Reinsurance Program	By January 1, 2014, states are required to establish a reinsurance program. The reinsurance program will be funded through payments made by group health plans, and the program will provide payments to individual insurers that cover high-risk individuals in the insurance market. States must coordinate with or eliminate any existing high-risk pool in the state in order to implement this provision.	The state must adopt state law or regulations to implement the reinsurance program, and must determine if additional costs will be collected from insurers to cover the administrative costs of the program.	None specified.
Risk Adjustment	States are required to assess a charge on health plans if the actuarial risk of the enrollees of the plan is less than the average actuarial risk of all enrollees in all plans. States must provide payments to health plans if the actuarial risk of the enrollees of the plan is greater than the average actuarial risk of all enrollees in all plans.	Legislation or rules establishing how the charge will be assessed on health plans, the amount of the charge, and how the charges will be redistributed to other plans is necessary.	None specified.

Table 1
Summary of the Federal Health Care Reform Legislation (Cont.)

Provision	Description	State Action Required	Funding Available to States
	Health Insurance (Cont.)		
Individual Mandate	The act requires individuals to maintain minimal essential health care coverage beginning in 2014. Those individuals who do not maintain adequate coverage are subject to a Shared Responsibility Payment. The act waives criminal and civil penalties for failure to pay the Shared Responsibility Payment. Individuals who met the following requirements are not assessed a penalty for failure to maintain coverage: • individuals who claim an exemption based in their religious beliefs; • individuals who are not covered for only short periods of time; • individuals who are required to pay more than 8% of their household income towards the cost of coverage; • individuals with a taxable income of less than 100% FPL; • Native Americans; and • individuals who have a hardship with respect to obtaining coverage. Individuals may obtain acceptable coverage through: • a plan offered inside or outside of the exchange; • a plan that was grandfathered in under the act; • an employer-sponsored plan; • Medicaid, Medicare, or the Children's Health Insurance Program; • TRICARE or the Veterans' Administration; or • a federal employee health benefit plan.	The individual mandate is enforced through a federal tax penalty.	None specified.
Employer Responsibilities	The act requires employers with more than 200 employees to automatically enroll new employees in a health care plan and provide information about how the employee can opt out of coverage. Employers must also provide information to employees about the exchange.	Employer responsibilities with regard to reform are enforced through federal penalties.	None specified.

Table 1
Summary of the Federal Health Care Reform Legislation (Cont.)

Provision	Description	State Action Required	Funding Available to States
Health Insurance (Cont.)			
Employer Responsibilities (Cont.)	The act imposes fines on large employers (employers with 50 or more employees) who fail to offer full-time employees the opportunity to enroll in health care coverage or who have a waiting period of more than 60 days for the employee to enroll in coverage. Large employers must also submit an annual report on the health insurance coverage provided to their full-time employees.		
Health Information Technology Standards	The act requires the Secretary to develop interoperable and secure standards and protocols that facilitate enrollment of individuals in federal and state health and human services programs. Grants are available to states and local governments to develop and adapt technology systems to implement the standards and protocols.	The state must submit a needs analysis of current systems to determine whether enrollment standards and protocols can be met.	Funding of $20 million is anticipated to be available for Enrollment Health and Information Technology grants, although no announcements have been made. HCPF and the Office of Information Technology will apply for funding.
Medicaid and the Children's Basic Health Plan			
Medicaid Coverage Expansions	Beginning in 2014, the act makes the following changes to the state's Medicaid program: • expands coverage to children and adults with incomes up to 133% of the FPL. All newly eligible adults are guaranteed a benefit package that meets the essential health benefits available through the exchange; • requires the essential health benefits package to include coverage of prescription drugs and mental health services; • extends coverage to former foster care children who are under 26 years of age; and • allows the states the option of providing Medicaid coverage to all non-elderly individuals with incomes above 133% of the FPL.	States may expand coverage to adults with incomes up to 133% of the FPL as early as April 1, 2010, but are required to do so by 2014. States may extend Medicaid coverage to individuals with incomes above 133% beginning January 1, 2011.	States will receive: • 100% federal funding for the Medicaid expansion for 2014 through 2016; • 95% funding for 2017; • 94% funding for 2018; • 93% funding for 2019; and • 90% funding for 2020 and subsequent years. States that have already expanded eligibility to adults with incomes up to 100% of the FPL will receive a phased-in increase in the federal medical assistance percentage (FMAP) for childless adults.

Table 1
Summary of the Federal Health Care Reform Legislation (Cont.)

Provision	Description	State Action Required	Funding Available to States
Medicaid and the Children's Basic Health Plan (Cont.)			
Medicaid Eligibility	The act: • requires states to use an individual's or household's modified gross income to determine eligibility, without applying a disregard for income or expenses or an asset or resource test; • allows a state to offer Medicaid wrap-around benefits to individuals who are eligible for Medicaid but who are enrolled in an employer-sponsored insurance program; • prohibits the state from requiring, as a condition of Medicaid eligibility, that an individual apply for enrollment in qualified employer-sponsored coverage; • requires the state to maintain income eligibility levels for children who are eligible for Medicaid until 2019; • allows states to cover family planning services and supplies under a presumptive eligibility period for a categorically needy group of individuals; and • creates an optional eligibility category to provide full Medicaid benefits to individuals receiving home- and community-based services.	Colorado may need to conform its existing laws and rules concerning Medicaid eligibility to comply with federal legislation.	None specified.
Enrollment Simplification	The act: • requires the state to enroll newly eligible participants who apply through the exchange in the Medicaid program; • requires states to develop a single form for applying for state health subsidy programs that can be filed online, in person, by mail, or by phone; • requires states to establish procedures to allow individuals to enroll and reenroll in Medicaid through a website, and requires that the website be linked to the exchange's website; • permits exchanges to contract with state Medicaid agencies to determine eligibility for tax credits in the exchanges; and • permits hospitals to provide Medicaid services during a period of presumptive eligibility to members of all Medicaid eligibility categories.	The state will have to coordinate the development of the health insurance exchange with the eligibility determination processes of Medicaid and CHP+.	None specified.

Table 1
Summary of the Federal Health Care Reform Legislation (Cont.)

Provision	Description	State Action Required	Funding Available to States
Medicaid and the Children's Basic Health Plan (Cont.)			
Benefits and Services	The act makes the following changes to Medicaid benefits and services requirements: • effective immediately, requires coverage of free- standing birth center services; • effective immediately, allows children who are receiving hospice care to continue to receive full Medicaid benefits; • effective January 1, 2013, requires states to cover preventative care, including vaccines for adults, and gives states financial incentives to implement this provision without any cost-sharing requirements; and • effective October 1, 2010, requires coverage for tobacco cessation services for pregnant women; and • allows Medicaid coverage of certain drugs used to promote smoking cessation, barbiturates, and benzodiazepines.	Colorado may need to conform its existing laws and rules concerning Medicaid eligibility to comply with federal legislation.	Awards states that remove cost-sharing for preventive services with a one percentage point increase in the FMAP for these services.
Emergency Psychiatric Demonstration Program	The act establishes a three-year demonstration program to allow up to eight states to increase the number of Medicaid emergency inpatient psychiatric care beds in the state.	States must apply to be part of the program. Funds may not be awarded to a public institution.	A total of $75 million is available over the three-year period. HCPF and DHS will apply for the grants.
Medicaid Health Homes	Beginning January 1, 2011, allows states to implement, through a Medicaid state plan amendment, a program to provide coordinated care to individuals with chronic illness through a health home. A health home is a model of care that uses a health assessment plan, integrates service providers, tracks referrals, reviews all medications, and allows for the use of health information technology to provide services in the home.	States must meet specified requirements regarding coordination of physical health services with substance abuse and mental health services, reporting, and payment of home health services.	For the first two years a state operates a program, the state will receive an enhanced FMAP of 90% of the costs of the program. Beginning January 1, 2011, planning grants are available to states to implement this provision. States must match the amount received based on their FMAP. A total of $25 million is available.

Table 1
Summary of the Federal Health Care Reform Legislation (Cont.)

Provision	Description	State Action Required	Funding Available to States
Medicaid and the Children's Basic Health Plan (Cont.)			
Payments to Disproportionate Share Hospitals	Medicaid Disproportionate Share Hospital (DSH) allotments are distributed to providers who serve a large number of uninsured patients. The act reduced DSH payments provided to states in the aggregate by: • $0.5 billion in 2014; • $0.6 billion in 2015; • $0.6 billion in 2016; • $1.8 billion in 2017; • $5 billion in 2018; • $5.6 billion in 2019; and • $4 billion in 2020. Effective October 1, 2011, the act requires the Secretary to develop a methodology to distribute the DSH reductions in a manner that imposes the largest reduction in DSH allotments for states with the lowest percentage of uninsured individuals or those that do not target DSH payments, imposes smaller reductions for low-DSH states, and accounts for DSH allotments used for certain Medicaid waivers.	Colorado will have to determine how to implement the reduction in DSH payments. Over the long-term, the state will have to consider how existing programs that are funded through DSH payments, namely the Colorado Indigent Care Program, will operate with the broader changes required by the act, including the health care exchange and the Medicaid coverage expansions.	Not applicable.
Payments to Primary Care Providers	The act increases Medicaid payments for primary care services to 100 percent of the Medicare payment rates for 2013 and 2014.	Colorado will likely need to revise its current payment rates to comply with this provision. Payment rates are generally set through rules issued by the state Board of Medical Services.	States will receive 100% federal funding for the increase payment rates.
Demonstration Projects for Payments to Providers	The act establishes three demonstration projects related to payment of providers. The projects are: • a project to allow up to eight states to evaluate the use of bundled payments for the provision of integrated care to a Medicaid beneficiary; • a project in which a participating state may adjust payments to an eligible safety net hospital from a fee-for-service structure to a capitated payment model; and • a project to allow pediatric medical providers to be recognized as accountable care organization for the purpose of receiving incentive payments.	Selected states must submit plans to the federal government and report specific data.	No specific funding was included in the act for the demonstration projects, but HCPF and the Center for Improving Value in Health Care will apply when funding is available.

Table 1
Summary of the Federal Health Care Reform Legislation (Cont.)

Provision	Description	State Action Required	Funding Available to States
Medicaid and the Children's Basic Health Plan (Cont.)			
Grants for Wellness Programs	The act provides grants to states to provide incentives to Medicaid beneficiaries who participate in wellness programs to lower health risk and demonstrate improved outcomes.	In order to receive a grant, states must continue the wellness program for at least three years. The programs must be based on criteria developed by the Secretary. States must set standards and health status targets for beneficiaries, and evaluate the success of the program in meeting the standards.	Grants for state wellness programs will be awarded as soon as January 1, 2011. A total of $100 million over a five-year period is available. HCPF and the Department of Public Health and Environment (DPHE) will apply for the grants.
Children's Health Insurance Program	The act makes the following changes to the Children's Health Insurance Program (CHIP): • requires states to maintain current income eligibility levels until 2019; • requires states to enroll newly eligible participants who apply through the exchange; • specifies that children who are eligible for enrollment, but cannot enroll due to enrollment caps, are eligible for tax credits in the exchange; and • provides states with the option to provide coverage to children of state employees who are eligible for health benefits if certain conditions are met.		Beginning in 2015, states will receive a 23 percentage point increase in the CHIP match rate up to a cap of 100%. The amount funded depends on prior years' spending. The act extended funding for existing CHIP Obesity Demonstration Programs for fiscal years 2009-10 through 2013-14. Total funds available are $25 million. HCPF will apply for funding.
Funding for Providers that Serve the Uninsured			
Strengthening Community Health Centers	Effective federal fiscal year 2010-11, the act provides funds to build new and expand existing community health centers, school-based health clinics, and other health facilities. In most cases, the funds or programs must be applied for by individual health centers, not the state. ***Community Health Center Fund.*** The act establishes a Community Health Center Fund to provide additional funding for community health centers. ***Demonstration Project for the Uninsured.*** The act establishes a three-year demonstration project for up to 10 states to provide access to health care services to the uninsured at a reduced rate. Participating entities must be a state-based, nonprofit, public-private partnership.	Varies, but in general, funds are distributed directly to providers.	***Community Health Center Fund.*** Total funding under this program ranges from $1 billion in FY 2010-11 to $3.6 billion in FY 2015-16. ***Demonstration Project for the Uninsured.*** Each selected state will receive $2 million to carry out the program. ***School-based Health Centers.*** A total of $50 million will be awarded for FY 2009-10 through FY 2012-13. ***Trauma Care Centers Grants.*** Trauma Care Centers grants are available for FY 2009-10 through FY 2014-15. Approximately $100 million is authorized for each fiscal year as matching funds for safety net trauma centers. The DPHE will apply and award sub-grants to eligible entities when the program is funded.

Table 1
Summary of the Federal Health Care Reform Legislation (Cont.)

Provision	Description	State Action Required	Funding Available to States
Funding for Providers that Serve the Uninsured (Cont.)			
Strengthening Community Health Centers (Cont.)	***School-based Health Centers.*** School-based Health Center grants are available to individual centers. ***Trauma Care Centers Grants.*** Grants are available to qualified public and private trauma centers to assist in defraying uncompensated care costs and provide emergency relief to ensure the continued operation of trauma centers. ***Co-locating Primary and Specialty Care in Community-Based Mental Health Settings Grants.*** Grants are available for demonstration projects for the provision of coordinated and integrated services to special populations through the co-location of primary and specialty care services. ***Health Care Quality Improvements Grants.*** Grants are available to eligible entities that establish community-based interdisciplinary teams to support primary care practices. ***Grants to Promote the Community Health Workforce*** which are available to eligible entities to promote positive health behaviors for populations in medically-underserved areas of the state through the use of community health workers. Funds are also used to educate individuals regarding public health programs such as CHIP, Medicaid, and Medicare.		***Co-locating Primary and Specialty Care in Community-Based Mental Health Settings Grants*** are anticipated to be available for FY 2009-10 through FY 2013-14. The program has been authorized, but not yet funded. HCPF, the Department of Human Services (DHS), and DPHE will apply. ***Health Care Quality Improvements grants*** are not yet funded. DPHE will apply for the grants. A number of other grant opportunities are anticipated, including ***Grants to Promote the Community Health Workforce***. Funding announcements have not been made yet, but will be applied for by DPHE.
Health Care Workforce			
Health Care Workforce Analysis	***State Health Care Workforce Development Grants.*** The program will award grants to facilitate state partnerships to complete comprehensive planning and to facilitate workforce strategies. ***State and Regional Centers for Health Workforce Analysis.*** The Secretary must award grants to states and other entities to collect, analyze, and report data on the health care workforce.	To receive State and Regional Centers for Health Workforce Analysis funds, the state must coordinate with the national center. Eligible entities, including the state, must apply for funding.	***State Health Care Workforce Grants.*** State Health Care Workforce Grants are being awarded for both planning and implementation phases. DPHE requested $150,000 as a planning grant, and a two-year $2 million implementation grant. ***Health Care Workforce Analysis.*** A total of $4.5 million for FY 2009-10 to FY 2013-14 is available for State and Regional Centers for Health Workforce Analysis grants. Funding announcements have not been made yet, but DPHE will apply for the grants.

Table 1
Summary of the Federal Health Care Reform Legislation (Cont.)

Provision	Description	State Action Required	Funding Available to States
	Health Care Workforce (Cont.)		
Increasing the Supply of the Health Care Workforce	The act expands and improves several low-interest student loan programs, scholarships, and loan repayments for health students and professionals. These programs, in general, do not provide funding to the state, but rather directly to health care professionals, academic institutions, or health care facilities. Some of the programs affected or created by the act include: • the ***Primary Care Extension Program,*** which will provide funding to allow states to establish state or multi-state level state hubs. Hubs will consist of designated state health agencies, health professionals, associations, consumer groups and other entities. The hubs will provide support and assistance to educate primary care providers about preventive medicine, health promotion, chronic disease management, mental and behavioral health services, and evidence-based and evidence-informed therapies and techniques. • the ***Nursing Student Loan Program***, which raises the cap on the maximum annual loan amount from $2,500 to $3,300 per year, except for a student's final two years where limits are increased from $4,000 to $5,200 per year, and raises the overall aggregate amount from $13,000 to $17,000 beginning in FY 2009-10 and FY 2010-11; • the ***Pediatric Specialty Loan Repayment Program*** which requires recipients to commit to two years of employment in a pediatric specialty field in an area with identified shortages, and allows payments to be made on student loans of up to $35,000 per year up to three years of service;	Varies.	***The Primary Care Extension Program*** is currently authorized to provide a total of $120 million per year, but is not yet funded. For fiscal years 2009-10 through 2013-14, $5 million is available for ***Continuing Educational Support for Health Professionals Serving in Underserved Communities*** grants. The state is evaluating the grant opportunity. The Public Health Service Act authorizes $338 million for fiscal year 2009-10, and sums as necessary for FY 2010-11 through FY 2015-16 to fund nursing development programs. The state is evaluating the grant opportunity.

Table 1
Summary of the Federal Health Care Reform Legislation (Cont.)

Provision	Description	State Action Required	Funding Available to States
	Health Care Workforce (Cont.)		
Increasing the Supply of the Health Care Workforce (Cont.)	• the ***Public Health Workforce Recruitment and Retention Program*** which provides loan repayment to public health professionals employed by federal, state, or local public health agencies. Individuals must be employed for up to three years of service, and may receive up to $35,000 in loan repayment. Additional funding is available for to fund scholarships for mid-career public health professionals to receive additional training; • the ***Continuing Educational Support for Health Professionals Serving in Underserved Communities*** grant program, which provides grants to eligible entities to improve health care, increase retention, increase representation of minority faculty members and to provide educational support to reduce professional isolation.		
Improving Workforce Training	With regard to training programs for individuals in the health care workforce, effective July 1, 2010, the act: • increases flexibility in laws and regulations that govern Graduate Medical Education (GME) training positions to promote training in outpatient settings; • supports the development of interdisciplinary mental and behavioral health training programs and establishes a training program for oral health professionals; • addresses the projected shortage and retention of nurses by increasing the capacity for education, supporting training programs, providing loan repayment and retention grants, and creating a career ladder to nursing; and • supports the development of training programs that focus on primary care models such as medical homes, team management of chronic disease, and those that integrate physical and mental health services.	Varies.	Training in Family Medicine, General Internal Medicine, General Pediatrics, and Physician Assistantship funds will be available to develop and operate training programs for FY 2009-10 through FY 2013-14. Awards will be for five years. The program has been authorized, but not yet funded. DPHE and the University of Colorado will apply for funding. Enhancing Health Care Workforce Education and Training grants will be available for FY 2009-10 through FY 2013-14. Funding information is not yet available. The state is evaluating the grant opportunity.

Table 1
Summary of the Federal Health Care Reform Legislation (Cont.)

Provision	Description	State Action Required	Funding Available to States
	Health Care Workforce (Cont.)		
Improving Workforce Training (Cont.)	Effective July 1, 2011, the act: • increases the number of GME training positions by redistributing currently unused slots, with priorities given to primary care and general surgery and to states with the lowest resident physician-to-population ratios; • establishes Teaching Health Centers, defined as community-based, ambulatory patient care centers; • provides grants for up to three years to employ and provide training to family nurse practitioners who provide primary care in federally qualified health centers and nurse-managed health clinics; and • funds research on emergency medicine and develop demonstration programs for models for emergency care systems. In most cases, the state will not directly receive funds related to workforce training. Funding will be distributed directly to health professionals, educational institutions, and health care facilities.		
Medical Malpractice	The act awards five-year demonstration grants to states to develop, implement, and evaluate alternatives to current tort litigations.	States must submit applications specifying the terms of the alternative program, the areas of the state in which the alterative program will operate, and how compensation will be distributed under the program.	The Governor's Office is evaluating whether to apply for the State Demonstration Programs to Evaluate Alternatives to Current Medical Tort Litigation. For the five fiscal years beginning with 2010-11, $50 million is authorized but not yet funded.

Table 1
Summary of the Federal Health Care Reform Legislation (Cont.)

Provision	Description	State Action Required	Funding Available to States
		Long-term Care	
CLASS Act	Effective January 1, 2011, the act establishes a national, voluntary insurance program for purchasing community living assistance services and supports (CLASS Independence Benefit Plan). Following a five-year vesting period, the program will provide individuals with functional limitations a cash benefit of not less than an average of $50 per day to purchase non-medical services and supports necessary to maintain community residence. The program is financed through voluntary payroll deductions; all working adults will be automatically enrolled in the program, unless they choose to opt-out.	The state must coordinate CLASS coverage with Medicaid benefits. In addition, the state must, in 2012, assess the extend to which providers of long-term care services are serving or have the capacity to serve individuals receiving benefits under the CLASS program. States must designate or create entities to serve as fiscal agents for employing workers serving individual in the CLASS program.	None; the program will be funded through voluntary payroll deductions.
Older Adults	Effective October 1, 2010, the act creates the Elder Justice Act to add federal programs and authorization for federal appropriations for Adult Protective Services, the Long-term Care Ombudsman Program, long-term care facilities and licensing entities, and other programs that provide services for at-risk elders.	Varies.	Up to $100 million per year for FY 2010-11 through FY 2013-14 has been authorized, but not yet funded. DHS will apply for grants under this act. State Demonstration Program Concerning Elder Abuse Grants of $25 million total are authorized for fiscal years 2010-11 through 2013-14. DHS will apply for these grants.
Medicaid	Several of the act's changes to Medicaid impact long-term care. Specifically, the act: Effective October 1, 2010: • provides states with new options for offering home- and community-based services through a Medicaid state plan rather than through a waiver for individuals with incomes of up to 300% of the maximum SSI payment and who have a higher level of need; • permits states to extend full Medicaid benefits to individuals receiving home and community-based services under a state plan; • extends the Medicaid Money Follows the Person Rebalancing Demonstration through September 2016 and allocates $10 million per year for five years to continue the Aging and Disability Resource Center initiatives; and • continues the Nationwide Program for National and State Background Checks on Direct Patient Access Employees of Long-term Care Facilities.	Participation in the Nationwide Program for National and State Background Checks on Direct Patient Access Employees of Long-term Care Facilities and Providers Program requires Colorado to contribute matching funds to the program. Participation in the State Plan Option Promoting Health Homes for Enrollees for Chronic Conditions requires a state Medicaid plan amendment.	The State Plan Option Promoting Healthy Homes for Enrollees for Chronic Conditions provides an enhanced match of 90% FMAP for two years for states that take up the option as of January 1, 2011. Planning grants have been authorized but not yet funded. HCPF will apply for the grants. HCPF has applied for a Medicaid Money Follows the Person Rebalancing Demonstration grant. Funding is competitive and could be up to $1 million. The state does not qualify for the portion of these funds that are for nursing home transitions. Six additional FMAP points will be available for states that implement the Community First Choice Option as of October 1, 2011. Medicaid Infrastructure grants are available to help implement a Medicaid Buy-in Program. HCPF will apply for the grants.

Table 1
Summary of the Federal Health Care Reform Legislation (Cont.)

Provision	Description	State Action Required	Funding Available to States
		Long-term Care (Cont.)	
Medicaid (Cont.)	Effective October 1, 2011: • establishes the Community First Choice Option to provide community-based services to individuals with disabilities who require an institutional level of care. Provide states with an additional 6% federal match for reimbursable expenses; • creates the State Balancing Incentive Program to provide matching funds to eligible states to increase the proportion of non-institutionally-based long-term care services, effective through 2015; and • requires skilled nursing facilities under Medicare and nursing facilities under Medicaid to disclose information regarding ownership, accountability requirements, and expenditures.		Federal funds of three times the amount a state guarantees will be available for the Nationwide Program for National and State Background Checks on Direct Patient Access Employees of Long-term Care Facilities and Providers. Funds will not exceed $3 million for newly participating states and $1.5 million for previously participating states. Other funding is anticipated to be available to increase home and community-based services through the State Balancing Incentives Program, although no announcements have been made. Funding will total a 2 to 5% increase in FMAP. A total of $10 million annually will be distributed for Aging and Disability Resource Centers. DHS expects to receive a portion of these funds on a formula basis for FY 2009-10 through FY 2013-14. DHS's application was for $492,469. There is a total of $40 million available through 50 grants under the Medicare Improvements for Patients and Providers (MIPPA). DHS requested $345,072. The Hospital Care Transition Models program, a program to assist individuals in navigating the long-term care system, was appropriated a total of $2.5 million in funding, which will be awarded in five to seven competitive grants. DHS applied for $399,183.
		Public Health	
Public Health Infrastructure	The act establishes a Prevention and Public Health Fund to provide for expanded and sustained national investment in prevention and public health programs to improve health and help restrain the rate of growth in private and public sector health care costs.	Not specified.	Total funding for all states ranges from $500 million in FY 2009-10 to $2 billion in FY 2014-15. Colorado is eligible for $300,000 each year for five years. The DPHE applied for a grant on August 5, 2010.

Table 1
Summary of the Federal Health Care Reform Legislation (Cont.)

Provision	Description	State Action Required	Funding Available to States
		Public Health (Cont.)	
Community Preventative Health	***Community Transformation Grants.*** The act requires the Secretary, acting through the Director of the Centers for Disease Control and Prevention (CDC), to award grants to state and local governmental agencies and community-based organizations for the implementation, evaluation, and dissemination of evidence-based community preventive health activities in order to reduce chronic disease rates, prevent the development of secondary conditions, address health disparities, and develop a stronger evidence base of effective prevention programming. ***Healthy Aging, Living Well Grants.*** The act requires the Secretary, acting through the Director of CDC, to award grants to state or local health departments and Indian tribes to carry out pilot programs to provide public health community interventions, screenings, and clinical referrals for individuals who are between 55 and 64 years of age.	***Community Transformation Grants.*** Eligible entities must submit a detailed community transformation plan that includes the policy, environmental, programmatic, and as appropriate infrastructure changes needed to promote healthy living and reduce disparities. ***Healthy Aging, Living Well Grants.*** Eligible entities must design a strategy for improving the health of the 55-to-64 year-old population through community-based public health interventions; and demonstrate the ability to implement the interventions.	The DPHE estimates that the state may be eligible to receive $200,000 to $1.3 million under these initiatives. The department will apply for grant moneys when they are made available.
Oral Healthcare Prevention	The act requires the Secretary, through the Director of CDC, to carry out oral health activities, including: • establishing a national public education campaign that is focused on oral health care prevention and education; • awarding demonstration grants for research-based dental caries disease management activities; • awarding grants for the development of school-based dental sealant programs; and • entering into cooperative agreements with state, territorial, and Indian tribes or tribal organizations for oral health data collection and interpretation, a delivery system for oral health, and science-based programs to improve oral health.	Applications must be submitted for funds, and a 20% state match is required.	The DPHE will apply for grant moneys when they are made available.
Epidemiology and Laboratory Capacity	Requires the Secretary, acting through the Director of CDC, to establish an Epidemiology and Laboratory Capacity Grant Program to award grants to assist public health agencies in improving surveillance for, and response to, infectious diseases and other conditions of public health importance.	Not specified.	A total of $190 million is available for FY 2009-10 through FY 2012-13. The DPHE is applying for $2 million in funding.

Table 1
Summary of the Federal Health Care Reform Legislation (Cont.)

Provision	Description	State Action Required	Funding Available to States
		Public Health (Cont.)	
Immunizations	The act authorizes the Secretary to negotiate and enter into contracts with vaccine manufacturers for the purchase and delivery of vaccines for adults. States are allowed to purchase additional quantities of adult vaccines from manufacturers at the applicable price negotiated by the Secretary. The act requires the Secretary, through the Director of CDC, to establish a demonstration program to award grants to states to improve the provision of recommended immunizations for children and adults through the use of evidence-based, population-based interventions for high-risk populations.	States must submit a state plan explaining how the grant moneys will be used for specific interventions, and how the interventions will align with local need.	A total of $1 million in FY 2009-10 is available. DPHE and DHS will apply for funding.
Environmental Health Hazards	Competitive grants are available to state and health care facilities for the purpose of screening individuals for environmental health conditions and disseminating information regarding environmental health and the availability of treatment for certain individuals through Medicare.	Eligible entities must submit an application containing specified information.	For FY 2009-10 through FY 2013-14, $23 million is available; $20 million will be available for each five-year fiscal year period thereafter.
		Other	
Home Visitation Services	States, or if a state does not apply, eligible nonprofit entities may apply for grants to establish early childhood home visitation programs for certain at-risk families.	By September 2010, states must conduct needs assessments of communities and measure certain health-related indicators. Entities that are awarded grants must establish certain benchmarks, and report on their progress in meeting the benchmarks.	The total funding available for grants to states and other eligible entities is: • $100 million in 2010; • $250 million in 2011; • $350 million in 2012; • $400 million in 2013; and • $400 million in 2014. The DPHE applied for initial funding in the amount of $500,000. Additional applications are due September 1, 2010.
Funding for Research on Postpartum Depression	States may apply for grants to provide services related to postpartum depression.	States, as well as nonprofit entities, may apply for the funding.	A total of $3 million is available in 2010. DPHE will apply for funding.

Table 1
Summary of the Federal Health Care Reform Legislation (Cont.)

Provision	Description	State Action Required	Funding Available to States
		Other (Cont.)	
Support for Young Women Diagnosed with Breast Cancer	Grants are available to organizations that provide information from credible sources and assistance to young women diagnosed with breast cancer.	Priority is to be given to applicants that deal specifically with young women diagnosed with breast cancer and pre-neoplastic breast disease.	A total of $9 million will be available for FY 2009-10 through FY 2013-14. DPHE will apply for funding.
Pregnancy Assistance Fund	States may be awarded grants to assist teens and women who are pregnant or parenting. Funds may be used by institutions of higher education, high schools, or community services centers to offer services. In addition, funds may be used to assist victims of domestic violence or to create a public awareness campaign.	Institutions of higher education that are awarded funding must contribute 25% matching funds.	A total of $25 million is available annually through FY 2018-19. DHS will apply for funding.
Personal Responsibility Education for Adulthood Training	inancial literacy, and healthy relationships.	A state may not receive funding until the state submits a two-part application for the funds, but funds are awarded to all states that apply.	A total of $55 million is available each year from 2010 through 2014. Colorado is expected to receive $793,058 per year for five years. Colorado's application is being coordinated by DHS, DPHE, and the Department of Education.
Regionalized Systems for Emergency Care	States, or partnerships of states and local governments, may be awarded four multiyear contracts or grants to support pilot projects that design, implement, and evaluate innovative models of regionalist, comprehensive, and accountable emergency care and trauma systems.	Eligible entities must apply for the program. States must contribute matching funds of $1 for every $3 of federal funding received.	Not specified.
		Taxation	
Premium Assistance Tax Credits	The act provides premium tax credits and cost-sharing reductions available through the exchanges to make coverage more affordable to lower income individuals. Premium tax credits are available for individuals not eligible for qualified coverage, with incomes above 100% and below 400% of poverty (under $88,000 for a family of four).	None.	Not applicable.

Table 1
Summary of the Federal Health Care Reform Legislation (Cont.)

Provision	Description	State Action Required	Funding Available to States
	Taxation (Cont.)		
Small Business Health Insurance Tax Credit	The act provides a sliding-scale tax credit for small businesses (25 or fewer employees with average annual wages under $50,000) that purchase health insurance for employees if the employer contributes at least 50% of the total premium cost or 50% of a benchmark premium. • Phase I (tax years 2010 through 2013): provides a tax credit of up to 35% of the employer's contribution toward the employee's health insurance. Tax-exempt small businesses meeting these requirements are eligible for tax credits of up to 25 percent of the employer's contribution. • Phase II (tax years 2014 and 2015): provides a tax credit of up to 50% of the employer's contribution toward the employee's health insurance premium. Tax-exempt small businesses meeting these requirements are eligible for tax credits of up to 35% of the employer's contribution.	None.	Not applicable.
Adoption Tax Credit	For tax years 2010 and 2011, the act increases the adoption tax credit and adoption assistance exclusion by $1,000 and makes the credit refundable.	None.	Not applicable.
Therapeutic Project Tax Credit	The act provides a tax credit for businesses with 250 or fewer employees that invest in acute and chronic disease research during 2009 and 2010.	None.	Not applicable.
Tax Relief for Health Professional State Loan Repayments	Excludes state loan repayment or loan forgiveness programs intended to provide increased availability of health care services in under-served areas from gross income payments. This provision is effective for amounts received by an individual in taxable years beginning after December 31, 2008.	None.	Not applicable.

Table 1
Summary of the Federal Health Care Reform Legislation (Cont.)

Provision	Description	State Action Required	Funding Available to States
	Taxation (Cont.)		
Blue Cross Blue Shield (BCBS) [illegible]on Tax Benefit	Starting tax year 2010, the act requires that non-profit BCBS organizations devote 85% or more of their premium dollars to patient care in order to claim the special tax benefits under Internal Revenue Code (IRC) Section 833. Special tax benefits include a 25% deduction of claims and expenses and a 100% deduction for unearned premium reserves.	None.	Not applicable.
Individual Coverage Requirement	Beginning tax year 2014, the act requires that individuals maintain minimum essential health insurance coverage. Failure to obtain minimum coverage will result in a penalty on the individual's federal tax return. The penalty will be phased in starting in 2014, reaching the greater of $695 for individuals ($2,250 for families) or 2.5% of income in 2016.	None.	Not applicable.
Medicare Hospital Insurance (HI) Rate	Starting tax year 2013, the provision increases the Medicare Hospital Insurance (HI) tax rate from 0.5 to 0.9% on single taxpayers earning more than $200,000 and joint filers earning more than $250,000.	None.	Not applicable.
High Cost Plan Excise Tax	Beginning tax year 2018, the act imposes a nondeductible 40% excise tax on excess benefits provided in any month under a employer-sponsored health plan.	None.	Not applicable.
Tax on Indoor Tanning Services	Starting tax year 2010, imposes a 10% tax on amounts paid for indoor tanning services.	None.	Not applicable.
Medical Device Excise Tax	Starting in 2013, imposes a 2.3% excise tax on the sale of medical devices by manufacturers and importers.	None.	Not applicable.
Deductions for Executive Compensation	Starting tax year 2013, limits deductions for executive compensation for insurance providers to $500,000 if at least 25% of the provider's gross premium income from health business is derived from health insurance plans that meet the minimum essential coverage requirements. The $500,000 limit applies to all officers, employees, directors, and other workers or service providers performing services, for or on behalf of, a covered health insurance provider.	None.	Not applicable.

Table 1
Summary of the Federal Health Care Reform Legislation (Cont.)

Provision	Description	State Action Required	Funding Available to States
		Taxation (Cont.)	
Deductions for Medicare Part D Subsidy	Employers are entitled to a subsidy if they offer retiree prescription drug coverage that is at least as valuable as Medicare Part D. Employers can deduct the entire cost of providing the coverage, even though a portion is offset by the subsidy. Starting tax year 2013, eliminates deductions for the subsidy for employers who maintain prescription drug plans for their Medicare Part D eligible retirees.	None.	Not applicable.
Deductions for Medical Expenses	Starting tax year 2013, increases the adjusted gross income threshold for claiming the itemized deduction for medical expenses from 7.5 to 10%. Those 65 and older can claim at 7.5% until tax year 2017.	None.	Not applicable.
Corporate Estimates Tax	For tax year 2014, increases the Corporate Estimates Tax imposed under the Corporate Estimated Tax Shift Act of 2009 by 15.75%.	None.	Not applicable.
"Black Liquor" Tax Credit Exclusion	In 2009, the IRS found that "black liquor," a byproduct of the process for making paper, may qualify for both the cellulosic biofuel producer credit and the refundable alternative fuel mixture credit. Starting tax year 2010, the act *excludes* black liquor as eligible for this tax credit.	None.	Not applicable.
Health Insurance Provider Fee	Starting in 2010, imposes an annual flat fee of $6.7 billion on the health insurance sector, allocated across the industry based on market share.	None.	Not applicable.
Pharmaceutical Manufacturing Fee	Starting in 2011, imposes an annual flat fee of $2.3 billion on the pharmaceutical manufacturing sector, allocated across the industry based on market share. The funds generated from the fee are intended to offset some of the costs of implementing the act.	None.	Not applicable.

Table 1
Summary of the Federal Health Care Reform Legislation (Cont.)

Provision	Description	State Action Required	Funding Available to States
Taxation (Cont.)			
Employer Fee	The act does not require that employers offer health coverage but imposes penalties encouraging them to do so. Penalties apply to employers with more than 50 employees. Starting in 2014, employers with 50 or more full time employees that do not offer health insurance coverage but have at least one employee receiving a premium tax credit must pay a fee of $2,000 per year ($166 per month) per employee, excluding the first 30 employees (e.g., a firm with 51 workers will pay an amount equal to 51 minus 30, or 21 times the applicable per employee payment amount).	None.	Not applicable.
Fees to Support the Patient Centered Outcome Research Trust Fund	For fiscal years 2012-13 through 2018-19, imposes a fee on each specified health insurance policies and self-insured health plan. The fee is equal to the product of $2 multiplied by the average number of lives covered under the policy or plan.	None.	Not applicable.