



What are the First-Year Benefits of Health Reform

The health reform law includes market reforms that will bring immediate benefits to millions of Americans, including those who currently have coverage. The following benefits will be available within the first year.

Beginning Immediately

- Small business tax credits. Small businesses will receive tax credits to make employee health insurance coverage more affordable. Tax credits of up to 35 percent of premiums will be immediately available to firms that choose to offer coverage. The full credit will be available to firms with 10 or fewer employees with average annual wages of \$25,000, while firms with up to 25 or fewer employees and average annual wages of up to \$50,000 will also be eligible for the credit. Later, when health insurance exchanges are operational, tax credits will be up to 50 percent of premiums.
- Closes the 'doughnut hole' in Medicare coverage. Medicare beneficiaries who fall in the coverage gap in the Medicare Part D Program will receive a \$250 rebate check. Beginning in 2011, a 50 percent discount on brand-name drugs in the 'doughnut hole' will go into effect.
- Access to quality care for vulnerable populations. Community health centers will receive an \$11 billion investment over five years to provide the funding needed to expand access to health care in communities where it is needed most.
- Health insurance consumer information. States will be given federal aid to establish "health insurance consumer information agencies" to assist individuals with the filing of complaints and appeals, enrollment in a health plan, and, eventually, to assist consumers with resolving problems with tax credit eligibility.
- Increasing the number of primary care providers. A new investment in training programs will be provided to increase the number of primary care doctors, nurses, and public health professionals.

By July 2010

- Access to affordable coverage for the uninsured with pre-existing conditions. A temporary insurance program will be created to provide affordable coverage to uninsured Americans with pre-existing conditions. This will remain in place until new health insurance exchanges are operational in 2014.
- Re-insurance for retiree health benefit plans. A temporary re-insurance program will be created to help employer health plans maintain coverage for early retirees between the ages of 55 and 64. This will help protect coverage while reducing premiums for employers and retirees. This program will expire in 2014.
- Public access to comparable information on insurance options. By July 2010, a new website will be created to provide consumers with information on their insurance options.

By September 2010

- No Pre-existing Coverage Exclusions for Children. Health insurers will be prohibited from excluding coverage of pre-existing conditions for children. This will apply to all employer plans and new plans in the individual market, and apply to all health plans in 2014.
- Patient Protections. Patients will be able to choose their own doctors through protections that allow plan members to pick any participating primary care provider. Insurers will be prohibited from requiring women to seek prior authorization before seeing an OB-GYN or accessing emergency care. This provision applies to all new plans.
- Extension of Coverage for Young Adults. Within the first six months, children will be able to stay on their parents' health insurance plans until the age of 26. This applies to all plans in the individual market, new employer plans, and existing employer plans if a young adult is not eligible for employer coverage.
- Free Prevention Benefits. Within the first six months, health plans will be required to cover prevention and wellness benefits in all new plans and exempts these benefits from deductibles and other cost-sharing requirements in public and private insurance coverage.
- No lifetime coverage limits. Within the first six months, health insurance companies will be prohibited from imposing lifetime limits on benefits.
- Regulations on annual coverage limits. Within the first six months, tight regulations will be put in place on annual limits to health insurance coverage. This will ensure access to needed care in all employer plans and all new individual plans. These tight restrictions will be defined by the Secretary of Health and Human Services. When the exchanges are operational in 2014, the use of annual limits will be banned for new plans in the individual market and all employer plans.
- Protection from rescissions of existing coverage. Insurance companies will no longer be able to rescind insurance coverage when claims are filed, except in cases of fraud or intentional misrepresentation of material fact. This will apply to all new and existing plans.
- Prohibits discrimination based on salary. New group health plans will not be able to establish any eligibility rules for health care coverage that discriminate in favor of higher-wage employees.
- Appeals process. All health plans will be required to implement an effective process for appeals of coverage determinations and claims. States also will provide an external appeals process to ensure an independent review.

By January 2011

- New, voluntary, long-term care insurance program. A new long-term care insurance program will be created and will be paid-for by voluntary payroll deductions. This new program will provide benefits to disabled adults
- Free prevention and wellness visits in Medicare. Medicare beneficiaries will receive a free, annual wellness visit and will have all cost-sharing waived for preventive services.
- Ensuring value for premium payments. Insurance overhead standards and public disclosure requirements will be put in place to ensure that health plan enrollees get maximum value for their premium dollars. Plans in the individual and small group market will be required to spend 80 percent of premium dollars on clinical services and quality activities, and 85 percent for plans in the large group market. Health insurance plans that do not meet these thresholds will provide rebates to their policyholders. This provision applies to all plans, including grandfathered plans, with the exception of self-insured plans.