month with respect to an eligible individual but for subsection (f)(2)(A), such month shall be treated as an eligible coverage month with respect to such eligible individual solely for purposes of determining the amount of the credit under this section with respect to any qualifying family members of such individual (and any advance payment of such credit under section 7527). This subparagraph shall only apply with respect to the first 24 months after such eligible individual is first entitled to the benefits described in subsection (f)(2)(A).

"(B) DIVORCE.—In the case of the finalization of a divorce between an eligible individual and such individual's spouse, such spouse shall be treated as an eligible individual for purposes of this section and section 7527 for a period of 24 months beginning with the date of such finalization, except that the only qualifying family members who may be taken into account with respect to such spouse are those individuals who were qualifying family members immediately before such finalization.

"(C) DEATH.—In the case of the death of an eligible individual—

"(i) any spouse of such individual (determined at the time of such death) shall be treated as an eligible individual for purposes of this section and section 7527 for a period of 24 months beginning with the date of such death, except that the only qualifying family members who may be taken into account with respect to such spouse are those individuals who were qualifying family members immediately before such death, and

"(ii) any individual who was a qualifying family member of the decedent immediately before such death (or, in the case of an individual to whom paragraph (4) applies, the taxpayer to whom the deduction under section 151 is allowable) shall be treated as an eligible individual for purposes of this section and section 7527 for a period of 24 months beginning with the date of such death, except that in determining the amount of such credit only such qualifying family member may be taken into account.".

(b) CONFORMING AMENDMENT.—Section 173(f) of the Workforce Investment Act of 1998 (29 U.S.C. 2918(f)) is amended by adding at the end the following:

"(8) CONTINUED QUALIFICATION OF FAMILY MEMBERS AFTER CERTAIN EVENTS.—In the case of eligible coverage months beginning before January 1, 2011—

"(A) MEDICARE ELIGIBILITY.—In the case of any month which would be an eligible coverage month with respect to an eligible individual but for paragraph (7)(B)(i), such month shall be treated as an eligible coverage month with respect to such eligible individual solely for purposes of determining the eligibility of qualifying family members of such individual under this subsection. This subparagraph shall only apply with respect to the first 24 months after such eligible individual is first entitled to the benefits described in paragraph (7)(B)(i).

"(B) DIVORCE.—In the case of the finalization of a divorce between an eligible individual and such individual's spouse, such spouse shall be treated as an eligible individual for purposes of this subsection for a period of 24 months beginning with the date of such finalization, except that the only qualifying family members who may be taken into account with respect to such spouse are those individuals who were qualifying family members immediately before such finalization.

"(C) DEATH.—In the case of the death of an eligible individual—

"(i) any spouse of such individual (determined at the time of such death) shall be treated as an eligible individual for purposes of this subsection for a period of 24 months beginning with the date of such death, except that the only qualifying family members who may be taken into account with respect to such spouse are those individuals who were qualifying family members immediately before such death, and

"(ii) any individual who was a qualifying family member of the decedent immediately before such death shall be treated as an eligible individual for purposes this subsection for a period of 24 months beginning with the date of such death, except that no qualifying family members may be taken into account with respect to such individual.".

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to months beginning after December 31, 2009.

SEC. 1899F. EXTENSION OF COBRA BENEFITS FOR CERTAIN TAA-ELIGIBLE INDIVIDUALS AND PBGC RECIPIENTS.

(a) ERISA AMENDMENTS.—Section 602(2)(A) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1162(2)(A)) is amended—

(1) by moving clause (v) to after clause (iv) and before the flush left sentence beginning with "In the case of a qualified beneficiary";

(2) by striking "In the case of a qualified beneficiary" and inserting the following:

"(vi) SPECIAL RULE FOR DISABILITY.—In the case of a qualified beneficiary"; and

(3) by redesignating clauses (v) and (vi), as amended by paragraphs (1) and (2), as clauses (vii) and (viii), respectively, and by inserting after clause (iv) the following new clauses:

"(v) SPECIAL RULE FOR PBGC RECIPIENTS.—In the case of a qualifying event described in section 603(2) with respect to a covered employee who (as of such qualifying event) has a nonforfeitable right to a benefit any portion of which is to be paid by the Pension Benefit Guaranty Corporation under title IV, notwithstanding clause (i) or (ii), the date of the death of the covered employee, or in the case of the surviving spouse or dependent children of the covered employee, 24 months after the date of the death of the covered employee. The preceding sentence shall not require any period of coverage to extend beyond December 31, 2010.

"(vi) SPECIAL RULE FOR TAA-ELIGIBLE INDIVIDUALS.—In the case of a qualifying event described in section 603(2) with respect to a covered employee who is (as of the date that the period of coverage would, but for this clause or clause (vii), otherwise terminate under clause (i) or (ii)) a TAA-eligible individual (as defined in section 605(b)(4)(B)), the period of coverage shall not terminate by reason of clause (i) or (ii), as the case may be, before the later of the date specified in such clause or the date on which such individual ceases to be such a TAA-eligible individual. The preceding sentence shall not require any period of coverage to extend beyond December 31, 2010.".

(b) IRC AMENDMENTS.—Clause (i) of section 4980B(f)(2)(B) of the Internal Revenue Code of 1986 is amended—

(1) by striking "In the case of a qualified beneficiary" and inserting the following:

"(VI) SPECIAL RULE FOR DISABILITY.—In the case of a qualified beneficiary", and

(2) by redesignating subclauses (V) and (VI), as amended by paragraph (1), as subclauses (VII) and (VIII), respectively, and by inserting after clause (IV) the following new subclauses:

"(V) SPECIAL RULE FOR PBGC RECIPIENTS.—In the case of a qualifying event described in paragraph (3)(B) with respect to a covered employee who (as of such qualifying event) has a nonforfeitable right to a benefit any portion of which is to be paid by the Pension Benefit Guaranty Corporation under title IV of the Employee Retirement Income Security Act of 1974, notwithstanding subclause (I) or (II), the date of the death of the covered employee, or in the case of the surviving spouse or dependent children of the covered employee, 24 months after the date of the death of the covered employee. The preceding sentence shall not require any period of coverage to extend beyond December 31, 2010.

"(VI) SPECIAL RULE FOR TAA-ELIGIBLE INDIVIDUALS.—In the case of a qualifying event described in paragraph (3)(B) with respect to a covered employee who is (as of the date that the period of coverage would, but for this subclause or subclause (VII), otherwise terminate under subclause (I) or (II)) a TAA-eligible individual (as defined in paragraph (5)(C)(iv)(II)), the period of coverage shall not terminate by reason of subclause (I) or (II), as the case may be, before the later of the date specified in such subclause or the date on which such individual ceases to be such a TAA-eligible individual. The preceding sentence shall not require any period of coverage to extend beyond December 31, 2010.".

(c) PHSA AMENDMENTS.—Section 2202(2)(A) of the Public Health Service Act (42 U.S.C. 300bb-2(2)(A)) is amended—

(1) by striking "In the case of a qualified beneficiary" and inserting the following:

"(v) SPECIAL RULE FOR DISABILITY.—In the case of a qualified beneficiary"; and

(2) by redesignating clauses (iv) and (v), as amended by paragraph (1), as clauses (v) and (vi), respectively, and by inserting after clause (iii) the following new clause:

"(iv) SPECIAL RULE FOR TAA-ELIGIBLE INDIVIDUALS.—In the case of a qualifying event described in section 2203(2) with respect to a covered employee who is (as of the date that the period of coverage would, but for this clause or clause (v), otherwise terminate under clause (i) or (ii)) a TAA-eligible individual (as defined in section 2205(b)(4)(B)), the period of coverage shall not terminate by reason of clause (i) or (ii), as the case may be, before the later of the date specified in such clause or the date on which such individual ceases to be such a TAA-eligible individual. The preceding sentence shall not require any period of coverage to extend beyond December 31, 2010.".

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to periods of coverage which would (without regard to the amendments made by this section) end on or after the date of the enactment of this Act.

SEC. 1899G. ADDITION OF COVERAGE THROUGH VOLUNTARY EMPLOYEES' BENEFICIARY ASSOCIATIONS.

(a) IN GENERAL.—Paragraph (1) of section 35(e) of the Internal Revenue Code of 1986 is amended by adding at the end the following new subparagraph:

"(K) In the case of eligible coverage months beginning before January 1, 2011, coverage under an employee benefit plan funded by a voluntary employees' beneficiary association (as defined in section 501(c)(9)) established pursuant to an order of a bankruptcy court, or by agreement with an authorized representative, as provided in section 1114 of title 11, United States Code.".

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to coverage months beginning after the date of the enactment of this Act.

SEC. 1899H. NOTICE REQUIREMENTS.

(a) IN GENERAL.—Subsection (d) of section 7527 of the Internal Revenue Code of 1986 (relating to qualified health insurance costs credit eligibility certificate) is amended to read as follows:

"(d) QUALIFIED HEALTH INSURANCE COSTS ELIGIBILITY CERTIFICATE.—

"(1) IN GENERAL.—For purposes of this section, the term 'qualified health insurance costs eligibility certificate' means any written statement that an individual is an eligible individual (as defined in section 35(c)) if such statement provides such information as the Secretary may require for purposes of this section and—

"(A) in the case of an eligible TAA recipient (as defined in section 35(c)(2)) or an eligible alternative TAA recipient (as defined in section 35(c)(3)), is certified by the Secretary of Labor (or by any other person or entity designated by the Secretary), or

"(B) in the case of an eligible PBGC pension recipient (as defined in section 35(c)(4)), is certified by the Pension Benefit Guaranty Corporation (or by any other person or entity designated by the Secretary).

added by this Act), and other provisions of this Act or the amendments made by this Act relating to the Internal Revenue Code of 1986.

(2) For the Commissioner of Social Security—

(A) such sums as may be necessary for payments to individuals certified by the Commissioner of Social Security as entitled to receive a payment under this section; and

(B) $90,000,000 for the Social Security Administration's Limitation on Administrative Expenses for costs incurred in carrying out this section.

(3) For the Railroad Retirement Board—

(A) such sums as may be necessary for payments to individuals certified by the Railroad Retirement Board as entitled to receive a payment under this section; and

(B) $1,400,000 to the Railroad Retirement Board's Limitation on Administration for administrative costs incurred in carrying out this section.

(4)(A) For the Secretary of Veterans Affairs—

(i) such sums as may be necessary for the Compensation and Pensions account, for payments to individuals certified by the Secretary of Veterans Affairs as entitled to receive a payment under this section; and

(ii) $100,000 for the Information Systems Technology account and $7,100,000 for the General Operating Expenses account for administrative costs incurred in carrying out this section.

(B) The Department of Veterans Affairs Compensation and Pensions account shall hereinafter be available for payments authorized under subsection (a)(1)(A) to individuals entitled to a benefit payment described in subsection (a)(1)(B)(iii).

SEC. 2202. SPECIAL CREDIT FOR CERTAIN GOVERNMENT RETIREES.

(a) IN GENERAL.—In the case of an eligible individual, there shall be allowed as a credit against the tax imposed by subtitle A of the Internal Revenue Code of 1986 for the first taxable year beginning in 2009 an amount equal $250 ($500 in the case of a joint return where both spouses are eligible individuals).

(b) ELIGIBLE INDIVIDUAL.—For purposes of this section—

(1) IN GENERAL.—The term "eligible individual" means any individual—

(A) who receives during the first taxable year beginning in 2009 any amount as a pension or annuity for service performed in the employ of the United States or any State, or any instrumentality thereof, which is not considered employment for purposes of chapter 21 of the Internal Revenue Code of 1986, and

(B) who does not receive a payment under section 2201 during such taxable year.

(2) IDENTIFICATION NUMBER REQUIREMENT.—Such term shall not include any individual who does not include on the return of tax for the taxable year—

(A) such individual's social security account number, and

(B) in the case of a joint return, the social security account number of one of the taxpayers on such return.

For purposes of the preceding sentence, the social security account number shall not include a TIN (as defined in section 7701(a)(41) of the Internal Revenue Code of 1986) issued by the Internal Revenue Service. Any omission of a correct social security account number required under this subparagraph shall be treated as a mathematical or clerical error for purposes of applying section 6213(g)(2) of such Code to such omission.

(c) TREATMENT OF CREDIT.—

(1) REFUNDABLE CREDIT.—

(A) IN GENERAL.—The credit allowed by subsection (a) shall be treated as allowed by subpart C of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986.

(B) APPROPRIATIONS.—For purposes of section 1324(b)(2) of title 31, United States Code, the credit allowed by subsection (a) shall be treated in the same manner a refund from the credit allowed under section 36A of the Internal Revenue Code of 1986 (as added by this Act).

(2) DEFICIENCY RULES.—For purposes of section 6211(b)(4)(A) of the Internal Revenue Code of 1986, the credit allowable by subsection (a) shall be treated in the same manner as the credit allowable under section 36A of the Internal Revenue Code of 1986 (as added by this Act).

(d) REFUNDS DISREGARDED IN THE ADMINISTRATION OF FEDERAL PROGRAMS AND FEDERALLY ASSISTED PROGRAMS.—Any credit or refund allowed or made to any individual by reason of this section shall not be taken into account as income and shall not be taken into account as resources for the month of receipt and the following 2 months, for purposes of determining the eligibility of such individual or any other individual for benefits or assistance, or the amount or extent of benefits or assistance, under any Federal program or under any State or local program financed in whole or in part with Federal funds.

TITLE III—PREMIUM ASSISTANCE FOR COBRA BENEFITS

SEC. 3000. TABLE OF CONTENTS.

The table of contents of this title is as follows:

SEC. 3001. PREMIUM ASSISTANCE FOR COBRA BENEFITS.

(a) PREMIUM ASSISTANCE FOR COBRA CONTINUATION COVERAGE FOR INDIVIDUALS AND THEIR FAMILIES.—

(1) PROVISION OF PREMIUM ASSISTANCE.—

(A) REDUCTION OF PREMIUMS PAYABLE.—In the case of any premium for a period of coverage beginning on or after the date of the enactment of this Act for COBRA continuation coverage with respect to any assistance eligible individual, such individual shall be treated for purposes of any COBRA continuation provision as having paid the amount of such premium if such individual pays (or a person other than such individual's employer pays on behalf of such individual) 35 percent of the amount of such premium (as determined without regard to this subsection).

(B) PLAN ENROLLMENT OPTION.—

(i) IN GENERAL.—Notwithstanding the COBRA continuation provisions, an assistance eligible individual may, not later than 90 days after the date of notice of the plan enrollment option described in this subparagraph, elect to enroll in coverage under a plan offered by the employer involved, or the employee organization involved (including, for this purpose, a joint board of trustees of a multiemployer trust affiliated with one or more multiemployer plans), that is different than coverage under the plan in which such individual was enrolled at the time the qualifying event occurred, and such coverage shall be treated as COBRA continuation coverage for purposes of the applicable COBRA continuation coverage provision.

(ii) REQUIREMENTS.—An assistance eligible individual may elect to enroll in different coverage as described in clause (i) only if—

(I) the employer involved has made a determination that such employer will permit assistance eligible individuals to enroll in different coverage as provided for this subparagraph;

(II) the premium for such different coverage does not exceed the premium for coverage in which the individual was enrolled at the time the qualifying event occurred;

(III) the different coverage in which the individual elects to enroll is coverage that is also offered to the active employees of the employer at the time at which such election is made; and

(IV) the different coverage is not—

(aa) coverage that provides only dental, vision, counseling, or referral services (or a combination of such services);

(bb) a flexible spending arrangement (as defined in section 106(c)(2) of the Internal Revenue Code of 1986); or

(cc) coverage that provides coverage for services or treatments furnished in an on-site medical facility maintained by the employer and that consists primarily of first-aid services, prevention and wellness care, or similar care (or a combination of such care).

(C) PREMIUM REIMBURSEMENT.—For provisions providing the balance of such premium, see section 6432 of the Internal Revenue Code of 1986, as added by paragraph (12).

(2) LIMITATION OF PERIOD OF PREMIUM ASSISTANCE.—

(A) IN GENERAL.—Paragraph (1)(A) shall not apply with respect to any assistance eligible individual for months of coverage beginning on or after the earlier of—

(i) the first date that such individual is eligible for coverage under any other group health plan (other than coverage consisting of only dental, vision, counseling, or referral services (or a combination thereof), coverage under a flexible spending arrangement (as defined in section 106(c)(2) of the Internal Revenue Code of 1986), or coverage of treatment that is furnished in an on-site medical facility maintained by the employer and that consists primarily of first-aid services, prevention and wellness care, or similar care (or a combination thereof)) or is eligible for benefits under title XVIII of the Social Security Act, or

(ii) the earliest of—

(I) the date which is 9 months after the first day of the first month that paragraph (1)(A) applies with respect to such individual,

(II) the date following the expiration of the maximum period of continuation coverage required under the applicable COBRA continuation coverage provision, or

(III) the date following the expiration of the period of continuation coverage allowed under paragraph (4)(B)(ii).

(B) TIMING OF ELIGIBILITY FOR ADDITIONAL COVERAGE.—For purposes of subparagraph (A)(i), an individual shall not be treated as eligible for coverage under a group health plan before the first date on which such individual could be covered under such plan.

(C) NOTIFICATION REQUIREMENT.—An assistance eligible individual shall notify in writing the group health plan with respect to which paragraph (1)(A) applies if such paragraph ceases to apply by reason of subparagraph (A)(i). Such notice shall be provided to the group health plan in such time and manner as may be specified by the Secretary of Labor.

(3) ASSISTANCE ELIGIBLE INDIVIDUAL.—For purposes of this section, the term "assistance eligible individual" means any qualified beneficiary if—

(A) at any time during the period that begins with September 1, 2008, and ends with December 31, 2009, such qualified beneficiary is eligible for COBRA continuation coverage,

(B) such qualified beneficiary elects such coverage, and

(C) the qualifying event with respect to the COBRA continuation coverage consists of the involuntary termination of the covered employee's employment and occurred during such period.

(4) EXTENSION OF ELECTION PERIOD AND EFFECT ON COVERAGE.—

(A) IN GENERAL.—For purposes of applying section 605(a) of the Employee Retirement Income Security Act of 1974, section 4980B(f)(5)(A) of the Internal Revenue Code of 1986, section 2205(a) of the Public Health Service Act, and section 8905a(c)(2) of title 5, United States Code, in the case of an individual who does not have an election of COBRA continuation coverage in effect on the date of the enactment of this Act but who would be an assistance eligible individual if such election were so in effect, such individual may elect the COBRA continuation coverage under the COBRA continuation coverage provisions containing such sections during

the period beginning on the date of the enactment of this Act and ending 60 days after the date on which the notification required under paragraph (7)(C) is provided to such individual.

(B) COMMENCEMENT OF COVERAGE; NO REACH-BACK.—Any COBRA continuation coverage elected by a qualified beneficiary during an extended election period under subparagraph (A)—

(i) shall commence with the first period of coverage beginning on or after the date of the enactment of this Act, and

(ii) shall not extend beyond the period of COBRA continuation coverage that would have been required under the applicable COBRA continuation coverage provision if the coverage had been elected as required under such provision.

(C) PREEXISTING CONDITIONS.—With respect to a qualified beneficiary who elects COBRA continuation coverage pursuant to subparagraph (A), the period—

(i) beginning on the date of the qualifying event, and

(ii) ending with the beginning of the period described in subparagraph (B)(i), shall be disregarded for purposes of determining the 63-day periods referred to in section 701(c)(2) of the Employee Retirement Income Security Act of 1974, section 9801(c)(2) of the Internal Revenue Code of 1986, and section 2701(c)(2) of the Public Health Service Act.

(5) EXPEDITED REVIEW OF DENIALS OF PREMIUM ASSISTANCE.—In any case in which an individual requests treatment as an assistance eligible individual and is denied such treatment by the group health plan, the Secretary of Labor (or the Secretary of Health and Human Services in connection with COBRA continuation coverage which is provided other than pursuant to part 6 of subtitle B of title I of the Employee Retirement Income Security Act of 1974), in consultation with the Secretary of the Treasury, shall provide for expedited review of such denial. An individual shall be entitled to such review upon application to such Secretary in such form and manner as shall be provided by such Secretary. Such Secretary shall make a determination regarding such individual's eligibility within 15 business days after receipt of such individual's application for review under this paragraph. Either Secretary's determination upon review of the denial shall be de novo and shall be the final determination of such Secretary. A reviewing court shall grant deference to such Secretary's determination. The provisions of this paragraph, paragraphs (1) through (4), and paragraph (7) shall be treated as provisions of title I of the Employee Retirement Income Security Act of 1974 for purposes of part 5 of subtitle B of such title.

(6) DISREGARD OF SUBSIDIES FOR PURPOSES OF FEDERAL AND STATE PROGRAMS.—Notwithstanding any other provision of law, any premium reduction with respect to an assistance eligible individual under this subsection shall not be considered income or resources in determining eligibility for, or the amount of assistance or benefits provided under, any other public benefit provided under Federal law or the law of any State or political subdivision thereof.

(7) NOTICES TO INDIVIDUALS.—

(A) GENERAL NOTICE.—

(i) IN GENERAL.—In the case of notices provided under section 606(a)(4) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1166(4)), section 4980B(f)(6)(D) of the Internal Revenue Code of 1986, section 2206(4) of the Public Health Service Act (42 U.S.C. 300bb-6(4)), or section 8905a(f)(2)(A) of title 5, United States Code, with respect to individuals who, during the period described in paragraph (3)(A), become entitled to elect COBRA continuation coverage, the requirements of such sections shall not be treated as met unless such notices include an additional notification to the recipient of—

(I) the availability of premium reduction with respect to such coverage under this subsection, and

(II) the option to enroll in different coverage if the employer permits assistance eligible individuals to elect enrollment in different coverage (as described in paragraph (1)(B)).

(ii) ALTERNATIVE NOTICE.—In the case of COBRA continuation coverage to which the notice provision under such sections does not apply, the Secretary of Labor, in consultation with the Secretary of the Treasury and the Secretary of Health and Human Services, shall, in consultation with administrators of the group health plans (or other entities) that provide or administer the COBRA continuation coverage involved, provide rules requiring the provision of such notice.

(iii) FORM.—The requirement of the additional notification under this subparagraph may be met by amendment of existing notice forms or by inclusion of a separate document with the notice otherwise required.

(B) SPECIFIC REQUIREMENTS.—Each additional notification under subparagraph (A) shall include—

(i) the forms necessary for establishing eligibility for premium reduction under this subsection,

(ii) the name, address, and telephone number necessary to contact the plan administrator and any other person maintaining relevant information in connection with such premium reduction,

(iii) a description of the extended election period provided for in paragraph (4)(A),

(iv) a description of the obligation of the qualified beneficiary under paragraph (2)(C) to notify the plan providing continuation coverage of eligibility for subsequent coverage under another group health plan or eligibility for benefits under title XVIII of the Social Security Act and the penalty provided under section 6720C of the Internal Revenue Code of 1986 for failure to so notify the plan,

(v) a description, displayed in a prominent manner, of the qualified beneficiary's right to a reduced premium and any conditions on entitlement to the reduced premium, and

(vi) a description of the option of the qualified beneficiary to enroll in different coverage if the employer permits such beneficiary to elect to enroll in such different coverage under paragraph (1)(B).

(C) NOTICE IN CONNECTION WITH EXTENDED ELECTION PERIODS.—In the case of any assistance eligible individual (or any individual described in paragraph (4)(A)) who became entitled to elect COBRA continuation coverage before the date of the enactment of this Act, the administrator of the group health plan (or other entity) involved shall provide (within 60 days after the date of enactment of this Act) for the additional notification required to be provided under subparagraph (A) and failure to provide such notice shall be treated as a failure to meet the notice requirements under the applicable COBRA continuation provision.

(D) MODEL NOTICES.—Not later than 30 days after the date of enactment of this Act—

(i) the Secretary of the Labor, in consultation with the Secretary of the Treasury and the Secretary of Health and Human Services, shall prescribe models for the additional notification required under this paragraph (other than the additional notification described in clause (ii)), and

(ii) in the case of any additional notification provided pursuant to subparagraph (A) under section 8905a(f)(2)(A) of title 5, United States Code, the Office of Personnel Management shall prescribe a model for such additional notification.

(8) REGULATIONS.—The Secretary of the Treasury may prescribe such regulations or other guidance as may be necessary or appropriate to carry out the provisions of this subsection, including the prevention of fraud and abuse under this subsection, except that the Secretary of Labor and the Secretary of Health and Human Services may prescribe such regulations (including interim final regulations) or other guidance as may be necessary or appropriate to carry out the provisions of paragraphs (5), (7), and (9).

(9) OUTREACH.—The Secretary of Labor, in consultation with the Secretary of the Treasury and the Secretary of Health and Human Services, shall provide outreach consisting of public education and enrollment assistance relating to premium reduction provided under this subsection. Such outreach shall target employers, group health plan administrators, public assistance programs, States, insurers, and other entities as determined appropriate by such Secretaries. Such outreach shall include an initial focus on those individuals electing continuation coverage who are referred to in paragraph (7)(C). Information on such premium reduction, including enrollment, shall also be made available on websites of the Departments of Labor, Treasury, and Health and Human Services.

(10) DEFINITIONS.—For purposes of this section—

(A) ADMINISTRATOR.—The term "administrator" has the meaning given such term in section 3(16)(A) of the Employee Retirement Income Security Act of 1974.

(B) COBRA CONTINUATION COVERAGE.—The term "COBRA continuation coverage" means continuation coverage provided pursuant to part 6 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (other than under section 609), title XXII of the Public Health Service Act, section 4980B of the Internal Revenue Code of 1986 (other than subsection (f)(1) of such section insofar as it relates to pediatric vaccines), or section 8905a of title 5, United States Code, or under a State program that provides comparable continuation coverage. Such term does not include coverage under a health flexible spending arrangement under a cafeteria plan within the meaning of section 125 of the Internal Revenue Code of 1986.

(C) COBRA CONTINUATION PROVISION.—The term "COBRA continuation provision" means the provisions of law described in subparagraph (B).

(D) COVERED EMPLOYEE.—The term "covered employee" has the meaning given such term in section 607(2) of the Employee Retirement Income Security Act of 1974.

(E) QUALIFIED BENEFICIARY.—The term "qualified beneficiary" has the meaning given such term in section 607(3) of the Employee Retirement Income Security Act of 1974.

(F) GROUP HEALTH PLAN.—The term "group health plan" has the meaning given such term in section 607(1) of the Employee Retirement Income Security Act of 1974.

(G) STATE.—The term "State" includes the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Commonwealth of the Northern Mariana Islands.

(H) PERIOD OF COVERAGE.—Any reference in this subsection to a period of coverage shall be treated as a reference to a monthly or shorter period of coverage with respect to which premiums are charged with respect to such coverage.

(11) REPORTS.—

(A) INTERIM REPORT.—The Secretary of the Treasury shall submit an interim report to the Committee on Education and Labor, the Committee on Ways and Means, and the Committee on Energy and Commerce of the House of Representatives and the Committee on Health, Education, Labor, and Pensions and the Committee on Finance of the Senate regarding the premium reduction provided under this subsection that includes—

(i) the number of individuals provided such assistance as of the date of the report; and

(ii) the total amount of expenditures incurred (with administrative expenditures noted separately) in connection with such assistance as of the date of the report.

(B) FINAL REPORT.—As soon as practicable after the last period of COBRA continuation

coverage for which premium reduction is provided under this section, the Secretary of the Treasury shall submit a final report to each Committee referred to in subparagraph (A) that includes—

(i) the number of individuals provided premium reduction under this section;

(ii) the average dollar amount (monthly and annually) of premium reductions provided to such individuals; and

(iii) the total amount of expenditures incurred (with administrative expenditures noted separately) in connection with premium reduction under this section.

(12) COBRA PREMIUM ASSISTANCE.—

(A) IN GENERAL.—Subchapter B of chapter 65 of the Internal Revenue Code of 1986, as amended by this Act, is amended by adding at the end the following new section:

"SEC. 6432. COBRA PREMIUM ASSISTANCE.

"(a) IN GENERAL.—The person to whom premiums are payable under COBRA continuation coverage shall be reimbursed as provided in subsection (c) for the amount of premiums not paid by assistance eligible individuals by reason of section 3002(a) of the Health Insurance Assistance for the Unemployed Act of 2009.

"(b) PERSON ENTITLED TO REIMBURSEMENT.—For purposes of subsection (a), except as otherwise provided by the Secretary, the person to whom premiums are payable under COBRA continuation coverage shall be treated as being—

"(1) in the case of any group health plan which is a multiemployer plan (as defined in section 3(37) of the Employee Retirement Income Security Act of 1974), the plan,

"(2) in the case of any group health plan not described in paragraph (1)—

"(A) which is subject to the COBRA continuation provisions contained in—

"(i) the Internal Revenue Code of 1986,

"(ii) the Employee Retirement Income Security Act of 1974,

"(iii) the Public Health Service Act, or

"(iv) title 5, United States Code, or

"(B) under which some or all of the coverage is not provided by insurance,

the employer maintaining the plan, and

"(3) in the case of any group health plan not described in paragraph (1) or (2), the insurer providing the coverage under the group health plan.

"(c) METHOD OF REIMBURSEMENT.—Except as otherwise provided by the Secretary—

"(1) TREATMENT AS PAYMENT OF PAYROLL TAXES.—Each person entitled to reimbursement under subsection (a) (and filing a claim for such reimbursement at such time and in such manner as the Secretary may require) shall be treated for purposes of this title and section 1324(b)(2) of title 31, United States Code, as having paid to the Secretary, on the date that the assistance eligible individual's premium payment is received, payroll taxes in an amount equal to the portion of such reimbursement which relates to such premium. To the extent that the amount treated as paid under the preceding sentence exceeds the amount of such person's liability for such taxes, the Secretary shall credit or refund such excess in the same manner as if it were an overpayment of such taxes.

"(2) OVERSTATEMENTS.—Any overstatement of the reimbursement to which a person is entitled under this section (and any amount paid by the Secretary as a result of such overstatement) shall be treated as an underpayment of payroll taxes by such person and may be assessed and collected by the Secretary in the same manner as payroll taxes.

"(3) REIMBURSEMENT CONTINGENT ON PAYMENT OF REMAINING PREMIUM.—No reimbursement may be made under this section to a person with respect to any assistance eligible individual until after the reduced premium required under section 3002(a)(1)(A) of such Act with respect to such individual has been received.

"(d) DEFINITIONS.—For purposes of this section—

"(1) PAYROLL TAXES.—The term 'payroll taxes' means—

"(A) amounts required to be deducted and withheld for the payroll period under section 3402 (relating to wage withholding),

"(B) amounts required to be deducted for the payroll period under section 3102 (relating to FICA employee taxes), and

"(C) amounts of the taxes imposed for the payroll period under section 3111 (relating to FICA employer taxes).

"(2) PERSON.—The term 'person' includes any governmental entity.

"(e) REPORTING.—Each person entitled to reimbursement under subsection (a) for any period shall submit such reports (at such time and in such manner) as the Secretary may require, including—

"(1) an attestation of involuntary termination of employment for each covered employee on the basis of whose termination entitlement to reimbursement is claimed under subsection (a),

"(2) a report of the amount of payroll taxes offset under subsection (a) for the reporting period and the estimated offsets of such taxes for the subsequent reporting period in connection with reimbursements under subsection (a), and

"(3) a report containing the TINs of all covered employees, the amount of subsidy reimbursed with respect to each covered employee and qualified beneficiaries, and a designation with respect to each covered employee as to whether the subsidy reimbursement is for coverage of 1 individual or 2 or more individuals.

"(f) REGULATIONS.—The Secretary shall issue such regulations or other guidance as may be necessary or appropriate to carry out this section, including—

"(1) the requirement to report information or the establishment of other methods for verifying the correct amounts of reimbursements under this section, and

"(2) the application of this section to group health plans that are multiemployer plans (as defined in section 3(37) of the Employee Retirement Income Security Act of 1974).".

(B) SOCIAL SECURITY TRUST FUNDS HELD HARMLESS.—In determining any amount transferred or appropriated to any fund under the Social Security Act, section 6432 of the Internal Revenue Code of 1986 shall not be taken into account.

(C) CLERICAL AMENDMENT.—The table of sections for subchapter B of chapter 65 of the Internal Revenue Code of 1986 is amended by adding at the end the following new item:

"Sec. 6432. COBRA premium assistance.".

(D) EFFECTIVE DATE.—The amendments made by this paragraph shall apply to premiums to which subsection (a)(1)(A) applies.

(E) SPECIAL RULE.—

(i) IN GENERAL.—In the case of an assistance eligible individual who pays, with respect to the first period of COBRA continuation coverage to which subsection (a)(1)(A) applies or the immediately subsequent period, the full premium amount for such coverage, the person to whom such payment is payable shall—

(I) make a reimbursement payment to such individual for the amount of such premium paid in excess of the amount required to be paid under subsection (a)(1)(A); or

(II) provide credit to the individual for such amount in a manner that reduces one or more subsequent premium payments that the individual is required to pay under such subsection for the coverage involved.

(ii) REIMBURSING EMPLOYER.—A person to which clause (i) applies shall be reimbursed as provided for in section 6432 of the Internal Revenue Code of 1986 for any payment made, or credit provided, to the employee under such clause.

(iii) PAYMENT OR CREDITS.—Unless it is reasonable to believe that the credit for the excess payment in clause (i)(II) will be used by the assistance eligible individual within 180 days of the date on which the person receives from the individual the payment of the full premium amount, a person to which clause (i) applies shall make the payment required under such clause to the individual within 60 days of such payment of the full premium amount. If, as of any day within the 180-day period, it is no longer reasonable to believe that the credit will be used during that period, payment equal to the remainder of the credit outstanding shall be made to the individual within 60 days of such day.

(13) PENALTY FOR FAILURE TO NOTIFY HEALTH PLAN OF CESSATION OF ELIGIBILITY FOR PREMIUM ASSISTANCE.—

(A) IN GENERAL.—Part I of subchapter B of chapter 68 of the Internal Revenue Code of 1986 is amended by adding at the end the following new section:

"SEC. 6720C. PENALTY FOR FAILURE TO NOTIFY HEALTH PLAN OF CESSATION OF ELIGIBILITY FOR COBRA PREMIUM ASSISTANCE.

"(a) IN GENERAL.—Any person required to notify a group health plan under section 3002(a)(2)(C)) of the Health Insurance Assistance for the Unemployed Act of 2009 who fails to make such a notification at such time and in such manner as the Secretary of Labor may require shall pay a penalty of 110 percent of the premium reduction provided under such section after termination of eligibility under such subsection.

"(b) REASONABLE CAUSE EXCEPTION.—No penalty shall be imposed under subsection (a) with respect to any failure if it is shown that such failure is due to reasonable cause and not to willful neglect.".

(B) CLERICAL AMENDMENT.—The table of sections of part I of subchapter B of chapter 68 of such Code is amended by adding at the end the following new item:

"Sec. 6720C. Penalty for failure to notify health plan of cessation of eligibility for COBRA premium assistance.".

(C) EFFECTIVE DATE.—The amendments made by this paragraph shall apply to failures occurring after the date of the enactment of this Act.

(14) COORDINATION WITH HCTC.—

(A) IN GENERAL.—Subsection (g) of section 35 of the Internal Revenue Code of 1986 is amended by redesignating paragraph (9) as paragraph (10) and inserting after paragraph (8) the following new paragraph:

"(9) COBRA PREMIUM ASSISTANCE.—In the case of an assistance eligible individual who receives premium reduction for COBRA continuation coverage under section 3002(a) of the Health Insurance Assistance for the Unemployed Act of 2009 for any month during the taxable year, such individual shall not be treated as an eligible individual, a certified individual, or a qualifying family member for purposes of this section or section 7527 with respect to such month.".

(B) EFFECTIVE DATE.—The amendment made by subparagraph (A) shall apply to taxable years ending after the date of the enactment of this Act.

(15) EXCLUSION OF COBRA PREMIUM ASSISTANCE FROM GROSS INCOME.—

(A) IN GENERAL.—Part III of subchapter B of chapter 1 of the Internal Revenue Code of 1986 is amended by inserting after section 139B the following new section:

"SEC. 139C. COBRA PREMIUM ASSISTANCE.

"In the case of an assistance eligible individual (as defined in section 3002 of the Health Insurance Assistance for the Unemployed Act of 2009), gross income does not include any premium reduction provided under subsection (a) of such section.".

(B) CLERICAL AMENDMENT.—The table of sections for part III of subchapter B of chapter 1 of such Code is amended by inserting after the item relating to section 139B the following new item:

"Sec. 139C. COBRA premium assistance.".

(C) EFFECTIVE DATE.—The amendments made by this paragraph shall apply to taxable years ending after the date of the enactment of this Act.

(b) ELIMINATION OF PREMIUM SUBSIDY FOR HIGH-INCOME INDIVIDUALS.—

(1) RECAPTURE OF SUBSIDY FOR HIGH-INCOME INDIVIDUALS.—If—

(A) premium assistance is provided under this section with respect to any COBRA continuation coverage which covers the taxpayer, the taxpayer's spouse, or any dependent (within the meaning of section 152 of the Internal Revenue Code of 1986, determined without regard to subsections (b)(1), (b)(2), and (d)(1)(B) thereof) of the taxpayer during any portion of the taxable year, and

(B) the taxpayer's modified adjusted gross income for such taxable year exceeds $125,000 ($250,000 in the case of a joint return),

then the tax imposed by chapter 1 of such Code with respect to the taxpayer for such taxable year shall be increased by the amount of such assistance.

(2) PHASE-IN OF RECAPTURE.—

(A) IN GENERAL.—In the case of a taxpayer whose modified adjusted gross income for the taxable year does not exceed $145,000 ($290,000 in the case of a joint return), the increase in the tax imposed under paragraph (1) shall not exceed the phase-in percentage of such increase (determined without regard to this paragraph).

(B) PHASE-IN PERCENTAGE.—For purposes of this subsection, the term "phase-in percentage" means the ratio (expressed as a percentage) obtained by dividing—

(i) the excess of described in subparagraph (B) of paragraph (1), by

(ii) $20,000 ($40,000 in the case of a joint return).

(3) OPTION FOR HIGH-INCOME INDIVIDUALS TO WAIVE ASSISTANCE AND AVOID RECAPTURE.—Notwithstanding subsection (a)(3), an individual shall not be treated as an assistance eligible individual for purposes of this section and section 6432 of the Internal Revenue Code of 1986 if such individual—

(A) makes a permanent election (at such time and in such form and manner as the Secretary of the Treasury may prescribe) to waive the right to the premium assistance provided under this section, and

(B) notifies the entity to whom premiums are reimbursed under section 6432(a) of such Code of such election.

(4) MODIFIED ADJUSTED GROSS INCOME.—For purposes of this subsection, the term "modified adjusted gross income" means the adjusted gross income (as defined in section 62 of the Internal Revenue Code of 1986) of the taxpayer for the taxable year increased by any amount excluded from gross income under section 911, 931, or 933 of such Code.

(5) CREDITS NOT ALLOWED AGAINST TAX, ETC.—For purposes determining regular tax liability under section 26(b) of such Code, the increase in tax under this subsection shall not be treated as a tax imposed under chapter 1 of such Code.

(6) REGULATIONS.—The Secretary of the Treasury shall issue such regulations or other guidance as are necessary or appropriate to carry out this subsection, including requirements that the entity to whom premiums are reimbursed under section 6432(a) of the Internal Revenue Code of 1986 report to the Secretary, and to each assistance eligible individual, the amount of premium assistance provided under subsection (a) with respect to each such individual.

(7) EFFECTIVE DATE.—The provisions of this subsection shall apply to taxable years ending after the date of the enactment of this Act.

TITLE IV—MEDICARE AND MEDICAID HEALTH INFORMATION TECHNOLOGY; MISCELLANEOUS MEDICARE PROVISIONS

SEC. 4001. TABLE OF CONTENTS OF TITLE.

The table of contents of this title is as follows:

Subtitle A—Medicare Incentives

SEC. 4101. INCENTIVES FOR ELIGIBLE PROFESSIONALS.

(a) INCENTIVE PAYMENTS.—Section 1848 of the Social Security Act (42 U.S.C. 1395w–4) is amended by adding at the end the following new subsection:

"(o) INCENTIVES FOR ADOPTION AND MEANINGFUL USE OF CERTIFIED EHR TECHNOLOGY.—

"(1) INCENTIVE PAYMENTS.—

"(A) IN GENERAL.—

"(i) IN GENERAL.—Subject to the succeeding subparagraphs of this paragraph, with respect to covered professional services furnished by an eligible professional during a payment year (as defined in subparagraph (E)), if the eligible professional is a meaningful EHR user (as determined under paragraph (2)) for the EHR reporting period with respect to such year, in addition to the amount otherwise paid under this part, there also shall be paid to the eligible professional (or to an employer or facility in the cases described in clause (A) of section 1842(b)(6)), from the Federal Supplementary Medical Insurance Trust Fund established under section 1841 an amount equal to 75 percent of the Secretary's estimate (based on claims submitted not later than 2 months after the end of the payment year) of the allowed charges under this part for all such covered professional services furnished by the eligible professional during such year.

"(ii) NO INCENTIVE PAYMENTS WITH RESPECT TO YEARS AFTER 2016.—No incentive payments may be made under this subsection with respect to a year after 2016.

"(B) LIMITATIONS ON AMOUNTS OF INCENTIVE PAYMENTS.—

"(i) IN GENERAL.—In no case shall the amount of the incentive payment provided under this paragraph for an eligible professional for a payment year exceed the applicable amount specified under this subparagraph with respect to such eligible professional and such year.

"(ii) AMOUNT.—Subject to clauses (iii) through (v), the applicable amount specified in this subparagraph for an eligible professional is as follows:

"(I) For the first payment year for such professional, $15,000 (or, if the first payment year for such eligible professional is 2011 or 2012, $18,000).

"(II) For the second payment year for such professional, $12,000.

"(III) For the third payment year for such professional, $8,000.

"(IV) For the fourth payment year for such professional, $4,000.

"(V) For the fifth payment year for such professional, $2,000.

"(VI) For any succeeding payment year for such professional, $0.

"(iii) PHASE DOWN FOR ELIGIBLE PROFESSIONALS FIRST ADOPTING EHR AFTER 2013.—If the first payment year for an eligible professional is after 2013, then the amount specified in this subparagraph for a payment year for such professional is the same as the amount specified in clause (ii) for such payment year for an eligible professional whose first payment year is 2013.

"(iv) INCREASE FOR CERTAIN ELIGIBLE PROFESSIONALS.—In the case of an eligible professional who predominantly furnishes services under this part in an area that is designated by the Secretary (under section 332(a)(1)(A) of the Public Health Service Act) as a health professional shortage area, the amount that would otherwise apply for a payment year for such professional under subclauses (I) through (V) of clause (ii) shall be increased by 10 percent. In implementing the preceding sentence, the Secretary may, as determined appropriate, apply provisions of subsections (m) and (u) of section 1833 in a similar manner as such provisions apply under such subsection.

"(v) NO INCENTIVE PAYMENT IF FIRST ADOPTING AFTER 2014.—If the first payment year for an eligible professional is after 2014 then the applicable amount specified in this subparagraph for such professional for such year and any subsequent year shall be $0.

"(C) NON-APPLICATION TO HOSPITAL-BASED ELIGIBLE PROFESSIONALS.—

"(i) IN GENERAL.—No incentive payment may be made under this paragraph in the case of a hospital-based eligible professional.

"(ii) HOSPITAL-BASED ELIGIBLE PROFESSIONAL.—For purposes of clause (i), the term 'hospital-based eligible professional' means, with respect to covered professional services furnished by an eligible professional during the EHR reporting period for a payment year, an eligible professional, such as a pathologist, anesthesiologist, or emergency physician, who furnishes substantially all of such services in a hospital setting (whether inpatient or outpatient) and through the use of the facilities and equipment, including qualified electronic health records, of the hospital. The determination of whether an eligible professional is a hospital-based eligible professional shall be made on the basis of the site of service (as defined by the Secretary) and without regard to any employment or billing arrangement between the eligible professional and any other provider.

"(D) PAYMENT.—

"(i) FORM OF PAYMENT.—The payment under this paragraph may be in the form of a single consolidated payment or in the form of such periodic installments as the Secretary may specify.

"(ii) COORDINATION OF APPLICATION OF LIMITATION FOR PROFESSIONALS IN DIFFERENT PRACTICES.—In the case of an eligible professional furnishing covered professional services in more than one practice (as specified by the Secretary), the Secretary shall establish rules to coordinate the incentive payments, including the application of the limitation on amounts of such incentive payments under this paragraph, among such practices.

"(iii) COORDINATION WITH MEDICAID.—The Secretary shall seek, to the maximum extent practicable, to avoid duplicative requirements from Federal and State governments to demonstrate meaningful use of certified EHR technology under this title and title XIX. The Secretary may also adjust the reporting periods under such title and such subsections in order to carry out this clause.

"(E) PAYMENT YEAR DEFINED.—

"(i) IN GENERAL.—For purposes of this subsection, the term 'payment year' means a year beginning with 2011.

"(ii) FIRST, SECOND, ETC. PAYMENT YEAR.—The term 'first payment year' means, with respect to covered professional services furnished by an eligible professional, the first year for which an incentive payment is made for such services under this subsection. The terms 'second payment year', 'third payment year', 'fourth payment year', and 'fifth payment year'

but no later than 120 days after the date of enactment. No Economic Recovery Payments shall be made after December 31, 2010.

SECTION 2202. SPECIAL CREDIT FOR CERTAIN GOVERNMENT RETIREES.

Current Law

No provision.

House Bill

No provision.

Senate Bill

No provision.

Conference Agreement

The conference agreement creates a $250 credit ($500 for a joint return where both spouses are eligible) against income taxes owed for tax year 2009 for individuals who receive a government pension or annuity from work not covered by Social Security, and were not eligible to receive a payment under section 2201. If the individual is also eligible for the "Making Work Pay" credit from Section 1001, that credit shall be reduced by the credit made under this section.μ Each tax return on which this credit is claimed must include the social security number of the taxpayer (in the case of a joint return, the social security number of at least one spouse).μ The provision states that the credit under this section shall be a refundable credit.

The provision provides that any credit or refund allowed or made by this provision shall not be taken into account as income and shall not be taken into account as resources for the month of receipt and the following two months for purposes of determining the eligibility of such individual or any other individual for benefits or assistance, or the amount or extent of benefits or assistance, under any Federal program or under any State or local program financed in whole or in part with Federal funds.

The provision is effective on the date of enactment.

TITLE III—HEALTH INSURANCE ASSISTANCE

A. ASSISTANCE FOR COBRA CONTINUATION COVERAGE (SEC. 3002(A) OF THE HOUSE BILL, SEC. 3001 OF THE SENATE AMENDMENT, SEC. 3001 OF THE CONFERENCE AGREEMENT, AND SEC. 4980B AND NEW SECS. 139C, 6432, AND 6720C OF THE CODE)

PRESENT LAW

In general

The Code contains rules that require certain group health plans to offer certain individuals ("qualified beneficiaries") the opportunity to continue to participate for a specified period of time in the group health plan ("continuation coverage") after the occurrence of certain events that otherwise would have terminated such participation ("qualifying events").[228] These continuation coverage rules are often referred to as "COBRA continuation coverage" or "COBRA," which is a reference to the acronym for the law that added the continuation coverage rules to the Code.[229]

The Code imposes an excise tax on a group health plan if it fails to comply with the COBRA continuation coverage rules with respect to a qualified beneficiary. The excise tax with respect to a qualified beneficiary generally is equal to $100 for each day in the noncompliance period with respect to the failure. A plan's noncompliance period generally begins on the date the failure first occurs and ends when the failure is corrected. Special rules apply that limit the amount of the excise tax if the failure would not have been discovered despite the exercise of reasonable diligence or if the failure is due to reasonable cause and not willful neglect.

In the case of a multiemployer plan, the excise tax generally is imposed on the group health plan. A multiemployer plan is a plan to which more than one employer is required to contribute, that is maintained pursuant to one or more collective bargaining agreements between one or more employee organizations and more than one employer, and that satisfies such other requirements as the Secretary of Labor may prescribe by regulation. In the case of a plan other than a multiemployer plan (a "single employer plan"), the excise tax generally is imposed on the employer.

Plans subject to COBRA

A group health plan is defined as a plan of, or contributed to by, an employer (including a self-employed person) or employee organization to provide health care (directly or otherwise) to the employees, former employees, the employer, and others associated or formerly associated with the employer in a business relationship, or their families. A group health plan includes a self-insured plan. The term group health plan does not, however, include a plan under which substantially all of the coverage is for qualified long-term care services.

The following types of group health plans are not subject to the Code's COBRA rules: (1) a plan established and maintained for its employees by a church or by a convention or association of churches which is exempt from tax under section 501 (a "church plan"); (2) a plan established and maintained for its employees by the Federal government, the government of any State or political subdivision thereof, or by any instrumentality of the foregoing (a "governmental plan")[230] and (3) a plan maintained by an employer that normally employed fewer than 20 employees on a typical business day during the preceding calendar year[231] (a "small employer plan").

Qualifying events and qualified beneficiaries

A qualifying event that gives rise to COBRA continuation coverage includes, with respect to any covered employee, the following events which would result in a loss of coverage of a qualified beneficiary under a group health plan (but for COBRA continuation coverage): (1) death of the covered employee; (2) the termination (other than by reason of such employee's gross misconduct), or a reduction in hours, of the covered employee's employment; (3) divorce or legal separation of the covered employee; (4) the covered employee becoming entitled to Medicare benefits under title XVIII of the Social Security Act; (5) a dependent child ceasing to be a dependent child under the generally applicable requirements of the plan; and (6) a proceeding in a case under the U.S. Bankruptcy Code commencing on or after July 1, 1986, with respect to the employer from whose employment the covered employee retired at any time.

A "covered employee" is an individual who is (or was) provided coverage under the group health plan on account of the performance of services by the individual for one or more persons maintaining the plan and includes a self-employed individual. A "qualified beneficiary" means, with respect to a covered employee, any individual who on the day before the qualifying event for the employee is a beneficiary under the group health plan as the spouse or dependent child of the employee. The term qualified beneficiary also includes the covered employee in the case of a qualifying event that is a termination of employment or reduction in hours.

Continuation coverage requirements

Continuation coverage that must be offered to qualified beneficiaries pursuant to COBRA must consist of coverage which, as of the time coverage is being provided, is identical to the coverage provided under the plan to similarly situated non-COBRA beneficiaries under the plan with respect to whom a qualifying event has not occurred. If coverage under a plan is modified for any group of similarly situated non-COBRA beneficiaries, the coverage must also be modified in the same manner for qualified beneficiaries. Similarly situated non-COBRA beneficiaries means the group of covered employees, spouses of covered employees, or dependent children of covered employees who (i) are receiving coverage under the group health plan for a reason other than pursuant to COBRA, and (ii) are the most similarly situated to the situation of the qualified beneficiary immediately before the qualifying event, based on all of the facts and circumstances.

The maximum required period of continuation coverage for a qualified beneficiary (i.e., the minimum period for which continuation coverage must be offered) depends upon a number of factors, including the specific qualifying event that gives rise to a qualified beneficiary's right to elect continuation coverage. In the case of a qualifying event that is the termination, or reduction of hours, of a covered employee's employment, the minimum period of coverage that must be offered to the qualified beneficiary is coverage for the period beginning with the loss of coverage on account of the qualifying event and ending on the date that is 18 months[232] after the date of the qualifying event. If coverage under a plan is lost on account of a qualifying event but the loss of coverage actually occurs at a later date, the minimum coverage period may be extended by the plan so that it is measured from the date when coverage is actually lost.

The minimum coverage period for a qualified beneficiary generally ends upon the earliest to occur of the following events: (1) the date on which the employer ceases to provide any group health plan to any employee, (2) the date on which coverage ceases under the plan by reason of a failure to make timely payment of any premium required with respect to the qualified beneficiary, and (3) the date on which the qualified beneficiary first becomes (after the date of election of continuation coverage) either (i) covered under any other group health plan (as an employee or otherwise) which does not include any exclusion or limitation with respect to any preexisting condition of such beneficiary or (ii) entitled to Medicare benefits under title XVIII of the Social Security Act. Mere eligibility for another group health plan or Medicare benefits is not sufficient to terminate the minimum coverage period. Instead, the qualified beneficiary must be actually covered by the other group health plan or enrolled in Medicare. Coverage under another group health plan or enrollment in Medicare

[228] Sec. 4980B

[229] The COBRA rules were added to the Code by the Consolidated Omnibus Budget Reconciliation Act of 1985, Pub. L. No. 99-272. The rules were originally added as Code sections 162(i) and (k). The rules were later restated as Code section 4980B, pursuant to the Technical and Miscellaneous Revenue Act of 1988, Pub. L. No. 100-647.

[230] A governmental plan also includes certain plans established by an Indian tribal government.

[231] If the plan is a multiemployer plan, then each of the employers contributing to the plan for a calendar year must normally employ fewer than 20 employees during the preceding calendar year.

[232] In the case of a qualified beneficiary who is determined, under Title II or XVI of the Social Security Act, to have been disabled during the first 60 days of continuation coverage, the 18 month minimum coverage period is extended to 29 months with respect to all qualified beneficiaries if notice is given before the end of the initial 18 month continuation coverage period.

does not terminate the minimum coverage period if such other coverage or Medicare enrollment begins on or before the date that continuation coverage is elected.

Election of continuation coverage

The COBRA rules specify a minimum election period under which a qualified beneficiary is entitled to elect continuation coverage. The election period begins not later than the date on which coverage under the plan terminates on account of the qualifying event, and ends not earlier than the later of 60 days or 60 days after notice is given to the qualified beneficiary of the qualifying event and the beneficiary's election rights.

Notice requirements

A group health plan is required to give a general notice of COBRA continuation coverage rights to employees and their spouses at the time of enrollment in the group health plan.

An employer is required to give notice to the plan administrator of certain qualifying events (including a loss of coverage on account of a termination of employment or reduction in hours) generally within 30 days of the qualifying event. A covered employee or qualified beneficiary is required to give notice to the plan administrator of certain qualifying events within 60 days after the event. The qualifying events giving rise to an employee or beneficiary notification requirement are the divorce or legal separation of the covered employee or a dependent child ceasing to be a dependent child under the terms of the plan. Upon receiving notice of a qualifying event from the employer, covered employee, or qualified beneficiary, the plan administrator is then required to give notice of COBRA continuation coverage rights within 14 days to all qualified beneficiaries with respect to the event.

Premiums

A plan may require payment of a premium for any period of continuation coverage. The amount of such premium generally may not exceed 102 percent[233] of the "applicable premium" for such period and the premium must be payable, at the election of the payor, in monthly installments.

The applicable premium for any period of continuation coverage means the cost to the plan for such period of coverage for similarly situated non-COBRA beneficiaries with respect to whom a qualifying event has not occurred, and is determined without regard to whether the cost is paid by the employer or employee. The determination of any applicable premium is made for a period of 12 months (the "determination period") and is required to be made before the beginning of such 12 month period.

In the case of a self-insured plan, the applicable premium for any period of continuation coverage of qualified beneficiaries is equal to a reasonable estimate of the cost of providing coverage during such period for similarly situated non-COBRA beneficiaries which is determined on an actuarial basis and takes into account such factors as the Secretary of Treasury prescribes in regulations. A self-insured plan may elect to determine the applicable premium on the basis of an adjusted cost to the plan for similarly situated non-COBRA beneficiaries during the preceding determination period.

A plan may not require payment of any premium before the day which is 45 days after the date on which the qualified beneficiary made the initial election for continuation coverage. A plan is required to treat any required premium payment as timely if it is made within 30 days after the date the premium is due or within such longer period as applies to, or under, the plan.

Other continuation coverage rules

Continuation coverage rules which are parallel to the Code's continuation coverage rules apply to group health plans under the Employee Retirement Income Security Act of 1974 (ERISA).[234] ERISA generally permits the Secretary of Labor and plan participants to bring a civil action to obtain appropriate equitable relief to enforce the continuation coverage rules of ERISA, and in the case of a plan administrator who fails to give timely notice to a participant or beneficiary with respect to COBRA continuation coverage, a court may hold the plan administrator liable to the participant or beneficiary in the amount of up to $110 a day from the date of such failure.

Although the Federal government and State and local governments are not subject to the Code and ERISA's continuation coverage rules, other laws impose similar continua ion coverage requirements with respect to plans maintained by such governmental employers.[235] In addition, many States have enacted laws or promulgated regulations that provide continuation coverage rights that are similar to COBRA continuation coverage rights in the case of a loss of group health coverage. Such State laws, for example, may apply in the case of a loss of coverage under a group health plan maintained by a small employer.

HOUSE BILL

Reduced COBRA premium

The provision provides that, for a period not exceeding 12 months, an assistance eligible individual is treated as having paid any premium required for COBRA continuation coverage under a group health plan if the individual pays 35 percent of the premium.[236] Thus, if the assistance eligible individual pays 35 percent of the premium, the group health plan must treat the individual as having paid the full premium required for COBRA continuation coverage, and the individual is entitled to a subsidy for 65 percent of the premium. An assistance eligible individual is any qualified beneficiary who elects COBRA continuation coverage and satisfies two additional requirements. First, the qualifying event with respect to the covered employee for that qualified beneficiary must be a loss of group health plan coverage on account of an involuntary termination of the covered employee's employment. However, a termination of employment for gross misconduct does not qualify (since such a termination under present law does not qualify for COBRA continuation coverage). Second, the qualifying event must occur during the period beginning September 1, 2008 and ending with December 31, 2009 and the qualified beneficiary must be eligible for COBRA continuation coverage during that period and elect such coverage.

An assistance eligible individual can be any qualified beneficiary associated with the relevant covered employee (e.g., a dependent of an employee who is covered immediately prior to a qualifying event), and such qualified beneficiary can independently elect COBRA (as provided under present law COBRA rules) and independently receive a subsidy. Thus, the subsidy for an assistance eligible individual continues after an intervening death of the covered employee.

Under the provision, any subsidy provided is excludible from the gross income of the covered employee and any assistance eligible individuals. However, for purposes of determining the gross income of the employer and any welfare benefit plan of which the group health plan is a part, the amount of the premium reduction is intended to be treated as an employee contribution to the group health plan. Finally, under the provision, notwithstanding any other provision of law, the subsidy is not permitted to be considered as income or resources in determining eligibility for, or the amount of assistance or benefits under, any public benefit provided under Federal or State law (including the law of any political subdivision).

Eligible COBRA continuation coverage

Under the provision, continuation coverage that qualifies for the subsidy is not limited to coverage required to be offered under the Code's COBRA rules but also includes continuation coverage required under State law that requires continuation coverage comparable to the continuation coverage required under the Code's COBRA rules for group health plans not subject to those rules (e.g., a small employer plan) and includes continuation coverage requirements that apply to health plans maintained by the Federal government or a State government. Comparable continuation coverage under State law does not include every State law right to continue health coverage, such as a right to continue coverage with no rules that limit the maximum premium that can be charged with respect to such coverage. To be comparable, the right generally must be to continue substantially similar coverage as was provided under the group health plan (or substantially similar coverage as is provided to similarly situated beneficiaries) at a monthly cost that is based on a specified percentage of the group health plan's cost of providing such coverage.

The cost of coverage under any group health plan that is subject to the Code's COBRA rules (or comparable State requirements or continuation coverage requirement under health plans maintained by the Federal government or any State government) is eligible for the subsidy, except contributions to a health flexible spending account.

Termination of eligibility for reduced premiums

The assistance eligible individual's eligibility for the subsidy terminates with the first month beginning on or after the earlier of (1) the date which is 12 months after the first day of the first month for which the subsidy applies, (2) the end of the maximum required period of continuation coverage for the qualified beneficiary under the Code's COBRA rules or the relevant State or Federal law (or regulation), or (3) the date that the assistance eligible individual becomes eligible for Medicare benefits under title XVIII of the Social Security Act or health coverage under another group health plan (including,

[233] In the case of a qualified beneficiary whose minimum coverage period is extended to 29 months on account of a disability determination, the premium for the period of the disability extension may not exceed 150 percent of the applicable premium for the period.

[234] Secs. 601 to 608 of ERISA.

[235] Continuation coverage rights similar to COBRA continuation coverage rights are provided to individuals covered by health plans maintained by the Federal government. 5 U.S.C. sec. 8905a. Group health plans maintained by a State that receives funds under Chapter 6A of Title 42 of the United States Code (the Public Health Service Act) are required to provide continuation coverage rights similar to COBRA continuation coverage rights for individuals covered by plans maintained by such State (and plans maintained by political subdivisions of such State and agencies and instrumentalities of such State or political subdivision of such State). 42 U.S.C. sec. 300bb-1.

[236] For this purpose, payment by an assistance eligible individual includes payment by another individual paying on behalf of the individual, such as a parent or guardian, or an entity paying on behalf of the individual, such as a State agency or charity. Further, the amount of the premium used to calculate the reduced premium is the premium amount that the employee would be required to pay for COBRA continuation coverage absent this premium reduction (e.g. 102 percent of the "applicable premium" for such period).

for example, a group health plan maintained by the new employer of the individual or a plan maintained by the employer of the individual's spouse). However, eligibility for coverage under another group health plan does not terminate eligibility for the subsidy if the other group health plan provides only dental, vision, counseling, or referral services (or a combination of the foregoing), is a health flexible spending account or health reimbursement arrangement, or is coverage for treatment that is furnished in an on-site medical facility maintained by the employer and that consists primarily of first-aid services, prevention and wellness care, or similar care (or a combination of such care).

If a qualified beneficiary paying a reduced premium for COBRA continuation coverage under this provision becomes eligible for coverage under another group health plan or Medicare, the provision requires the qualified beneficiary to notify, in writing, the group health plan providing the COBRA continuation coverage with the reduced premium of such eligibility under the other plan or Medicare. The notification by the assistance eligible individual must be provided to the group health plan in the time and manner as is specified by the Secretary of Labor. If an assistance eligible individual fails to provide this notification at the required time and in the required manner, and as a result the individual's COBRA continuation coverage continues to be subsidized after the termination of the individual's eligibility for such subsidy, a penalty is imposed on the individual equal to 110 percent of the subsidy provided after termination of eligibility.

This penalty only applies if the subsidy in the form of the premium reduction is actually provided to a qualified beneficiary for a month that the beneficiary is not eligible for the reduction. Thus, for example, if a qualified beneficiary becomes eligible for coverage under another group health plan and stops paying the reduced COBRA continuation premium, the penalty generally will not apply. As discussed below, under the provision, the group health plan is reimbursed for the subsidy for a month (65 percent of the amount of the premium for the month) only after receipt of the qualified beneficiary's portion (35 percent of the premium amount). Thus, the penalty generally will only arise when the qualified beneficiary continues to pay the reduced premium and does not notify the group health plan providing COBRA continuation coverage of the beneficiary's eligibility under another group health plan or Medicare.

Special COBRA election opportunity

The provision provides a special 60 day election period for a qualified beneficiary who is eligible for a reduced premium and who has not elected COBRA continuation coverage as of the date of enactment. The 60 day election period begins on the date that notice is provided to the qualified beneficiary of the special election period. However, this special election period does not extend the period of COBRA continuation coverage beyond the original maximum required period (generally 18 months after the qualifying event) and any COBRA continuation coverage elected pursuant to this special election period begins on the date of enactment and does not include any period prior to that date. Thus, for example, if a covered employee involuntarily terminated employment on September 10, 2008, but did not elect COBRA continuation coverage and was not eligible for coverage under another group health plan, the employee would have 60 days after date of notification of this new election right to elect the coverage and receive the subsidy. If the employee made the election, the coverage would begin with the date of enactment and would not include any period prior to that date. However, the coverage would not be required to last for 18 months. Instead the maximum required COBRA continuation coverage period would end not later than 18 months after September 10, 2008.

The special enrollment provision applies to a group health plan that is subject to the COBRA continuation coverage requirements of the Code, ERISA, Title 5 of the United States Code (relating to plans maintained by the Federal government), or the Public Health Service Act ("PHSA").

With respect to an assistance eligible individual who elects coverage pursuant to the special election period, the period beginning on the date of the qualifying event and ending with the day before the date of enactment is disregarded for purposes of the rules that limit the group health plan from imposing pre-existing condition limitations with respect to the individual's coverage.[237]

Reimbursement of group health plans

The provision provides that the entity to which premiums are payable (determined under the applicable COBRA continuation coverage requirement)[238] shall be reimbursed by the amount of the premium for COBRA continuation coverage that is no aid by an assistance eligible individual on account of the premium reduction. An entity is not eligible for subsidy reimbursement, however, until the entity has received the reduced premium payment from the assistance eligible individual. To the extent that such entity has liability for income tax withholding from wages[239] or FICA taxes[240] with respect to its employees, the entity is reimbursed by treating the amount that is reimbursable to the entity as a credit against its liability for these payroll taxes.[241] To the extent that such amount exceeds the amount of the entity's liability for these payroll taxes, the Secretary shall reimburse the entity for the excess directly. The provision requires any entity entitled to such reimbursement to submit such reports as the Secretary of Treasury may require, including an attestation of the involuntary termination of employment of each covered employee on the basis of whose termination entitlement to reimbursement of premiums is claimed, and a report of the amount of payroll taxes offset for a reporting period and the estimated offsets of such taxes for the next reporting period. This report is required to be provided at the same time as the deposits of the payroll taxes would have been required, absent the offset, or such times as the Secretary specifies.

Notice requirements

The notice of COBRA continuation coverage that a plan administrator is required to provide to qualified beneficiaries with respect to a qualifying event under present law must contain, under the provision, additional information including, for example, information about the qualified beneficiary's right to the premium reduction (and subsidy) and the conditions on the subsidy, and a description of the obligation of the qualified beneficiary to notify the group health plan of eligibility under another group health plan or eligibility for Medicare benefits under title XVIII of the Social Security Act, and the penalty for failure to provide this notification. The provision also requires a new notice to be given to qualified beneficiaries entitled to a special election period after enactment. In the case of group health plans that are not subject to the COBRA continuation coverage requirements of the Code, ERISA, Title 5 of the United States Code (relating to plans maintained by the Federal government), or PHSA, the provision requires that notice be given to the relevant employees and beneficiaries as well, as specified by the Secretary of Labor. Within 30 days after enactment, the Secretary of Labor is directed to provide model language for the additional notification required under the provision. The provision also provides an expedited 10–day review process by the Department of Labor, under which an individual may request review of a denial of treatment as an assistance eligible individual by a group health plan.

Regulatory authority

The provision provides authority to the Secretary of the Treasury to issue regulations or other guidance as may be necessary or appropriate to carry out the provision, including any reporting requirements or the establishment of other methods for verifying the correct amounts of payments and credits under the provision. For example, the Secretary of the Treasury might require verification on the return of an assistance eligible individual who is the covered employee that the individual's termination of employment was involuntary. The provision directs the Secretary of the Treasury to issue guidance or regulations addressing the reimbursement of the subsidy in the case of a multiemployer group health plan. The provision also provides authority to the Secretary of the Treasury to promulgate rules, procedures, regulations, and other guidance as is necessary and appropriate to prevent fraud and abuse in the subsidy program, including the employment tax offset mechanism.

Reports

The provision requires the Secretary of the Treasury to submit an interim and a final report regarding the implementation of the premium reduction provision. The interim report is to include information about the number of individuals receiving assistance, and the total amount of expenditures incurred, as of the date of the report. The final report, to be issued as soon as practicable after the last period of COBRA continuation coverage for which premiums are provided, is to include similar information as provided in the interim report, with the addition of information about the average dollar amount (monthly and annually) of premium reductions provided to such individuals. The reports are to be given to the Committee on Ways and Means, the Committee on Energy and Commerce, the Committee on Health

[237] Section 9801 provides that a group health plan may impose a pre-existing condition exclusion for no more than 12 months after a participant or beneficiary's enrollment date. Such 12-month period must be reduced by the aggregate period of creditable coverage (which includes periods of coverage under another group health plan). A period of creditable coverage can be disregarded if, after the coverage period and before the enrollment date, there was a 63-day period during which the individual was not covered under any creditable coverage. Similar rules are provided under ERISA and PHSA.

[238] Applicable continuation coverage that qualifies for the subsidy and thus for reimbursement is not limited to coverage required to be offered under the Code's COBRA rules but also includes continuation coverage required under State law that requires continuation coverage comparable to the continuation coverage required under the Code's COBRA rules for group health plans not subject to those rules (e.g., a small employer plan) and includes continuation coverage requirements that apply to health plans maintained by the Federal government or a State government.

[239] Sec. 3401.

[240] Sec. 3102 (relating to FICA taxes applicable to employees) and sec. 3111 (relating to FICA taxes applicable to employers).

[241] In determining any amount transferred or appropriated to any fund under the Social Security Act, amounts credited against an employer's payroll tax obligations pursuant to the provision shall not be taken into account.

Education, Labor and Pensions and the Committee on Finance.

Effective date

The provision is effective for premiums for months of coverage beginning on or after the date of enactment. However, it is intended that a group health plan will not fail to satisfy the requirements for COBRA continuation coverage merely because the plan accepts payment of 100 percent of the premium from an assistance eligible employee during the first two months beginning on or after the date of enactment while the premium reduction is being implemented, provided the amount of the resulting premium overpayment is credited against the individual's premium (35 percent of the premium) for future months or the overpayment is otherwise repaid to the employee as soon as practical.

SENATE AMENDMENT

The Senate amendment is the same as the House bill with certain modifications. The amount of the COBRA the premium reduction (or subsidy) is 50 percent of the required premium under the Senate amendment (rather than 65 percent as provided under the House bill).

In addition, a group health plan is permitted to provide a special enrollment right to assistance-eligible individuals to allow them to change coverage options under the plan in conjunction with electing COBRA continuation coverage. Under this special enrollment right, the assistance eligible individual must only be offered the option to change to any coverage option offered to employed workers that provides the same or lower health insurance premiums than the individual's group health plan coverage as of the date of the covered employee's qualifying event. If the individual elects a different coverage option under this special enrollment right in conjunction with electing COBRA continuation coverage, this is the coverage that must be provided for purposes of satisfying the COBRA continuation coverage requirement. However the coverage plan option into which the individual must be given the opportunity to enroll under this special enrollment right does not include the following: a coverage option providing only dental, vision, counseling, or referral services (or a combination of the foregoing); a health flexible spending account or health reimbursement arrangement; or coverage for treatment that is furnished in an on-site medical facility maintained by the employer and that consists primarily of first-aid services, prevention and wellness care, or similar care (or a combination of such care).

Effective date.—The provision is effective for months of coverage beginning after the date of enactment. In addition, the Senate amendment specifically provides rules for reimbursement of an assistance eligible individual if such individual pays 100 percent of the premium required for COBRA continuation coverage for any month during the 60-day period beginning on the first day of the first month after the date of enactment. The person who receives the premium overpayment is permitted to provide a credit to the assistance eligible individual for the amount overpaid against one or more subsequent premiums (subject to the 50 percent payment rule) for COBRA continuation coverage, but only if it is reasonable to believe that the credit for the excess will be used by the assistance eligible individual within 180 days of the individual's overpayment. Otherwise, the person must make a reimbursement payment to the individual for the amount of the premium overpayment within 60 days of receiving the overpayment. Further, if as of any day during the 180-day period it is no longer reasonable to believe that the credit will be used during that period by the assistance eligible individual (e.g., the individual ceases to be eligible for COBRA continuation coverage), payment equal to the remainder of the credit outstanding must be made to the individual within 60 days of such day.

CONFERENCE AGREEMENT

In general

The conference agreement generally follows the House bill. Thus, as under the House bill, the rate of the premium subsidy is 65 percent of the premium for a period of coverage. However, the period of the premium subsidy is limited to a maximum of 9 months of coverage (instead of a maximum of 12 months). As under the House bill and Senate amendment, the premium subsidy is only provided with respect to involuntary terminations that occur on or after September 1, 2008, and before January 1, 2010.

The conference agreement includes the provision in the Senate amendment that permits a group health plan to provide a special enrollment right to assistance eligible individuals to allow them to change coverage options under the plan in conjunction with electing COBRA continuation coverage.[242] This provision only allows a group health plan to offer additional coverage options to assistance eligible individuals and does not change the basic requirement under Federal COBRA continuation coverage requirements that a group health plan must allow an assistance eligible individual to choose to continue with the coverage in which the individual is enrolled as of the qualifying event.[243] However, once the election of the other coverage is made, it becomes COBRA continuation coverage under the applicable COBRA continuation provisions. Thus, for example, under the Federal COBRA continuation coverage provisions, if a covered employee chooses different coverage pursuant to being provided this option, the different coverage elected must generally be permitted to be continued for the applicable required period (generally 18 months or 36 months, absent an event that permits coverage to be terminated under the Federal COBRA continuation provisions) even though the premium subsidy is only for nine months.

The conference agreement adds an income threshold as an additional condition on an individual's entitlement to the premium subsidy during any taxable year. The income threshold applies based on the modified adjusted gross income for an individual income tax return for the taxable year in which the subsidy is received (i.e., either 2009 or 2010) with respect to which the assistance eligible individual is the taxpayer, the taxpayer's spouse or a dependent of the taxpayer (within the meaning of section 152 of the Code, determined without regard to sections 152(b)(1), (b)(2) and (d)(1)(B)). Modified adjusted gross income for this purpose means adjusted gross income as defined in section 62 of the Code increased by any amount excluded from gross income under section 911, 931, or 933 of the Code. Under this income threshold, if the premium subsidy is provided with respect to any COBRA continuation coverage which covers the taxpayer, the taxpayer's spouse, or any dependent of the taxpayer during a taxable year and the taxpayer's modified adjusted gross income exceeds $145,000 (or $290,000 for joint filers), then the amount of the premium subsidy for all months during the taxable year must be repaid. The mechanism for repayment is an increase in the taxpayer's income tax liability for the year equal to such amount. For taxpayers with adjusted gross income between $125,000 and $145,000 (or $250,000 and $290,000 for joint filers), the amount of the premium subsidy for the taxable year that must be repaid is reduced proportionately.

Under this income threshold, for example, an assistance eligible individual who is eligible for Federal COBRA continuation coverage based on the involuntary termination of a covered employee in August 2009 but who is not entitled to the premium subsidy for the periods of coverage during 2009 due to having income above the threshold, may nevertheless be entitled to the premium subsidy for any periods of coverage in the remaining period (e.g. 5 months of coverage) during 2010 to which the subsidy applies if the modified adjusted gross income for 2010 of the relevant taxpayer is not above the income threshold.

The conference report allows an individual to make a permanent election (at such time and in such form as the Secretary of Treasury may prescribe) to waive the right to the premium subsidy for all periods of coverage. For the election to take effect, the individual must notify the entity (to which premiums are reimbursed under section 6432(a) of the Code) of the election. This waiver provision allows an assistance eligible individual who is certain that the modified adjusted gross income limit prevents the individual from being entitled to any premium subsidy for any coverage period to decline the subsidy for all coverage periods and avoid being subject to the recapture tax. However, this waiver applies to all periods of coverage (regardless of the tax year of the coverage) for which the individual might be entitled to the subsidy. The premium subsidy for any period of coverage cannot later be claimed as a tax credit or otherwise be recovered, even if the individual later determines that the income threshold was not exceeded for a relevant tax year. This waiver is made separately by each qualified beneficiary (who could be an assistance eligible individual) with respect to a covered employee.

Technical chances

The conference agreement makes a number of technical changes to the COBRA premium subsidy provisions in the House bill. The conference agreement clarifies that a reference to a period of coverage in the provision is a reference to the monthly or shorter period of coverage with respect to which premiums are charged with respect to such coverage. For example, the provision is effective for a period of coverage beginning after the date of enactment. In the case of a plan that provides and charges for COBRA continuation coverage on a calendar month basis, the provision is effective for the first calendar month following date of enactment.

The conference agreement specifically provides that if a person other than the individual's employer pays on the individual's behalf then the individual is treated as paying 35 percent of the premium, as required to be entitled to the premium subsidy. Thus, the conference agreement makes clear that, for this purpose, payment by an assistance eligible individual includes payment by another individual paying on behalf of the individual, such as a parent or guardian, or an entity paying on behalf of the individual, such as a State agency or charity.

The conference agreement clarifies that, for the special 60 day election period for a qualified beneficiary who is eligible for a reduced premium and who has not elected COBRA continuation coverage as of the date of enactment provided in the House bill, the election period begins on the date of enactment and ends 60 days after the notice is provided to the qualified beneficiary of the special election period. In addition, the conference agreement clarifies that coverage

[242] An employer can make this option available to covered employees under current law.

[243] All references to "Federal COBRA continuation coverage" mean the COBRA continuation coverage provisions of the Code, ERISA, and PHSA.

elected under this special election right begins with the first period of coverage beginning on or after the date of enactment. The conference agreement also extends this special COBRA election opportunity to a qualified beneficiary who elected COBRA coverage but who is no longer enrolled on the date of enactment, for example, because the beneficiary was unable to continue paying the premium.

The conference agreement clarifies that a violation of the new notice requirements is also a violation of the notice requirements of the underlying COBRA provision. As under the House bill, a notice must be provided to all individuals who terminated employment during the applicable time period, and not just to individuals who were involuntarily terminated.

As under the House bill, coverage under a flexible spending account ("FSA") is not eligible for the subsidy. The conference agreement clarifies that a FSA is defined as a health flexible spending account offered under a cafeteria plan within the meaning of section 125 of the Code.[244]

As under the House bill, there is a provision for expedited review, by the Secretary of Labor or Health and Human Services (in consultation with the Secretary of the Treasury), of denials of the premium subsidy. Under the conference agreement, such reviews must be completed within 15 business days (rather than 10 business days as provided in the House bill) after receipt of the individual's application for review. The conference agreement is intended to give the Secretaries the flexibility necessary to make determinations within 15 business days based upon evidence they believe, in their discretion, to be appropriate. Additionally, the conference agreement intends that, if an individual is denied treatment as an assistance eligible individual and also submits a claim for benefits to the plan that would be denied by reason of not being eligible for Federal COBRA continuation coverage (or failure to pay full premiums), the individual would be eligible to proceed with expedited review irrespective of any claims for benefits that may be pending or subject to review under the provisions of ERISA 503. Under the conference agreement, either Secretary's determination upon review is de novo and is the final determination of such Secretary.

The conference agreement clarifies the reimbursement mechanism for the premium subsidy in several respects. First, it clarifies that the person to whom the reimbursement is payable is either (1) the multiemployer group health plan, (2) the employer maintaining the group health plan subject to Federal COBRA continuation coverage requirements, and (3) the insurer providing coverage under an insured plan. Thus, this is the person who is eligible to offset its payroll taxes for purposes of reimbursement. It also clarifies that the credit for the reimbursement is treated as a payment of payroll taxes. Thus, it clarifies that any reimbursement for an amount in excess of the payroll taxes owed is treated in the same manner as a tax refund. Similarly, it clarifies that overstatement of reimbursement is a payroll tax violation. For example, IRS can assert appropriate penalties for failing to truthfully account for the reimbursement. However, it is not intended that any portion of the reimbursement is taken into account when determining the amount of any penalty to be imposed against any person, required to collect, truthfully account for, and pay over any tax under section 6672 of the Code.

It is intended that reimbursement not be mirrored in the U.S. possessions that have mirror income tax codes (the Commonwealth of the Northern Mariana Islands, Guam, and the Virgin Islands). Rather, the intent of Congress is that reimbursement will have direct application to persons in those possessions. Moreover, it is intended that income tax withholding payable to the government of any possession (American Samoa, the Commonwealth of the Northern Mariana Islands, the Commonwealth of Puerto Rico, Guam, or the Virgin Islands) (in contrast with FICA withholding payable to the U.S. Treasury) will not be reduced as a result of the application of this provision. A person liable for both FICA withholding payable to the U.S. Treasury and income tax withholding payable to a possession government will be credited or refunded any excess of (1) the amount of FICA taxes treated as paid under the reimbursement rule of the provision over (2) the amount of the person's liability for those FICA taxes.

Effective date

The provision is effective for periods of coverage beginning after the date of enactment. In addition, specific rules are provided in the case of an assistance eligible individual who pays 100 percent of the premium required for COBRA continuation coverage for any coverage period during the 60-day period beginning on the first day of the first coverage period after the date of enactment. Such rules follow the Senate amendment.

B. EXTENSION OF MINIMUM COBRA CONTINUATION COVERAGE (SEC. 3002(B) OF THE HOUSE BILL)

PRESENT LAW

A covered employee's termination of employment (other than for gross misconduct), whether voluntary or involuntary, is a COBRA qualifying [245] A covered employee's reduction in hours of employment, whether voluntary or involuntary, is also a COBRA qualifying event if the reduction results in a loss of employer sponsored group health plan coverage.[246]

The minimum length of coverage continuation that must be offered to a qualified beneficiary depends upon a number of factors, including the specific qualifying event that gives rise to a qualified beneficiary's right to elect coverage continuation. In the case of a qualifying event that is the termination, or reduction of hours, of a covered employee's employment, the minimum period of coverage that must be offered to each qualified beneficiary generally must extend until 18 months after the date of the qualifying event.[247] Under certain circumstances, however, the coverage continuation period can be extended up to a maximum total of 36 months. For example, if a second qualifying event occurs within the initial 18 month continuation period the initial period will be extended up to an additional 18 months (for a total of 36 months) for qualified beneficiaries other than the covered employee. Similarly, if a qualified beneficiary is determined to be disabled for purposes of Social Security during the first 60 days of the initial 18 month continuation coverage period, the initial 18 month period may be extended up to an additional 11 months (for a total of 29 months) for the disabled beneficiary and all of his or her covered family members. If a second qualifying event then occurs during the additional 11 month coverage period, the continuation period may be extended for another seven months, for a total of 36 months of continuation coverage.

HOUSE BILL

The provision amends section 4980B(f)(2)(B) to provide extended COBRA coverage periods for covered employees who qualify for COBRA continuation coverage due to termination of employment or reduction in hours and who (a) are age 55 or older, or (b) have 10 or more years of service with the employer, at the time of the qualifying event. Such individuals would be permitted to continue their COBRA coverage until the earlier of enrollment for Medicare benefits under title XVIII of the Social Security Act, becomes covered under another group health plan. (described in section 4980B(f)(2)(B)(iv)), or termination of all health plans sponsored by the employer offering the COBRA coverage. The extended coverage period would apply to all qualified beneficiaries of the covered employee.

(3) The provision makes parallel changes to ERISA and PHSA.

Effective date.—The provision is effective for periods of coverage which would (without regard to any amendments made by the provision) end on or after the date of enactment.

SENATE AMENDMENT

No provision.

CONFERENCE AGREEMENT

The conference agreement does not include the House bill provision.

MODIFY THE HEALTH COVERAGE TAX CREDIT (SECS. 1899 TO 1899L OF THE CONFERENCE AGREEMENT AND SECS. 35, 4980B, 7527, AND 9801 OF THE CODE)

PRESENT LAW

In general

Under the Trade Act of 2002,[248] in the case of taxpayers who are eligible individuals, a refundable tax credit is provided for 6 percent of the taxpayer's premiums for qualified health insurance of the taxpayer and qualifying family members for each eligible coverage month beginning in the taxable year. The credit is commonly referred to as the health coverage tax credit ("HCTC"). The credit is available only with respect to amounts paid by the taxpayer. The credit is available on an advance basis.[249]

Qualifying family members are the taxpayer's spouse and any dependent of the taxpayer with respect to whom the taxpayer is entitled to claim a dependency exemption. Any individual who has other specified coverage is not a qualifying family member.

Persons eligible for the credit

Eligibility for the credit is determined on a monthly basis. In general, an eligible coverage month is any month if, as of the first day of the month, the taxpayer (1) is an eligible individual, (2) is covered by qualified health insurance, (3) does not have other specified coverage, and (4) is not imprisoned under Federal, State, or local authority.[250] In the case of a joint return, the eligibility

[244] Other FSA coverage does not terminate eligibility for coverage. Coverage under another group Health Reimbursement Account ("HRA") will not terminate an individual's eligibility for the subsidy as long as the HRA is properly classified as an FSA under relevant IRS guidance. See Notice 2002-45, 2002-2 CB 93.

[245] Sec. 4980B(f)(3)(B); Treas. Reg. 54.4980B-4.

[246] Sec. 4980(f)(3)(B).

[247] Sec. 4980B((f)(2)(B)(I)(I). If coverage under a plan is lost on account of a qualifying event but the loss of coverage actually occurs at a later date, the minimum coverage period may be extended by the plan so that it is measured from the date when coverage is actually lost.

[248] Pub. L. No. 107-210 (2002).

[249] An individual is eligible for the advance payment of the credit once a qualified health insurance costs credit eligibility certificate is in effect. Sec. 7527. Unless otherwise indicated, all "section" references are to the Internal Revenue Code of 1986, as amended.

[250] An eligible month must begin after November 4, 2002. This date is 90 days after the date of enactment of the Trade Act of 2002, which was August 6, 2002.

requirements are met if at least one spouse satisfies the requirements.

An eligible individual is an individual who is (1) an eligible TAA recipient, (2) an eligible alternative Trade Adjustment Assistance ("TAA") recipient, or (3) an eligible Pension Benefit Guaranty Corporation ("PBGC") pension recipient.

An individual is an eligible TAA recipient during any month the individual (1) is receiving for any day of such month a trade readjustment allowance[251] or who would be eligible to receive such an allowance but for the requirement that the individual exhaust unemployment benefits before being eligible to receive an allowance and (2) with respect to such allowance, is covered under a certification issued under subchapter A or D of chapter 2 of title II of the Trade Act of 1974. An individual is treated as an eligible TAA recipient during the first month that such individual would otherwise cease to be an eligible TAA recipient.

An individual is an eligible alternative TAA recipient during any month if the individual (1) is a worker described in section 246(a)(3)(B) of the Trade Act of 1974 who is participating in the program established under section 246(a)(1) of such Act, and (2) is receiving a benefit for such month under section 246(a)(2) of such Act. An individual is treated as an eligible alternative TAA recipient during the first month that such individual would otherwise cease to be an eligible TAA recipient.

An individual is a PBGC pension recipient for any month if he or she (1) is age 55 or over as of the first day of the month, and (2) is receiving a benefit any portion of which is paid by the PBGC. The IRS has interpreted the definition of PBGC pension recipient to also include certain alternative recipients and recipients who have received certain lump-sum payments on or after August 6, 2002. A person is not an eligible individual if he or she may be claimed as a dependent on another person's tax return.

An otherwise eligible taxpayer is not eligible for the credit for a month if, as of the first day of the month, the individual has other specified coverage. Other specified coverage is (1) coverage under any insurance which constitutes medical care (except for insurance substantially all of the coverage of which is for excepted benefits)[252] maintained by an employer (or former employer) if at least 50 percent of the cost of the coverage is paid by an employer[253] (or former employer) of the individual or his or her spouse or (2) coverage under certain governmental health programs. Specifically, an individual is not eligible for the credit if, as of the first day of the month, the individual is (1) entitled to benefits under Medicare Part A, enrolled in Medicare Part B, or enrolled in Medicaid or SCHIP, (2) enrolled in a health benefits plan under the Federal Employees Health Benefit Plan, or (3) entitled to receive benefits under chapter 55 of title 10 of the United States Code (relating to military personnel). An individual is not considered to be enrolled in Medicaid solely by reason of receiving immunizations.

A special rule applies with respect to alternative TAA recipients. For eligible alternative TAA recipients, an individual has other specified coverage if the individual is (1) eligible for coverage under any qualified health insurance (other than coverage under a COBRA continuation provision, State-based continuation coverage, or coverage through certain State arrangements) under which at least 50 percent of the cost of coverage is paid or incurred by an employer of the taxpayer or the taxpayer's spouse or (2) covered under any such qualified health insurance under which any portion of the cost of coverage is paid or incurred by an employer of the taxpayer or the taxpayer's spouse.

Qualified health insurance

Qualified health insurance eligible for the credit is: (1) COBRA continuation[254] coverage; (2) State-based continuation coverage provided by the State under a State law that requires such coverage; (3) coverage offered through a qualified State high risk pool; (4) coverage under a health insurance program offered to State employees or a comparable program; (5) coverage through an arrangement entered into by a State and a group health plan, an issuer of health insurance coverage, an administrator, or an employer; (6) coverage offered through a State arrangement with a private sector health care coverage purchasing pool; (7) coverage under a State-operated health plan that does not receive any Federal financial participation; (8) coverage under a group health plan that is available through the employment of the eligible individual's spouse; and (9) coverage under individual health insurance if the eligible individual was covered under individual health insurance during the entire 30-day period that ends on the date the individual became separated from the employment which qualified the individual for the TAA allowance, the benefit for an eligible alternative TAA recipient, or a pension benefit from the PBGC, whichever applies.[255]

Qualified health insurance does not include any State-based coverage (i.e., coverage described in (2)-(7) in the preceding paragraph), unless the State has elected to have such coverage treated as qualified health insurance and such coverage meets certain requirements.[256] Such State coverage must provide that each qualifying individual is guaranteed enrollment if the individual pays the premium for enrollment or provides a qualified health insurance costs eligibility certificate and pays the remainder of the premium. In addition, the State-based coverage cannot impose any pre-existing condition limitation with respect to qualifying individuals. State-based coverage cannot require a qualifying individual to pay a premium or contribution that is greater than the premium or contribution for a similarly situated individual who is not a qualified individual. Finally, benefits under the State-based coverage must be the same as (or substantially similar to) benefits provided to similarly situated individuals who are not qualifying individuals.

A qualifying individual is an eligible individual who seeks to enroll in the State-based coverage and who has aggregate periods of creditable coverage[257] of three months or longer, does not have other specified coverage, and who is not imprisoned. In general terms, creditable coverage includes health care coverage without a gap of more than 63 days. Therefore, if an individual's qualifying coverage were terminated more than 63 days before the individual enrolled in the State-based coverage, the individual would not be a qualifying individual and would not be entitled to the State-based protections. A qualifying individual also includes qualified family members of such an eligible individual.

Qualified health insurance does not include coverage under a flexible spending or similar arrangement or any insurance if substantially all of the coverage is for excepted benefits.

Other rules

Amounts taken into account in determining the credit may not be taken into account in determining the amount allowable under the itemized deduction for medical expenses or the deduction for health insurance expenses of self-employed individuals. Amounts distributed from a medical savings account or health savings accounts are not eligible for the credit. The amount of the credit available through filing a tax return is reduced by any credit received on an advance basis. Married taxpayers filing separate returns are eligible for the credit; however, if both spouses are eligible individuals and the spouses file separate returns, then the spouse of the taxpayer is not a qualifying family member.

The Secretary of the Treasury is authorized to prescribe such regulations and other guidance as may be necessary or appropriate to carry out the credit provision.

COBRA

The Consolidated Omnibus Reconciliation Act of 1985 ("COBRA") requires that a group health plan must offer continuation coverage to qualified beneficiaries in the case of a qualifying event. An excise tax under the Code applies on the failure of a group health plan to meet the requirement.[258] Qualifying events include the death of the covered employee, termination of the covered employee's employment, divorce or legal separation of the covered employee, and certain bankruptcy proceedings of the employer. In the case of termination from employment, the coverage must be extended for a period of not less than 18 months. In certain other cases, coverage must be extended for a period of not less than 36 months. Under such period of continuation coverage, the plan may require payment of a premium by the beneficiary of up to 102 percent of the applicable premium for the period.

HOUSE BILL

No provision.

[251] The eligibility rules and conditions for such an allowance are specified in chapter 2 of title II of the Trade Act of 1974. Among other requirements, payment of a trade readjustment allowance is conditioned upon the individual enrolling in certain training programs or receiving a waiver of training requirements.

[252] Excepted benefits are: (1) coverage only for accident or disability income or any combination thereof; (2) coverage issued as a supplement to liability insurance; (3) liability insurance, including general liability insurance and automobile liability insurance; (4) worker's compensation or similar insurance; (5) automobile medical payment insurance; (6) credit-only insurance; (7) coverage for on-site medical clinics; (8) other insurance coverage similar to the coverages in (1)–(7) specified in regulations under which benefits for medical care are secondary or incidental to other insurance benefits; (9) limited scope dental or vision benefits; (10) benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; and (11) other benefits similar to those in (9) and (10) as specified in regulations; (12) coverage only for a specified disease or illness; (13) hospital indemnity or other fixed indemnity insurance; and (14) Medicare supplemental insurance.

[253] An amount is considered paid by the employer if it is excludable from income. Thus, for example, amounts paid for health coverage on a salary reduction basis under an employer plan are considered paid by the employer. A rule aggregating plans of the same employer applies in determining whether the employer pays at least 50 percent of the cost of coverage.

[254] COBRA continuation is defined in section 9832(d)(1).

[255] For this purpose, "individual health insurance" means any insurance which constitutes medical care offered to individuals other than in connection with a group health plan. Such term does not include Federal- or State-based health insurance coverage.

[256] For guidance on how a State elects a health program to be qualified health insurance for purposes of the credit, see Rev. Proc. 2004-12, 2004-1 C.B. 528.

[257] Creditable coverage is determined under the Health Insurance Portability and Accountability Act, Sec. 9801(c).

[258] Sec. 4980B.

SENATE AMENDMENT

No provision.[259]

CONFERENCE AGREEMENT

Increase in credit percentage amount

The provision increases the amount of the HCTC to 80 percent of the taxpayer's premiums for qualified health insurance of the taxpayer and qualifying family members.

Effective date.—The provision is effective for coverage months beginning on or after the first day of the first month beginning 60 days after date of enactment. The increased credit rate does not apply to months beginning after December 31, 2010.

Payment for monthly premiums paid prior to commencement of advance payment of credit

The provision provides that the Secretary of Treasury shall make one or more retroactive payments on behalf of certified individuals equal to 80 percent of the premiums for coverage of the taxpayer and qualifying family members for qualified health insurance for eligible coverage months occurring prior to the first month for which an advance payment is made on behalf of such individual. The amount of the payment must be reduced by the amount of any payment made to the taxpayer under a national emergency grant pursuant to section 173(f) of the Workforce Investment Act of 1998 for a taxable year including such eligible coverage months.

Effective date.—The provision is effective for eligible coverage months beginning after December 31, 2008. The Secretary of the Treasury, however, is not required to make any payments under the provision until after the date that is six months after the date of enactment. The provision does not apply to months beginning after December 31, 2010.

TAA recipients not enrolled in training programs eligible for credit

The provision modifies the definition of an eligible TAA recipient to eliminate the requirement that an individual be enrolled in training in the case of an individual receiving unemployment compensation. In addition, the provision clarifies that the definition of an eligible TAA recipient includes an individual who would be eligible to receive a trade readjustment allowance except that the individual is in a break in training that exceeds the period specified in section 233(e) of the Trade Act of 1974, but is within the period for receiving the allowance.

Effective date.—The provision is effective for months beginning after the date of enactment in taxable years ending after such date. The provision does not apply to months beginning after December 31, 2010.

TAA pre-certification period rule for purposes of determining whether there is a 63-day lapse in creditable coverage

Under the provision, in determining if there has been a 63-day lapse in coverage (which determines, in part, if the State-based consumer protections apply), in the case of a TAA-eligible individual, the period beginning on the date the individual has a TAA-related loss of coverage and ending on the date which is seven days after the date of issuance by the Secretary (or by any person or entity designated by the Secretary) of a qualified health insurance costs credit eligibility certificate (under section 7527) for such individual is not taken into account.

Effective date.—The provision is effective for plan years beginning after the date of enactment. The provision does not apply to plan years beginning after December 31, 2010.

Continued qualification of family members after certain events

The provision provides continued eligibility for the credit for family members after certain events. The rule applies in the case of (1) the eligible individual becoming entitled to Medicare, (2) divorce and (3) death.

In the case of a month which would be an eligible coverage month with respect to an eligible individual except that the individual is entitled to benefits under Medicare Part A or enrolled in Medicare Part B, the month is treated as an eligible coverage month with respect to the individual solely for purposes of determining the amount of the credit with respect to qualifying family members (i.e., the credit is allowed for expenses paid for qualifying family members after the eligible individual is eligible for Medicare). Such treatment applies only with respect to the first 24 months after the eligible individual is first entitled to benefits under Medicare Part A or enrolled in Medicare Part B.

In the case of the finalization of a divorce between an eligible individual and the individual's spouse, the spouse is treated as an eligible individual for a period of 24 months beginning with the date of the finalization of the divorce. Under such rule, the only family members that may be taken into account with respect to the spouse as qualifying family members are those individuals who were qualifying family members immediately before such divorce finalization.

In the case of the death of an eligible individual, the spouse of such individual (determined at the time of death) is treated as an eligible individual for a period of 24 months beginning with the date of death. Under such rule, the only qualifying family members that may be taken into account with respect to the spouse are those individuals who were qualifying family members immediately before such death. In addition, any individual who was a qualifying family member of the decedent immediately before such death[260] treated as an eligible individual for a period of 24 months beginning with the date of death, except that in determining the amount of the HCTC only such qualifying family member may be taken into account.

Effective date.—The provision is effective for months beginning after December 31, 2009. The provision does not apply to months that begin after December 31, 2010.

Alignment of COBRA coverage

The maximum required COBRA continuation coverage period is modified by the provision with respect to certain individuals whose qualifying event is a termination of employment or a reduction in hours. First, in the case of such a qualifying event with respect to a covered employee who has a nonforfeitable right to a benefit any portion of which is paid by the PBGC, the maximum coverage period must end not earlier than the date of death of the covered employee (or in the case of the surviving spouse or dependent children of the covered employee, not earlier than 24 months after the date of death of the covered employee). Second, in the case of such a qualifying event where the covered employee is a TAA eligible individual as of the date that the maximum coverage period would otherwise terminate, the maximum coverage period must extend during the period that the individual is a TAA eligible individual.

Effective date.—The provision is effective for periods of coverage that would, without regard to the provision, end on or after the date of enactment, provided that the provision does not extend any periods of coverage beyond December 31, 2010.

Addition of coverage through voluntary employees' beneficiary associations

The provision expands the definition of qualified health insurance by including coverage under an employee benefit plan funded by a voluntary employees' beneficiary association ("VEBA", as defined in section 501(c)(9)) established pursuant to an order of a bankruptcy court, or by agreement with an authorized representative, as provided in section 1114 of title 11, United States Code.

Effective date.—The provision is effective on the date of enactment. The provision does not apply with respect to certificates of eligibility issued after December 31, 2010.

Notice requirements

The provision requires that the qualified health insurance costs credit eligibility certificate provided in connection with the advance payment of the HCTC must include (1) the name, address, and telephone number of the State office or offices responsible for providing the individual with assistance with enrollment in qualified health insurance, (2) a list of coverage options that are treated as qualified health insurance by the State in which the individual resides, (3) in the case of a TAA-eligible individual, a statement informing the individual that the individual has 63 days from the date that is seven days after the issuance of such certificate to enroll in such insurance without a lapse in creditable coverage, and (4) such other information as the Secretary may provide.

Effective date.—The provision is effective for certificates issued after the date that is six months after the date of enactment. The provision does not apply to months beginning after December 31, 2010.

Survey and report on enhanced health coverage tax credit program

Survey

The provision requires that the Secretary of the Treasury must conduct a biennial survey of eligible individuals containing the following information:

1. In the case of eligible individuals receiving the HCTC (including those participating in the advance payment program (the "HCTC program")) (A) demographic information of such individuals, including income and education levels, (B). satisfaction of such individuals with the enrollment process in the HCTC program, (C) satisfaction of such individuals with available health coverage options under the credit, including level of premiums, benefits, deductibles, cost-sharing requirements, and the adequacy of provider networks, and (D) any other information that the Secretary determines is appropriate.

2. In the case of eligible individuals not receiving the HCTC (A) demographic information on each individual, including income and education levels, (B) whether the individual was aware of the HCTC or the HCTC program, (C) the reasons the individual has not enrolled in the HCTC program, including whether such reasons include the burden of process of enrollment and the affordability of coverage, (D) whether the individual has health insurance coverage, and, if so, the source of such coverage, and (E) any other information that the Secretary determines is appropriate.

Not later than December 31 of each year in which a survey described above is conducted (beginning in 2010), the Secretary of Treasury must report to the Committee on Finance and the Committee on Health, Education, Labor, and Pensions of the Senate and the Committee on Ways and Means and the Committee on Education and Labor of the House of Representatives the findings of the most recent survey.

Report

Not later than October 1 of each year (beginning in 2010), the Secretary of Treasury

[259] The Senate amendment did not amend the HCTC, but section 1701 of the Senate amendment provided for a temporary extension of the Trade Adjustment Assistance Program (generally until December 31, 2010). Certain beneficiaries of this program are eligible for the HCTC.

[260] In the case of a dependent, the rule applies to the taxpayer to whom the personal exemption deduction under section 151 is allowable.

must report to the Committee on Finance and the Committee on Health, Education, Labor, and Pensions of the Senate and the Committee on Ways and Means and the Committee on Education and Labor of the House of Representatives the following information with respect to the most recent taxable year ending before such date:

1. In each State and nationally (A) the total number of eligible individuals and the number of eligible individuals receiving the HCTC, (B) the total number of such eligible individuals who receive an advance payment of the HCTC through the HCTC program, (C) the average length of the time period of participation of eligible individuals in the HCTC program, and (D) the total number of participating eligible individuals in the HCTC program who are enrolled in each category of qualified health insurance with respect to each category of eligible individuals.

2. In each State and nationality, an analysis of (A) the range of monthly health insurance premiums, for self-only coverage and for family coverage, for individuals receiving the benefit of the HCTC and (B) the average and median monthly health insurance premiums, for self-only coverage and for family coverage, for individuals receiving the HCTC with respect to each category of qualified health insurance.

3. In each State and nationally, an analysis of the following information with respect to the health insurance coverage of individuals receiving the HCTC who are enrolled in State-based coverage: (A) deductible amounts, (B) other out-of-pocket cost-sharing amounts, and (C) a description of any annual or lifetime limits on coverage or any other significant limits on coverage services or benefits. The information must be reported with respect to each category of coverage.

4. In each State and nationally, the gender and average age of eligible individuals who receive the HCTC in each category of qualified health insurance with respect to each category of eligible individuals.

5. The steps taken by the Secretary of the Treasury to increase the participation rates in the HCTC program among eligible individuals, including outreach and enrollment activities.

6. The cost of administering the HCTC program by function, including the cost of subcontractors, and recommendations on ways to reduce the administrative costs, including recommended statutory changes.

7. After consultation with the Secretary of Labor, the number of States applying for and receiving national emergency grants under section 173(f) of the Workforce Investment Act of 1998, the activities funded by such grants on a State-by-State basis, and the time necessary for application approval of such grants.

Other non-revenue provisions

The provision also authorizes appropriations for implementation of the revenue provisions of the provision and provides grants under the Workforce Investment Act of 1998 for purposes related to the HCTC.

GAO study

The provision requires the Comptroller General of the United States to conduct a study regarding the HCTC to be submitted to Congress no later than March 31, 2010. The study is to include an analysis of (1) the administrative costs of the Federal government with respect to the credit and the advance payment of the credit and of providers of qualified health insurance with respect to providing such insurance to eligible individuals and their families, (2) the health status and relative risk status of eligible individuals and qualified family members covered under such insurance, (3) participation in the credit and the advance payment of the credit by eligible individuals and their qualifying family members, including the reasons why such individuals did or did not participate and the effects of the provision on participation, and (4) the extent to which eligible individuals and their qualifying family members obtained health insurance other than qualifying insurance or went without insurance coverage. The provision provides the Comptroller General access to the records within the possession or control of providers of qualified health insurance if determined relevant to the study. The Comptroller General may not disclose the identity of any provider of qualified health insurance or eligible individual in making information available to the public.

EFFECTIVE DATE

The provision is generally effective upon the date of enactment, excepted as otherwise noted above.

TITLE IV—HEALTH INFORMATION TECHNOLOGY

Subtitle C—Incentives for the Use of Health Information Technology

Part II—Medicare Program

INCENTIVES FOR ELIGIBLE PROFESSIONALS. (HOUSE BILL SEC. 4311; SENATE BILL SEC. 4201; CONFERENCE AGREEMENT SEC. 4101)

CURRENT LAW

There are several current legislative and administrative initiatives to promote the use of Health Information Technology (HIT) and Electronic Health Records (EHR's) in the Medicare program. The Medicare Modernization Act of 2003 (MMA; P.L. 108-173) established a timetable for the Centers for Medicare and Medicaid Services (CMS) to develop e-prescribing standards, which provide for the transmittal of such information as eligibility and benefits (including formulary drugs), information on the drug being prescribed and other drugs listed in the patient's medication history (including drug-drug interactions), and information on the availability of lower-cost, therapeutically appropriate alternative drugs. CMS issued a set of foundation standards in 2005, then piloted and tested additional standards in 2006, several of which were part of a 2008 final rule. The final Medicare e-prescribing standards, which become effective on April 1, 2009, apply to all Part D sponsors, as well as to prescribers and dispensers that electronically transmit prescriptions and prescription-related information about Part D drugs prescribed for Part D eligible individuals. The MMA did not require Part D drug prescribers and dispensers to e-prescribe. Under its provisions, only those who choose to e-prescribe must comply with the new standards. However, the Medicare Improvement for Patients and Providers Act of 2008 (MIPPA; P.L. 110-275) included an e-prescribing mandate and authorized incentive bonus payments for e-prescribers between 2009 and 2013. Beginning in 2012, payments will be reduced for those who fail to e-prescribe.

CMS is administering a number of additional programs to promote EHR adoption. The MMA mandated a three-year pay-for-performance demonstration in four states (AR, CA, MA, UT) to encourage physicians to adopt and use EHR to improve care for chronically ill Medicare patients. Physicians participating in the Medicare Care Management Performance (MCMP) demonstration receive bonus payments for reporting clinical quality data and meeting clinical performance standards for treating patients with certain chronic conditions. They are eligible for an additional incentive payment for using a certified EHR and reporting the clinical performance data electronically.

CMS has developed a second demonstration to promote EHR adoption using its Medicare waiver authority. The five-year Medicare EHR demonstration is intended to build on the foundation created by the MCMP program. It will provide financial incentives to as many as 1,200 small- to medium-sized physician practices in 12 communities across the country for using certified EHRs to improve quality, as measured by their performance on specific clinical quality measures. Additional bonus payments will be made based on the number of EHR functionalities a physician group has incorporated into its practice.

The Tax Relief and Health Care Act of 2006 (P.L. 109-432) established a voluntary physician quality reporting system, including an incentive payment for Medicare providers who report data on quality measures. The Medicare Physician Quality Reporting Initiative (PQRI) was expanded by the Medicare, Medicaid, and SCHIP Extension Act of 2007 (P.L. 110-173) and by MIPPA, which authorized the program indefinitely and increased the incentive that eligible physicians can receive for satisfactorily reporting quality measures. In 2009, eligible physicians may earn a bonus payment equivalent to 2.0% of their total allowed charges for covered Medicare physician fee schedule services. The PQRI quality measures include a structural measure that conveys whether a physician has and uses an EHR.

HOUSE BILL

The House bill would add an incentive payment to certain eligible professionals for the adoption and "meaningful use," defined below, of a certified EHR system. Professionals eligible for the incentive payments are those who participate in Medicare and who are defined under Sec. 1861(r) of the Social Security Act.

Incentive payments. The amount of EHR incentive payments that eligible providers could receive would be capped, based on the

based on statements of earnings, revenues, gains, or other criteria that are found to be materially inaccurate to the next 20 most highly compensated employees of a TARP recipient; (2) expanding the prohibition on the payment of golden parachute payments from senior executive officers to the next five most highly compensated employees of the TARP recipient, and defining the term "golden parachute payment" as any payment to a senior executive officer for departure from a company for any reason, except for payments for services performed or benefits accrued; and (3) prohibiting a TARP recipient from paying or accruing any bonus, retention award, or incentive compensation to at least the 25 most highly compensated employees; and (4) prohibiting any compensation plan that would encourage manipulation of the reported earnings of a TARP recipient to enhance the compensation of any of its employees. The provision also provides rules relating to the compensation committees of TARP recipients, nonbinding shareholder votes on executive compensation payable by a TARP recipient, and the adoption by TARP recipients of policies regarding luxury expenditures such as entertainment, aviation, and office renovation expenses.

CONFERENCE AGREEMENT

The conference agreement follows the Senate amendment with several modifications. Among the modifications are (1) a rule that provides that financial assistance under TARP is not treated as outstanding for a period in which the United States only holds warrants to purchase common stock of the TARP recipient; (2) rules that phase-in the restriction on bonuses, retention awards, and other incentive compensation by the amount of financial assistance received by the entity receiving TARP assistance, and that permit compensation to be paid in the form of restricted stock; and (3) and a directive to the Secretary of the Treasury to review compensation paid to senior executive officers and the next 20 most highly compensated employees of an entity receiving TARP assistance before the date of enactment to determine whether such payments were inconsistent with the provision, the TARP, or public interest.

TAX COMPLEXITY ANALYSIS

Section 4022(b) of the Internal Revenue Service Reform and Restructuring Act of 1998 (the "IRS Reform Act") requires the staff of the Joint Committee on Taxation (in consultation with the Internal Revenue Service and the Treasury Department) to provide a tax complexity analysis. The complexity analysis is required for all legislation reported by the Senate Committee on Finance, the House Committee on Ways and Means, or any committee of conference if the legislation includes a provision that directly or indirectly amends the Internal Revenue Code and has widespread applicability to individuals or small businesses. For each such provision identified by the staff of the Joint Committee on Taxation a summary description of the provision is provided along with an estimate of the number and type of affected taxpayers, and a discussion regarding the relevant complexity and administrative issues.

Following the analysis of the staff of the Joint Committee on Taxation are the comments of the IRS and Treasury regarding each of the provisions included in the complexity analysis.

1. MAKE WORK PAY CREDIT

SUMMARY DESCRIPTION OF THE PROVISION

The provision creates a refundable tax credit for taxable years beginning in 2009 and 2010 equal to the lesser of (1) 6.2 percent of an individual's earned income or (2) $400 ($800 in the case of a joint return). The credit is phased out at a rate of two percent of the eligible individual's modified adjusted gross income above $75,000 ($150,000 in the case of a joint return).

NUMBER OF AFFECTED TAXPAYERS

It is estimated that the provision will affect in excess of 100 million individual tax returns.

DISCUSSION

The provision will require additional paperwork for taxpayers and additional processing burdens for IRS. It is expected that taxpayers will need to complete additional worksheets and or forms to compute the amount of the credit. Taxpayers may also wish to adjust their income tax withholding by filing the appropriate forms before the end of 2009. The IRS is anticipated to revise income tax withholding schedules and publish new schedules. These revised income tax withholding schedules should be designed to reduce taxpayers' income tax withheld for each remaining pay period in the remainder of 2009 so that the full benefit of the provision is reflected in the income tax withholding schedules during the balance of 2009.

2. EXTENSION OF ALTERNATIVE MINIMUM TAX RELIEF FOR INDIVIDUALS

SUMMARY DESCRIPTION OF THE PROVISION

The provision increases the individual AMT exemption amount for taxable years beginning in 2009 to $70,950 in the case of married individuals filing a joint return and surviving spouses; $46,700 in the case of other unmarried individuals; and $35,475 in the case of married individuals filing separate returns. In addition, for taxable years beginning in 2009, the provision allows an individual to offset the entire regular tax liability and alternative minimum tax liability by the nonrefundable personal credits.

NUMBER OF AFFECTED TAXPAYERS

It is estimated that the provision will affect approximately 25 million individual tax returns.

DISCUSSION

Many individuals will not have to compute their alternative minimum tax and file the IRS forms relating to that tax.

3. SPECIAL ALLOWANCE FOR CERTAIN PROPERTY ACQUIRED DURING 2009

SUMMARY DESCRIPTION OF THE PROVISION

The provision extends the additional first-year depreciation deduction for one year, generally through 2009 (through 2010 for certain longer-lived and transportation property).

NUMBER OF AFFECTED TAXPAYERS

It is estimated that more than 10 percent of small businesses will be affected by the provision.

DISCUSSION

It is not anticipated that small businesses will have to keep additional records due to this provision, nor will additional regulatory guidance be necessary to implement this provision. It is not anticipated that the provision will result in an increase in disputes between small businesses and the IRS. However, small businesses will have to perform additional analysis to determine whether property qualifies for the provision. In addition, for qualified property, small businesses will be required to perform additional calculations to determine the proper amount of allowable depreciation. Complexity may also be increased because the provision is temporary. For example, different tax treatment will apply for identical equipment based on the acquisition and placed in service date. Further, the Secretary of the Treasury is expected to have to make appropriate revisions to the applicable depreciation tax forms.

4. PREMIUM ASSISTANCE FOR COBRA BENEFITS

SUMMARY DESCRIPTION OF THE PROVISION

The provision reimburses employers providing COBRA continuation health coverage to employees to the extent of 65 percent of the premium amount for up to nine months and requires the eligible individual to pay 35 percent of the premium. The program is mandatory for employers required to offer COBRA continuation health coverage. Eligible individuals must have a qualifying event between September 1, 2008 and December 31, 2009, and must have been terminated involuntarily. Firms providing COBRA benefits will be able to allow those electing COBRA to choose from other insurance options at the time of the qualifying event, and firms will be able to contribute to the individual portion of the premium. Lastly, the benefit phases out for single taxpayers with modified adjusted gross incomes between $125,000 and $145,000 ($250,000 and $290,000 for joint filers) for the taxable year.

Employers will pay reduced payroll taxes in the aggregate amount of 65 percent of the premium for all individuals who opt into the provision, or, if COBRA subsidy exceeds payroll taxes, employers will be reimbursed directly through a program established by the Department of Treasury. COBRA continuation health coverage for this purpose includes not only coverage that applies to private, nongovernmental employers with 20 or more employees but also coverage rules that apply to Federal and State and local governmental employers pursuant to Federal law, and to State law mandates that apply to small employers (employers with less than 20 employees) and other employers not covered by Federal law, provided that such State law mandates require an employer or other entity to offer comparable continuation health coverage. The social security trust fund is held harmless from payroll tax offsets that are permitted under the program.

NUMBER OF AFFECTED TAXPAYERS

It is estimated that more than 10 percent of small businesses will be affected by the provision.

DISCUSSION

This provision will require additional processing by the IRS in three areas; accounting, income eligibility and provision enforcement. First, for all firms with eligible employees, the firm must deduct that amount from their payroll taxes, so IRS must be aware of the number of employees eligible for the reimbursement and the average monthly premium at the firm to properly assess the amount of the deduction from payroll taxes. The Department of Treasury must then transfer the appropriate amount of funds back into the social security trust fund. All employers bound by COBRA or COBRA-type legislation described above, and who terminate individuals from employment between September 1, 2008, and December 31, 2009, are affected by this provision. In addition, firms are permitted to collect full premiums from individuals for 60 days in accordance with their current premium billing cycles, but must then credit back the difference in later payments or if later payments are insufficient to credit back all funds, the employer will submit payment to the individual. The IRS must also distinguish between the 65 percent of subsidy contribution mandated and any optional firm contribution to the remaining 35 percent of premium.

Second, the income eligibility provision in the bill limits eligibility for the modified adjusted gross income limit of the provision

phasing out between $125,000 and $145,000 for single filers ($250,000 and $290,000 for joint filers) for the taxable year. While individuals may waive the subsidy if they believe their earnings will exceed the limit, if an individual accepts the subsidy and earns over the limit the individual will be responsible for paying the subsidy back to Treasury. For married individuals filing separately, if any family member is over the single modified adjusted gross income limit of $125,000, the entire non-subsidized portion (this accounts for the phase out) must be repaid. This clause requires IRS to match the incomes of spouses filing separately and determine if the modified adjusted gross income of either spouse disqualifies both for the subsidy received. Children not claimed as dependents, however, who are still on family plans have their incomes excluded from this limitation.

Third, the IRS must create rules and regulations to prevent fraud and abuse of this provision. For example, taxpayers may be required to provide evidence of eligibility for the subsidy including evidence of involuntary separation from work, which can include attestation from the former employer or certification from state unemployment insurance agencies. If a premium assistance eligible individual becomes eligible for other group coverage while receiving premium assistance, that individual must forfeit the subsidy or face a penalty and the IRS must attempt to prevent individuals from claiming the subsidy while eligible for other group coverage either through a spouse or through a new employer.

COMPLIANCE WITH CLAUSE 9 OF RULE XXI (EARMARKS)

Pursuant to clause 9 of rule XXI of the Rules of the House of Representatives, neither this conference report nor the accompanying joint statement of managers contains any congressional earmarks, limited tax benefits, or limited tariff benefits as defined in clause 9(e), 9(f), or 9(g) of rule XXI.

DAVID OBEY,
CHARLES RANGEL,
HENRY WAXMAN,
Managers on the Part of the House.

DANIEL K. INOUYE,
MAX BAUCUS,
HARRY REID,
Managers on the Part of the Senate.

RECESS

The SPEAKER pro tempore. Pursuant to clause 12(a) of rule I, the Chair declares the House in recess subject to the call of the Chair.

Accordingly (at 10 o'clock and 26 minutes p.m.), the House stood in recess subject to the call of the Chair.

□ 0001

AFTER RECESS

The recess having expired, the House was called to order by the Speaker pro tempore (Mr. PERLMUTTER) at 12 o'clock and 1 minute a.m.

REPORT ON RESOLUTION PROVIDING FOR CONSIDERATION OF CONFERENCE REPORT ON H.R. 1, AMERICAN RECOVERY AND REINVESTMENT ACT OF 2009

Mr. POLIS of Colorado, from the Committee on Rules, submitted a privileged report (Rept. No. 111–17) on the resolution (H. Res. 168) providing for consideration of the conference report to accompany the bill (H.R. 1) making supplemental appropriations for job preservation and creation, infrastructure investment, energy efficiency and science, assistance to the unemployed, and State and local fiscal stabilization, for the fiscal year ending September 30, 2009, and for other purposes, which was referred to the House Calendar and ordered to be printed.

SPECIAL ORDERS GRANTED

By unanimous consent, permission to address the House, following the legislative program and any special orders heretofore entered, was granted to:

(The following Members (at the request of Mr. ISRAEL) to revise and extend their remarks and include extraneous material:)

Ms. ROYBAL-ALLARD, for 5 minutes, today.

Ms. WOOLSEY, for 5 minutes, today.

Mr. DEFAZIO, for 5 minutes, today.

Ms. KAPTUR, for 5 minutes, today.

Mr. HOLT, for 5 minutes, today.

(The following Members (at the request of Mr. ROE of Tennessee) to revise and extend their remarks and include extraneous material:)

Mr. PAUL, for 5 minutes, today and February 13.

Mr. PENCE, for 5 minutes, today.

Mr. BROUN of Georgia, for 5 minutes, today.

Mr. ROE of Tennessee, for 5 minutes, today.

Mr. FRANKS of Arizona, for 5 minutes, today.

Mr. FORTENBERRY, for 5 minutes, today.

(The following Member (at her request) to revise and extend her remarks and include extraneous material:)

Ms. VELÁZQUEZ, for 5 minutes, today.

ADJOURNMENT

Mr. POLIS of Colorado. Mr. Speaker, I move that the House do now adjourn.

The motion was agreed to; accordingly (at 12 o'clock and 2 minutes a.m.), the House adjourned until today, Friday, February 13, 2009, at 9 a.m.

EXECUTIVE COMMUNICATIONS, ETC.

Under clause 8 of rule XII, executive communications were taken from the Speaker's table and referred as follows:

569. A letter from the Deputy Under Secretary for Acquisition and Technology, Department of Defense, transmitting a report identifying each extension of a contract period to a total of more than 10 years that was granted under 10 U.S.C. 2304a(f) for the Department's task and delivery order contracts during fiscal year 2008, pursuant to Public Law 108-375, section 813; to the Committee on Armed Services.

570. A letter from the Principal Deputy Assistant Attorney General, Department of Justice, transmitting notification that the Department complies with the guidelines of the No FEAR Act; to the Committee on Oversight and Government Reform.

571. A letter from the Chairman and Chief Executive Officer, Farm Credit Administration, transmitting notification that the Administration is in compliance with the Government in Sunshine Act for calendar year 2008; to the Committee on Oversight and Government Reform.

572. A letter from the Chairman, International Trade Commission, transmitting the Commission's semiannual report from the office of the Inspector General for the period April 1, 2008 through September 30, 2008, pursuant to 5 U.S.C. app. (Insp. Gen. Act) section 5(b); to the Committee on Oversight and Government Reform.

573. A letter from the Attorney Advisor, Department of Homeland Security, transmitting the Department's final rule — Saftey Zone; Flagler Museum New Year's Eve Celebration fireworks display, West Palm Beach, Florida [Docket No.: USCG-2008-1120] (RIN: 1625-AA00) received February 2, 2009, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

574. A letter from the Program Analyst, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; Airbus Model A318, A319, A320, and A321 Airplanes [Docket No.: FAA-2008-0558; Directorate Identifier 2007-NM-365-AD; Amendment 39-15783; AD 2009-01-04] (RIN: 2120-AA64) received January 30, 2009, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

575. A letter from the Program Analyst, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; Bombardier Model CL-600-2C10 (Regional Jet Series 700, 701, & 702) and Model CL-600-2D24 (Regional Jet Series 900) Airplanes [Docket No.: FAA-2008-0540; Directorate Identifier 2008-NM-031-AD; Amendment 39-15786; AD 2009-01-07] (RIN: 2120-AA64) received January 30, 2009, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

576. A letter from the Program Analyst, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; Turbomeca Arriel 2B and 2B1 Turboshaft Engines [Docket No.: FAA-2008-0935; Directorate Identifier 2008-NE-28-AD; Amendment 39-15790; AD 2009-01-11] (RIN: 2120-AA64) received January 30, 2009, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

577. A letter from the Program Analyst, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; Boeing Model 737-600,-700,-700C, -800 and -900 Series Airplanes [Docket No.: FAA-2007-28283; Directorate Identifier 2006-NM-254-AD; Amendment 39-15780; AD 2009-01-02] (RIN: 2120-AA64) received January 30, 2009, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

578. A letter from the Program Analyst, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; Polskie Zaklady Lotnicze Spolka zo.o Model PZL M26 01 Airplanes [Docket No.: FAA-2009-0010; Directorate Identifier 2009-CE-001-AD; Amendment 39-15792; AD 2009-02-02] (RIN: 2120-AA64) received January 30, 2009, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

579. A letter from the Program Analyst, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; Bombardier Model DHC-8-400 Series Airplanes [Docket No.: FAA-2008-1083; Directorate Identifier 2008-NM-130-AD;