HEALTH CARE REFORM

A SUMMARY FOR THE WONKISH

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TO MARIE

TABLE OF CONTENTS

INTRODUCTION

PATIENT PROTECTION AND AFFORDABLE HEALTH CARE ACT

TITLE I. Quality, Affordable Health Care
TITLE II. Role of Public Programs
TITLE III. Quality and Efficiency of Health Care
TITLE IV. Chronic Disease Prevention
TITLE V. Health Care Workforce
TITLE VI. Transparency and Program Integrity
TITLE VII. Access to Innovative Medical Therapies
TITLE VIII. CLASS Act
TITLE IX Revenue Provisions
TITLE X. Quality, Affordable Health Care for All

HEALTH CARE AND EDUCATION RECONCILIATION ACT

TITLE I. Coverage, Medicare, Medicaid, and Revenues
TITLE II. Education and Health

APPENDIX. Timeline for Selected Health Care Reforms

INTRODUCTION

Love it or hate it, you should know what's in it.

Through new federal legislation, breathtaking changes have been made in the nation's health care system. Americans need to know what health care reform entails and how it affects them. Yet few people have time to read literally thousands of pages of congressional legislation.

This summary relies principally on two sources: the Patient Protection and Affordable Care Act of 2010 (P.L. 111-148), which was signed into law on March 23, 2010, and the Health Care and Education Reconciliation Act of 2010 (P.L 111-152), signed March 30, 2010. Occasional editorial notes seek to explain or clarify certain points.

These Acts have to be read with care. Provisions written in in some places are written out later. For example, Section 2001 of the Patient Protection Act requires that health insurance coverage of dependents continues for an adult child who is not married up to age 26. Section 2301 of the Reconciliation Act drops "who is not married". That kind of thing happens a lot.

A 35,000 word summary is far from short. It is intended for Americans of wonkish bent who want to know what the new laws say without wading through dense legalese, internal cross-referencing, or amendments involving trips to related legislation.

The summary focuses on the final legislative product as constituted by the two new Acts. The two Acts will be further amended over time as discrepancies arise and experience is gained. But in their present form they convey the scope of reform. Where appropriate, reference is made to other existing laws that are modified, such as the Public Health Service Act and the Social Security Act.

Over the next decade, big changes in health care will unfold. While the private health care insurance sector remains intact and States continue to play a major role, the federal government, particularly the U.S. Department of Health and Human Services, takes on vast new responsibilities in the regulation, financing and coordination of the health care system.

Not all the legislated reforms come into force immediately, but come they will. (See timeline in the Appendix.)

Health care insurance coverage is mandated for most U.S. residents. Insurance companies are barred from discriminating based on pre-existing conditions. A network of mainly State-based American Health Benefits Exchanges will make coverage affordable and available to more people. An estimated

additional 34 million people will acquire coverage between 2010 and 2019. Many individuals and families will receive premium and cost-sharing subsidies.

Eligibility for Medicaid is expanded to non-elderly individuals with incomes below 133 percent of the federal poverty line. There is additional funding for the Children's Health Insurance Program (CHIP). The Medicare prescription drug "donut hole" is completely filled by 2020. A new non-subsidized federal insurance program will support people needing long-term care.

There is emphasis on wellness, disease prevention primary care, medical team practice, and patient-centered medical homes. Investments are made in the healthcare workforce to expand primary care and other areas of practice.

Much of this is praiseworthy but little of it comes free. Total health care spending is estimated to grow by over $800 billion between 2010 and 2019.

To offset higher costs, federal revenues are increased through measures like an excise tax on high-cost insurance plans, fees or excise taxes on drugs, higher Medicare payroll taxes and a tax on capital gains for upper income taxpayers.

Employers not offering health care insurance must make payments to the government. Penalties are imposed or expanded for fraud and abuse. The growth rate of Medicare payments for most services will be reduced. Payments to Medicare Advantage plans will be scaled down.

Cautionary cost estimates have been released by the Congressional Budget Office (March 20, 2010) and the Office of the Actuary in the Center for Medicare and Medicaid Services (CMS), an agency within the U.S. Department of Health and Human Services (April 22, 2010). The Congressional Budget Office projects a $124 billion reduction in the federal deficit over a ten-year period. In other words the reforms are fully paid for. But . . .

Crucially this estimate depends on whether the legislation's cost-cutting and revenue-increasing provisions remain unchanged over the 2010-2019 period. The congressional track record in this regard is not encouraging. In 1997, to remedy out-of-control Medicare physician payments, Congress created a Sustainable Growth Rate formula that would reduce physician payments by about 4-5 percent annually. For each of the past seven years, Congress has overridden the mandated reductions.

CMS' Office of the Actuary concludes that payment reductions for health care services based on economy-wide productivity gains will most likely prove unworkable.

Measures to slow medical spending growth rates face headwinds from segments of the health care industry. When providers anticipate payment reductions, they step up the volume and intensity of services. The expansions of health care coverage and use of services by new enrollees could more than offset planned reductions in health care cost growth.

If the projected savings do not materialize over the next decade, the federal deficit could well grow, not shrink.

Many reforms are unprecedented and relevant historical experience is wanting. Legal challenges have been raised against certain elements of the new legislation, e.g. the mandate for individuals to purchase health insurance or pay a penalty. Adjustments (at a minimum) will be needed.

Consequently the specific impacts on the nation's health, health care expenditures, the insurance industry, employer behavior, individual choices, the federal debt and the economy as a whole are impossible to predict with confidence.

In short the health care reform process has not ended.

Stay tuned.

Note 1. The Patient Protection and Affordable Care Act has ten titles. Some sections of Title X modify or repeal certain sections in Titles I-IX. The same is true of sections in the separate Health Care and Education Reconciliation Act. These changes are included and referenced within the relevant sections of Titles I-IX. The sections that do not amend earlier titles but add substantive new provisions remain lodged within the Title X and Reconciliation Act section summaries.

Note 2. Unless otherwise indicated, "Secretary" refers to the Secretary of Health and Human Services. The Comptroller General is the head of the Government Accountability Office, a research and investigative arm of Congress.

Robert F. Clark
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PATIENT PROTECTION AND AFFORDABLE CARE ACT OF 2010
(P.L. 111-148)

TITLE I.
QUALITY, AFFORDABLE HEALTH CARE

Subtitle A. Improvements in Health Care Coverage

Section 1001. The Public Health Service Act is amended by this section and Section 10101. Group health plans and individual or group health care insurers may not establish lifetime limits or, beginning in 2014, set annual limits on the dollar value of benefits. Insurers may not rescind coverage, except for fraud or intentional misrepresentation of material fact.

Insurers shall provide evidence-based preventive services; immunizations; preventive care and screenings for infants, children and adolescents and additional preventive care and screenings for women. As amended by Section 2301 of the Reconciliation Act, dependent coverage of adult children, married or unmarried, shall continue until age 26.

Insurers shall provide a summary of benefits and coverage. Insurers shall disclose information such as claims policies and ratings information as required under Section 1311 of this Act. A plan not offered through an Exchange must make the information available to the Secretary, State insurance commissioners and general public. If plans are modified, insurers will notify enrollees within 60 days of the modification.

[EDITOR'S NOTE. An American Health Benefits Exchange will be a government agency or a nonprofit entity established by the State to facilitate the purchase of qualified health plans. It will help establish a Small Business Health Options Program (SHOP Exchange) that assists small businesses in the enrollment of their employees in qualified health plans in the small group market. See Section 1311 and more below.]

Sponsors of a group health plan (except for self-insured plans) may not set eligibility for coverage rules based on the salary of an employee or otherwise discriminate in favor of higher wage employees. Group health plans may not discriminate in favor of highly compensated employees (e.g. by restricting eligibility for certain benefits to them).

As amended by Section 10101, wellness and prevention programs may not require the disclosure of information regarding individuals' lawful possession of firearms.

Within two years of enactment, the Secretary shall promulgate regulations on health plan and insurance reimbursement. The Government Accountability Office shall study the impact of changes under this section on the quality and cost of health care.

Insurers shall provide the Secretary with a clear annual accounting for costs. If the ratio of premium revenue spent on costs to total premium revenue is less than 85 percent for group plans and less than 80 percent for individual plans—or lower percentages as set by State regulation—enrollees shall receive an annual rebate from their insurers equal to the exceeded amounts.

Hospitals shall establish, update and make public a list of charges for items and services including Diagnosis Related Groups (DRG). Insurers shall implement a process for appeals of coverage determinations and claims.

[EDITOR'S NOTE. Section 1886(d) of the Social Security Act prescribes a system of payment for acute care hospital inpatient stays under Medicare Part A based on prospectively set rates. Under this Prospective Payment System (PPS), each case is categorized into one of several hundred diagnosis-related groups (DRG). Based on diagnosis, procedures, age, sex and other factors, patients clustered in a group are expected to use a similar level of hospital resources. Each DRG has a payment weight assigned to it, based on the average resources used to treat Medicare patients in that DRG.]

Enrollees may select their primary care provider from any available participating provider. Prior authorizations or cost-sharing for emergency services are eliminated, whether the emergency service is in or out of network. Plans may not require prior authorization or referral for participants seeking coverage for gynecological or obstetrical services.

Section 1002. The Secretary shall award grants to States or Exchanges to support offices of health insurance consumer assistance or ombudsman programs. $30 million is appropriated

for such grants for the first fiscal year and such sums as may be required thereafter.

Section 1003. The Secretary shall award grants over a five year period beginning in 2010 to assist States in monitoring trends in premium increases. Particular insurers may be excluded from participating in Exchanges based on unjustifiable premium increases. The appropriation for such grants is $250 million. As added by Section 10101, medical reimbursement data centers are established to develop market-based fee schedules for medical services.

Section 1004. The provisions of this subtitle and amendments shall become effective for plan years on or after six months from the date of enactment of this Act, except for Sections 1002 and 1003 which become effective on the date of enactment.

Subtitle B. Actions to Preserve and Expand Coverage

Section 1101. Within 90 days after enactment, the Secretary shall establish a temporary high risk health insurance pool program. A high risk pool insurance issuer shall not exclude otherwise eligible individuals based on any pre-existing conditions; shall provide coverage that is not less than 65 percent of total allowed costs; shall set out-of-pocket limits as determined by the Internal Revenue Code of 1986 (section 223(c)(2)) unless modified by the Secretary; and vary premiums only within certain designated parameters (e.g. a factor no greater than 4 to 1 based on age). The program will end January 1, 2014.

[EDITOR'S NOTE. In 2014, the Exchanges open in the States.]

If dumping by an insurer—that is, encouraging certain enrollees to disenroll and obtain coverage in the high risk pool program—is found, the insurer shall be required to reimburse the program for medical expenses incurred by their former enrollee. $5 billion are appropriated with no fiscal year limitation to pay claims against and administrative costs of the high risk pool not otherwise covered by premiums.

Section 1102. The Secretary shall establish a temporary reinsurance program that reimburses employment-based plans for a portion of the cost of providing health insurance coverage for early retirees and to their eligible spouses, surviving spouses and dependents.

[EDITOR'S NOTE. Early retirees are retired persons aged 55 or older but not eligible for coverage under Title XVIII of the Social Security Act (Medicare).]

The Secretary shall reimburse participating plans for 80 percent of the costs attributable to a claim that exceeds $15,000 but not more than $90,000. Adjustments shall be made each fiscal year based on the medical care component of the Consumer Price Index. $5 billion are appropriated for the program with no fiscal year limitation. The program ends January 1, 2014.

Section 1103. The Secretary, in consultation with the States, shall establish a mechanism, including a website, by which State residents can identify affordable health care

insurance. The options include coverage by health insurance issuers, Medicaid, Title XXI of the Social Security Act (State Children's Health Insurance Program or SCHIP), State health benefits high risk pool if such exists and the federal temporary high risk health insurance pool program under Section 1101.

Section 1104. The Secretary shall develop operating rules that reduce the clerical burden on patients, health care providers, and health plans. Operating rules shall cover eligibility for a health plan, claim status transactions, electronic funds transfers, payments, remittances, enrollments, disenrollments, referrals, and authorizations. The Secretary shall impose penalty fees on health plans for failure to comply with standards and operating rules.

Subtitle C. Quality Health Insurance Coverage

PART I—HEALTH INSURANCE MARKET REFORMS

Section 1201. As amended by Section 1001, insurance premiums may vary only by whether coverage is for an individual or family; the rating area; age and tobacco use. If rating areas have not been set by the State or are found to be inadequate, the Secretary may establish them. The Secretary, in consultation with the National Association of Insurance Commissioners, shall establish age bands for rating purposes.

Each health insurance issuer in the individual or group market must accept every employer and individual that applies for coverage in the State. Enrollment may be restricted to open or special enrollment periods. A health insurance issuer must renew or continue in force its coverage in the individual or group market at the option of the plan sponsor or individual.

Rules governing eligibility for coverage may *not* be established that use the following factors: health status; medical condition; claims experience; receipt of health care; medical history; genetic information; evidence of insurability; disability; any other health status-related factor determined by the Secretary.

A employer-sponsored health promotion and disease prevention (or wellness) program that includes a reward like a premium discount or rebate shall normally not impose a health status standard that a participant must meet. If there is a health status-related standard, the value of the reward may not exceed 30 percent of the cost of coverage for a participating employee; the Secretary may increase the reward percentage up to 50 percent. The program shall be made available to all similarly situated individuals.

No later than July 1, 2014, the Secretary, in consultation with the Secretary of the Treasury and the Secretary of Labor, shall establish a ten-State demonstration project under which enrollment and reward provisions of this section are applied to wellness programs offered by insurers in the individual market (as distinct from employer-sponsored programs). If the demonstration is effective, the Secretary may expand it to additional States beginning July 1, 2017.

No later than three years after enactment, the Secretary, in consultation with the Secretary of the Treasury and the Secretary of Labor, shall report to the appropriate committees of Congress on the impact of wellness programs and the effectiveness of different types of rewards.

An insurer shall not discriminate against any health care provider acting within the scope of its State license or certification.

An insurer in the individual or small group market must offer coverage that includes a package of essential health benefits as described in section 1302(a). Child-only plans must receive the same type and level of coverage as other plans. Dental only plans are excluded from this provision. Enrollment waiting periods may not exceed 90 days.

PART II—OTHER PROVISIONS

Section 1251. As amended by Section 10103 of this Act and Section 2301 of the Reconciliation Act, no one is required to terminate existing health care insurance coverage as a result of this legislation. This subtitle shall not apply to a plan in which an individual was enrolled prior to enactment of this legislation. Collective bargaining agreements reached under such plans shall remain in force until the termination date of the agreements.

Section 1252. Any standard or requirement adopted by a State under this title shall be applied uniformly to all insurance plans in the covered market.

Section 1253. The effective date of this subtitle and amendments is January 1, 2014.

Subtitle D. Available Coverage Choices

PART I—QUALIFIED HEALTH PLANS

Section 1301. A qualified health plan is one that (a) meets the requirements of each Exchange where it is offered; (b) provides essential health benefits; (c) offers at least one plan at the silver level and one at the gold; (d) agrees to charge the same premium whether the plan is offered through the Exchange, directly from the issuer or through an agent; and (d) complies with regulations issued by the Secretary and requirements of the applicable Exchange.

Section 1302. Essential health benefits shall include at a minimum: ambulatory patient service, emergency services, hospitalization, maternity and newborn care, mental health and substance abuse services, prescription drugs, habilitative and rehabilitative services and devices, laboratory services, prevention and wellness services, pediatric services including oral and vision care. The Secretary shall ensure that the scope of essential health benefits is equal to what is offered under a typical employer plan.

The Secretary shall make sure that an appropriate balance is maintained among the essential health benefit elements. Rates, coverage and benefits may not discriminate against individuals on the basis of age, disability of remaining life expectancy. Benefits must meet the needs of a diverse population, including women, children, and people with disabilities.

Plans may not impose prior authorization requirements or other limitations on emergency departments that go beyond those in force for emergency departments with which plans have a contractual relationship. Cost-sharing requirements for out-of-network services shall not exceed those applied to in-network services.

Out of pocket limits may not exceed those of Health Savings Accounts. For health plans in a small group market, the deductible shall not exceed $2,000 for a plan covering an individual and $4,000 for any other plan. For plan years beginning after 2014 the deductible for individuals is indexed according to the increase in average per capita premiums. This provision shall be applied without affecting the actuarial value of a plan.

Catastrophic-only coverage may be offered to persons under age 30 in the individual market in cases of hardship or if broader coverage is unaffordable. As amended by Section 10104, payments to federally qualified health centers by qualified health plans may not be less than payments to such centers under Medicaid.

Levels of coverage are specified as follows. A bronze level plan provides benefits that are actuarially equivalent to 60 percent of the full actuarial benefits provided under the plan. For silver, gold and platinum levels, the corresponding percentages are 70 percent, 80 percent and 90 percent respectively.

By regulation, the Secretary may take into consideration an employer's contributions to a health savings account in determining the coverage level for an employer's plan. A plan offered by an issuer under the Exchange at any level (bronze, silver, gold, platinum) shall also be offered as a plan at that level where the only enrollees are under age 21.

Section 1303. The issuer of a qualified health plan may decide whether or not to include abortion services as part of its essential health benefits. There can be no payment for abortion services attributable to the tax credit under section 36b of the Internal Revenue Code of 1986 or cost-sharing reduction. For plans offering abortion services where no federal funds may be expended, the Secretary shall segregate the costs from all other plan services.

Federal funds may be used to pay for abortion services where and as permitted under Title XIX (Medicaid) of the Social Security Act. For each Exchange, the Secretary shall make sure that there is at least one qualified health plan that provides for abortion services, whether or not paid for with federal funds, and at least one plan that does not provide for abortion services. If contrary to moral or religious beliefs, no provider of care or health care facility may be discriminated against for refusing to directly provide, cover, pay for or make referrals for abortions.

Section 1304. Group market refers to the market through which individuals many obtain health care insurance coverage for themselves and dependents under a group plan offered by an employer. Individual market refers to the market through

which individuals many obtain health care insurance coverage for themselves and dependents in a manner different from employer-based group coverage.

A large employer is one that employs an average of at least 101 employees on business days during the preceding calendar year and has at least one employee on day 1 of the plan year. Under a similar construction, a small employer is one that employs between 1 and 100 employees. For plan years beginning prior to January 1, 2016, a State may alter the size categories by substituting 51 for 101 and 50 for 100.

PART II—HEALTH BENEFIT EXCHANGES

Section 1311. As amended by Section 10203, the Secretary shall award grants to States for the purpose of establishing American Health Benefits Exchanges. No grant shall be awarded for this purpose after January 1, 2015.

Through regulation, the Secretary shall establish criteria for the certification of qualified health plans. The Secretary shall develop a rating system for qualified health plans at each level (bronze, silver, etc.) offered by an Exchange on the basis of relative quality and price. Additionally the Secretary shall evaluate enrollee satisfaction with qualified health plans that had 500 or more enrollees the previous year. The Secretary shall maintain an Internet portal and assist States in setting up their own portals as sources of information and assistance to individuals and employers.

No later than January 1, 2012, the Secretary shall require Exchanges to provide for an initial enrollment period, annual enrollment periods thereafter, special enrollment periods as specified under Internal Revenue Code of 1986 and part D of Title XVIII (Medicare prescription drug benefits) of the Social Security Act, and special monthly enrollment periods for Indians.

A plan that offers only limited scope dental benefits may be offered through the Exchange provided it meets the relevant requirements under the Internal Revenue Code of 1986.

A State may require that health plans offered through the Exchange offer benefits in addition to the essential health benefits specified in this Act. To defray their cost of required

additional benefits, the State shall make payments to individuals for the premium tax credit under 36B of the Internal Revenue Code of 1986 and any cost-sharing reduction under section 1402 of this Act in cases where an individual is not eligible for such credit or reduction.

An Exchange shall at a minimum certify, decertify and/or recertify health plans as qualified health plans under guidelines developed by the Secretary. It shall provide for a toll-free telephone hotline for enrollees and maintain an Internet website. It shall assign a rating to each qualified health plan in accordance with the criteria developed by the Secretary.

The Exchange shall use a standardized format for presenting health benefits options. It shall inform individuals of eligibility requirements for enrollment in Medicaid, the Children's Health Insurance Program or CHIP (respectively, Titles XIX and XXI of the Social Security Act) and other applicable State or local programs and shall enroll eligible individuals in such programs.

The Exchange shall develop an electronically based calculator for determining the actual cost of coverage after the application of a premium tax credit or cost-sharing reduction.

An Exchange shall publish on a website the average costs of licensing, regulatory fees, administration, and other payments, as well as funds lost to waste, fraud and abuse. An Exchange may not exclude an otherwise qualified health plan from certification based on the plan being fee-for-service or by imposing premium price controls or on grounds that treatments to prevent patients' deaths are inappropriate or too costly.

Health plans seeking certification must submit to the Exchange justification for any proposed premium increase. The Exchange will take into account evidence of patterns of excessive or unjustified premium increases within the State and comparisons of premium growth inside and outside the Exchange.

An Exchange may operate in more than one State if each State gives permission and the Secretary so approves. States may establish subsidiary Exchanges if they serve geographically distinct areas and each area is at least as large as the rating area specified in section 2701(a) of the Public Health Service Act.

An Exchange may reward qualified health plan entities with increased reimbursement and other incentives for improved health outcomes achieved through such means as effective case management, care coordination and the medical home model; reduced hospital readmissions through patient education and comprehensive discharge planning; fewer medical errors through appropriate use of the best clinical practices and health information technologies; and implementation of health and wellness activities.

Beginning January 1, 2015 a qualified health plan may contract with a hospital with more than 50 beds provided that it utilizes an approved patient safety evaluation system and comprehensive discharge planning. It may also contract with a health care provider that implements health care quality mechanisms. The Secretary may permit exceptions to these requirements and may adjust the number of beds required for a hospital to qualify.

An Exchange shall award grants to "navigators" that raise awareness about qualified health plans, facilitate enrollment, make referrals to consumer assistance agencies or ombudsmen regarding enrollee questions, complaints or grievances and disseminate information in culturally and linguistically appropriate forms to populations being served.

Navigators may include such entities as trade associations, fishing, ranching and farming organizations, consumer-focused nonprofit organizations, chambers of commerce, unions, small business development centers, and licensed insurance agents and brokers.

There shall be parity between mental health benefits and other benefits (e.g. regarding dollar limits) offered by qualified health plans.

Section 1312. A qualified individual may enroll in any available qualified health plan. An exception is a catastrophic health plan where enrollment is limited to an eligible individual as determined under section 1302(e). For the individual market and for the small group market separately, an insuring entity shall consider all enrollees in all qualified health plans (except grandfathered plans) offered by the Exchange and all enrollees in other non-Exchange plans to be part of a single risk pool. A State may require the merger of the two markets.

Members of Congress shall obtain coverage through a qualified health plan offered under an Exchange.

The Secretary shall establish rules under which agents and brokers may enroll individuals in a qualified health plan offered by an Exchange in the individual or small group market and may assist individuals in applying for premium tax credits and cost sharing reductions.

Section 1313. The Exchange shall keep an accurate accounting of all activities, expenditures and receipts and submit a report annually to the Secretary. Exchanges are subject to an annual audit by the Secretary, who may also examine and investigate an Exchange's affairs, properties and records.

If an Exchange or a State has engaged in serious misconduct, the Secretary may desist from making payments of up to one percent a year until adequate corrective actions have been taken. The Secretary shall have the authority to implement measures or procedures designed to reduce fraud and abuse.

Payments made by or through an Exchange are subject to the False Claims Act. Civil penalties imposed on persons found liable for fraud and abuse shall be increased by not less than three times and not more than six times the damages sustained by the government.

No later than five years after the Exchanges are required to be operational, the Government Accountability Office shall engage in an ongoing study of Exchange activities and their enrollees.

PART III—STATE FLEXIBILITY

Section 1321. In consultation with the National Association Insurance Commissioners and other stakeholders, the Secretary shall issue regulations regarding Exchanges, qualified health plans, reinsurance and risk adjustment programs, and other appropriate requirements. If a State fails to establish an Exchange or implement the Secretary's requirements by January 1, 2014, the Secretary may directly or through a nonprofit entity establish an Exchange in that State.

For a State Exchange operating prior to January 1, 2010, the Secretary shall presume that it meets the standards for Exchanges (unless there is a determination to the contrary) and shall assist any such State in bringing the Exchange into full compliance.

Section 1322. The Secretary shall establish a Consumer Operated and Oriented Program (CO-OP) whose purpose is to create nonprofit health insurers that issue qualified health plans in a State's individual and small group market.

To be qualified, a nonprofit organization shall be subject to a majority vote of its members, have built-in protections against insurance industry involvement and interference, and operate with a strong consumer focus. An organization's profits shall be used to lower premiums, improve benefits and implement other measures for improving the quality of its members' health care.

CO-OP participants may establish a private purchasing council to make collective purchases of items and services (e.g. claims administration, actuarial services). The Secretary shall ensure that there is sufficient funding to establish at least one nonprofit health insurer in each State. The CO-OP shall have an advisory board on no fewer than 15 members appointed by the U.S. Comptroller General. The Advisory Board shall terminate no later than December 31, 2014. $6 billion is appropriated to carry out the CO-OP.

The Government Accountability Office shall study competition and market concentration in the United States and the impact of market reforms in this Act. By December 31 of 2014 and each even numbered year thereafter, the Comptroller General shall report the results of its study and recommendations to the appropriate committees of Congress.

Section 1323. This section established a community health insurance option. It was eliminated by Section 10104 of this Act. Under Section 1204 of the Reconciliation Act, this new Section 1323 is added that increases by $2 billion the federal funding for Puerto Rico, Virgin Islands, Guam, American Samoa and the Northern Marianas Islands. The cap on federal funding is raised and the Territories may elect to operate a health benefits exchange.

[EDITOR'S NOTE. The community health insurance option was also known as the public plan.]

Section 1324. In general private health insurers shall not be subject to federal or State law under this Act if a qualified health plan under the CO-OP, community health insurance option, or nationwide qualified health plan is exempt from such law.

Section 1331. Under a basic health program, intended for low income individuals not eligible for Medicaid, States may offer eligible individuals one or more standard health plans providing essential health benefits as specified in section 1302(b). The premium shall not be more than the premium if an individual had enrolled in the applicable second lowest cost silver plan through the Exchange.

Cost sharing under a basic health plan shall not exceed the cost sharing under a platinum plan for individuals whose household income is below 150 percent of the poverty line and may not exceed cost sharing under a gold plan for all other income levels. For a plan insured by a health insuring entity, the medical loss ratio must be at least 85 percent.

[EDITOR'S NOTE. A medical loss ratio is the percentage of revenues from premiums that is used to pay for health care services.]

A State shall seek to make multiple standard health plans available and may enter into regional compacts with other States to cover eligible individuals. A State shall coordinate the basic health program with its Medicaid program and Child Health Insurance Program (Titles XIX and XXI of the Social Security Act) and any other State-administered health programs.

The State shall set up a trust fund for funds transferred to the State by the Secretary. The amount transferred shall be that which is determined to be equal to 85 percent of the premium tax credit under Title 36B of the Internal Revenue Code of 1986 and the cost sharing reductions under section 1402 below that eligible individuals would have received if they had been allowed to enroll in a qualified health plan under the Exchange.

To be eligible for the basic health program, an individual must be a resident of a State who is not eligible for a State's Medicaid program; whose household income is between 133-200 percent of the poverty line; who is not eligible for an employer-sponsored health plan; and who is below age 65. individuals eligible for this program shall not be treated as qualified to enroll in the Exchange as set forth in section 1312.

For plan years beginning on or after January 1, 2017, a State may apply to the Secretary for a waiver of any or all requirements concerning premium tax credits, cost sharing reductions, and/or small business credits. However, under such waivers, the Secretary shall provide alternative means by which the State shall be paid an amount equivalent to that which would have been paid in the absence of such waivers.

A waiver may be granted only if the Secretary determines that coverage and cost-sharing reductions will be at least as comprehensive as they would be without the waiver and will not increase the federal deficit.

The Secretary shall develop a process for coordinating the waiver provisions of this Act with other waivers authorized under Titles XVIII (Medicaid), XIX (Medicare) and XXI (State Children's Health Insurance Program) of the Social Security Act. The Secretary shall make a determination on whether to grant the waiver not later than 180 days after receipt of a State's waiver application.

If granted, the waiver period shall not extend beyond 5 years unless the State requests a continuation and the Secretary does not within 90 days deny the request or require the submission of additional information.

Section 1333. No later than January 1, 2013, the Secretary, in consultation with the National Association of Insurance Commissioners, shall issue regulations for creating health care choice compacts among States. By this means, two or more States may agree to let one or more qualified health plans be offered in all participating States subject to the laws and regulations of the State where a plan was initially written or issued.

The Secretary shall approve such health care choice compacts among States only if the coverage will be at least as comprehensive as that offered by the Exchanges, will provide

coverage and cost-sharing protection against excessive out-of-pocket spending and will not increase the federal deficit. A health care choice compact shall not take effect before January 1, 2016.

The issuer of a nationwide qualified health plan in the individual or small group market may offer the plan in more than one State and only the State laws where the plan was written shall apply. A State may by law opt out of accepting the plan. To qualify nationwide, a health plan must offer a uniform benefits package. The plan's issuer must be licensed in each State where the plan is offered and be subject to State law that is not inconsistent with this Act or Part A of Title XXVII of the Public Health Service Act.

[EDITOR'S NOTE: This provision concerns portability, access and renewability requirements for group markets.]

The issuer must meet all the requirements of a qualified health care plan including offering the silver and gold levels of the plan in each Exchange. The issuer shall notify and clearly explain to consumers which benefits under its nationwide plan may differ from those mandated by the State for other plans. An issuer may appeal a State's disapproval of a nationwide health plan to the Secretary.

PART V – REINSURANCE AND RISK ADJUSTMENT

Section 1341. No later that January 1, 2014, each State shall implement a health reinsurance program either directly or under contract with one or more reinsurance entities. The program shall conform to regulations issued by the Secretary in consultation with the National Association of Insurance Commissioners.

Third party administrators of group health plans shall make payments to a reinsurance entity for any plan year beginning during a three year period starting January 1, 2014. The reinsurance entity shall make payments to health plan issuers covering high risk individuals during plan years over the 3 year period. A reinsurance entity may at each State's discretion carry out the program in two or more States.

A high risk individual shall be identified based on at least 50 but no more than 100 high risk conditions or any other comparable objective method recommended by the American

Academy of Actuaries. Payment amounts may be specified for each identified high risk condition or comparable method as recommended by the American Academy of Actuaries.

Contributions to the reinsurance program shall be based proportionally on each contributing issuer's fully insured commercial book of business, the value of all fees charged by the issuer, and the cost of coverage where the issuer is a third party administrator. The aggregate contributions for all States (excluding the reinsurer's administrative expenses) shall be $10 billion for plan years beginning in 2014, $6 billion for 2015, and $4 billion for 2016.

Additionally, for each calendar year in the three year period, each contributor's amount reflects its proportionate share of an additional $2 billion for 2014, and additional $2 billion for 2015 and an additional $1 billion for 2016.

The contribution amounts may be used in any year of the three year period or to reflect experience in a prior period. Unexpended amounts may be used for a reinsurance program beginning in 2017 for a two year period. An exception is the additional proportionate share from each contributor; any unexpended funds from this source shall be deposited in the U.S. Treasury.

Section 1342. For the years 2014, 2015, and 2016, the Secretary shall establish a program of risk corridors similar to the program under Part D, Title XVIII of the Social Security Act. If a participating plan's allowable costs for a plan year are over 103 percent but not more than 108 percent, the Secretary will pay the plan an amount equal to half of the amount over 103 percent. If a plan's costs are over 108 percent, the Secretary shall pay the plan 2.5 percent of the target amount plus 80 percent of the costs over the 108 percent threshold.

Conversely if a plan's allowable costs are less than 97 percent but not less than 92 percent, the plan shall pay the Secretary an amount equal to half the amount that is in excess of 97 percent . If the plan's allowable costs are less than 92 percent, the plan shall pay the Secretary 2.5 percent of the target amount plus 80 percent of the costs over the 92 percent threshold.

If a plan has a low actuarial risk compared to the average actuarial risk for all other plans and coverage in the State for a

plan year, the State shall assess a charge on the health insuring entity. If a plan has high actuarial coverage, the State shall make a payment to the plan and the health insuring entity. (Excluded from such actuarial charges or payments are self-insured group health plans that are subject to the Employee Retirement Income Security Act of 1974.)

The risk corridor program is applicable to insurers in the individual and small group market. Allowable costs are total costs for benefits minus administrative expenses and as reduced by risk adjustment and reinsurance payments. The target amount is equal to all premiums minus administrative costs.

[EDITOR'S NOTE: Risk corridors are designed to protect insurers and enrollees against significant cost fluctuations due to factors like expensive new medications.]

Subtitle E. Affordable Coverage Choices

PART I—PREMIUM TAX CREDITS

Section 1401. To assist with the cost of health care premiums, the Internal Revenue Code of 1986 is amended by a new section 36B, Section 10501 of this Act and Sections 1001 and 1004 of the Reconciliation Act. A premium tax credit is calculated on a sliding scale that ranges from 2.0 percent for households below 133 percent of the federal poverty line up to 9.5 percent for households at 400 percent of the poverty line.

Apart from certain specified dental benefits, if a qualified health plan offers benefits beyond the required essential health benefits, the portion of the premium allocable to these additional benefits shall not be taken into account in determining the monthly premium relevant to the tax credit. No later than five years after enactment, the Comptroller General shall conduct a study of the affordability of health insurance coverage.

Section 1402. The issuer of a qualified heath plan shall reduce the cost-sharing for an eligible individual, that is, an individual who is enrolled in a silver level of coverage and whose household income exceeds 100 percent and but is less than 400 percent of the federal poverty line. For individuals between 300-400 percent, 200-300 percent, and 100-200 percent of the poverty line, out of pocket costs shall be reduced by 1/3, 1/ 2, or 2/3, respectively.

As amended by Section 1001 of the Reconciliation Act, the Secretary shall make sure that such cost reductions do not increase the plan's share to more than 94 percent of total allowed costs for individuals at 100-150 percent of poverty, more than 87 percent at 150-200 percent of poverty, or more than 73 percent at 200-250 percent of poverty and 70 percent at 250-400 percent of poverty. The Secretary shall make periodic and timely payments to issuers equal to the value of the cost reductions.

These cost reduction provisions apply only to essential health benefits, not additional benefits offered by the issuer or mandated by the State. Cost-sharing rules related to poverty lines shall not apply to reductions properly allocated to pediatric dental benefits that are included as an essential

health benefit but offered separately from a qualified health plan.

The issuer shall eliminate any cost-sharing for an Indian whose household income does not exceed 300 percent of the poverty line. Cost-sharing reductions shall not be made for otherwise eligible individuals who are not lawfully present as aliens or as citizens or nationals of the United States.

Section 1411. The Secretary shall establish procedures for determining: whether an individual who seeks coverage in the individual market through the Exchange or who claims a premium tax credit or reduced cost-sharing is a U.S. citizen or national or a lawfully present alien; (b) whether an individual claiming a tax credit or reduced cost-sharing meets the income and coverage requirements and if so the amount of the credit or cost-sharing; (c) whether an individual's coverage under an employer-sponsored plan can be treated as unaffordable; (d) whether an individual is exempt from the responsibility to maintain essential coverage every month starting in 2013 for him/herself and any dependent.

Applicants for enrollment in a qualified health plan in the individual market through the Exchange shall provide the name, address and birth date for everyone to be covered. To be eligible for coverage in the individual market, premium tax credit, and/or cost-sharing reduction, applicants shall provide as applicable information for determining citizenship, immigration status, income, family size, change in circumstances (e.g. marital status, employment), and lack of minimum essential benefits or affordability of employer-sponsored coverage.

Exemptions from maintaining coverage or paying a penalty can be made for members of exempt religious sects or divisions, members of a health care sharing ministry, Indians, persons eligible for a hardship exemption, persons lacking access to affordable coverage and persons with household income under 100 percent of the poverty line. The Secretary shall prescribe the information to be provided for determining such cases.

An Exchange shall submit the information on exemptions provided by individual applicants to the Secretary. The Secretary of Health and Human Services, Secretary of the Treasury, Secretary of Homeland Security and Commissioner of

Social Security shall develop a collaborative system for verifying the accuracy and consistency of the information.

If an applicant fails to provide correct information due to negligence or disregard, of regulations, the applicant may be subject to a civil penalty of not more than $25,000. Anyone who knowingly and willfully provides false or fraudulent information shall be subject to a penalty of not more than $250,000. Anyone who knowingly or willfully uses or discloses an applicant's confidential information for any other purpose shall be subject to a civil penalty of not more than $25,000.

For a 90 day period after receipt of a notice (or longer as determined by the Secretary for enrollments beginning in 2014), individuals will be able to correct inconsistent or unverifiable information in federal records. If the information cannot be verified by the end of that period, no exemption will be issued.

Applicants notified by the Exchange that the exemption has been denied may appeal that determination. A separate appeals process shall be established for employers who may be liable for additional taxes, based on their failure to provide an affordable employer-sponsored plan that provides minimum essential coverage.

Section 1412. At the request of an Exchange, the Secretary, in consultation with the Secretary of the Treasury, shall make an advance determination of an enrollee's eligibility (based on household income) for the premium tax credit and cost-sharing reductions. The Treasury Secretary shall make advance payments of credits or reductions to insurers to reduce the payments of eligible enrollees. Insurers shall notify the Secretary and the Exchange of the amounts of such reductions.

Section 1413. The Secretary shall establish a system under which eligible State residents may participate in State health subsidy programs. The system shall ensure that individuals who are applying for health insurance through the Exchange shall, if found eligible, be enrolled in Medicaid or the Child Health Insurance Program (CHIP). The States shall adopt a single streamlined application form. Under standards set by the Secretary, data matching among State health subsidy programs shall be used to verify an applicant's eligibility for participation.

Section 1414. In determining eligibility for the premium tax credit or cost-sharing reduction, or participation in Medicaid, CHIP or other State health subsidy program, the Secretary may obtain from the Secretary of the Treasury relevant information from an applicant's tax return.

Section 1415. In determining an individual's eligibility for any program financed in whole or in part with federal funds, any IRS credit or refund shall not be considered as income or resources. Likewise cost-sharing reduction payments or advance credit payments shall be treated as made to the health plan and not the individual.

PART II—SMALL BUSINESS TAX CREDIT

Section 1421. Beginning in 2014 the initial amount of a small employer's health insurance credit offering a qualified health plan through an Exchange is determined as follows. It is 50 percent—35 percent for tax-exempt small employers—of either (a) or (b), whichever is *smaller*, where (a) is the aggregate amount of non-elective contributions made by the employer toward employee premiums; and (b) is the aggregate amount of such contributions the employer *would have made* toward employee premiums if the premiums equaled the average premium in the rating area of the small group market in which an employee enrolls for coverage.

[EDITOR'S NOTE: This limits the credit amount to 50 percent of the market's average premium.]

For the years 2010 through 2013, the premium percentages are 35 percent instead of 50 percent for non-tax exempt employers and 25 percent instead of 35 percent for tax-exempt small employers. The credit for those years is equal to the *lesser* of the amount calculated using those smaller percentages or the amount of the employer's payroll taxes.

An eligible small employer is one that has no more than 25 full-time equivalent employees (FTE) in a calendar year. The number of FTEs is aggregate employee hours (excluding overtime) divided by 2,080 hours. The hours and wages of seasonal employees who work 120 days or less shall not be counted in determining FTEs.

A non-elective contribution is other than one involves a salary reduction arrangement.

A credit period is a two-year period during which an employer offered one or more qualified health plans through the Exchange. For the years 2011 through 2013, the credit shall be applied without regard to whether the taxable period is in a credit year. For taxable years beginning after 2014, no credit period shall be treated as having begun in a taxable year before 2014.

The initial amount of the credit shall be reduced by (a) the initial amount times a fraction, namely the number of FTEs over ten divided by 15 plus (b) the amount times a fraction, namely the excess of average annual wages over $25,000 for years 2011-2013 or $25,000 times a cost-of-living adjustment for subsequent years. The hours and wages of a seasonal worker who works for the employer 120 or fewer days in a taxable year shall not be counted.

[EDITOR'S NOTE: This provision favors small employers who employ low to moderate income workers.]

Subtitle F. Shared Responsibility

PART I—INDIVIDUAL RESPONSIBILITY

Section 1501. For each month beginning in 2014, individuals are required to have minimum essential health coverage for themselves and dependents. Exceptions are made for (a) religious conscience objection (b) membership in a health care sharing ministry (c) not being lawfully present in the U.S. (d) being incarcerated.

As amended by Section 1002 of the Reconciliation Act, failure to maintain coverage entails a penalty of whichever is greater—$95 or 1 percent of income in 2014, $325 or 2 percent in 2015, $695 or 2.5 percent in 2016 up to the average bronze level premium. Thereafter penalty amounts are adjusted for cost-of-living increases. Exempt from the penalty are persons who cannot afford coverage, members of Indian tribes, taxpayers with income below the IRS filing threshold, persons with a hardship waiver, and persons covered for more than nine months of the year.

Section 1502. A person, private employer or governmental unit that provides minimum essential coverage shall make a return to the Secretary on the nature of the coverage, benefits provided, premiums, cost-sharing arrangements, individuals covered and related information. Any individual covered in such returns shall receive a statement from the provider of coverage showing what was reported about that individual. Returns shall be submitted to the Secretary on or before January 31 of the year following the calendar year for which the information is provided. The effective date of this provision is the calendar year 2014.

PART II—EMPLOYER RESPONSIBILITIES

Section 1511. An employer with more than 200 employees and offering one or more health benefits plans shall automatically enroll new employees in one of those plans. Employees will be given the opportunity to opt out of any plan they were automatically enrolled in.

Section 1512. Employers are required to notify employees in writing about: (a) the existence of the Exchange; (b) the employee's potential eligibility for a tax credit if the employer's share of its plan falls below 60 percent; and (c) the

loss of the employer's contribution if the employee buys a plan directly through the Exchange.

Section 1513. As amended by Section 10106 of this Act and Section 1003 of the Reconciliation Act, for any month in which a large employer—one with at least 50 full-time employees—fails to offer employees an eligible employer-sponsored plan with at least minimum coverage and in which at least one full-time employee has enrolled in a qualified health plan, the employer shall be assessed a payment equal to the applicable amount times the number of full-time employees. For any month, the applicable payment amount is 1/12 of $2000. After 2014, this amount shall be increased by a premium growth adjustment percentage.

If an applicable large employer offers an eligible employer-sponsored plan with at least minimum coverage and in any given month at least one employee has enrolled in a plan under which the employee is eligible for a premium tax credit or cost-sharing reduction, the employer shall be assessed a payment equal to the number of full-time employees times an amount equal to 1/12 of $3000 for that month.

Section 1514. Every applicable large employer shall make a return in a manner prescribed by the Secretary on whether the employer offers an eligible employer-sponsored plan, the length of the waiting period for enrollment, the monthly premium for the lowest cost option in each plan category, the employer's share of costs of total allowable benefits, and the number of full-time employees for the year. Returns shall be submitted to the Secretary on or before January 31 of the year following the calendar year for which the information is provided. The effective date of this provision is the calendar year after 2013.

Section 1515. [Technical amendment.]

Subtitle G. Miscellaneous Provisions

Section 1551. Unless otherwise specified, the definitions in section 2791 of the Public Health Service Act are applicable to this title.

Section 1552. Within 30 days of enactment, the Secretary shall publish on the website of DHHS a list of all authorities provided to the Secretary under this Act.

Section 1553. No individual or institutional health care entity may be discriminated against for failure to provide any item or service aimed at assisting the death of an individual by means such as assisted suicide, euthanasia or mercy killing. Excluded from this provision are such activities as withholding medical care or treatment, withholding nutrition or hydration, abortion, or goods and services aimed at alleviating pain rather than causing death.

[EDITOR'S NOTE: This protects health care providers in a few states, e.g. Washington, Oregon, where in effect assisted suicide is legal.]

Section 1554. The Secretary is prohibited from issuing any regulation that poses barriers to an individual's access to care or interferes with provider-patient communications (e.g. regarding all available treatment options), full disclosure of relevant information and informed consent.

Section 1555. No individual, company or health insuring entity is required to participate in any federal health insurance program created under this Act.

Section 1556. [Technical amendment regarding Black Lung benefits for certain survivors.]

Section 1557. Based on Title VI of the 1964 Civil Rights Act, Title XIX of the 1972 Education Amendments, the Age Discrimination Act of 1975 and Section 504 of the Rehabilitation Act of 1973, no individual shall be denied access to benefits or be subject to discrimination relative to any federally-assisted health care activity under this title.

Section 1558. No employer may discriminate against any employee regarding compensation or any other privilege of employment as a result of the employee's receipt of a premium

tax credit or subsidy or reporting of an employer's apparent violation of this title under the Act to federal or State authorities.

Section 1559. The Inspector General of DHHS shall have oversight of the Department's implementation and administration of this title.

Section 1560. Neither this title or amendments thereof shall modify or supersede existing antitrust laws, Hawaii's Prepaid Health Care Act, college or university student health insurance plans, or—unless otherwise specified in statute—the role of the State agency responsible for determining eligibility for state health subsidy programs (e.g. Medicaid, CHIP).

Section 1561. No later than 180 days after enactment, the Secretary shall develop health information technology (HIT) standards and protocols for enrolling individuals in designated federal and State health and human services programs. Such standards shall allow for matching information on individuals in federal and State databases, submission of applicant information electronically, systems verification of eligibility and related streamlining functions. The Secretary shall award grants to eligible entities—States, political subdivisions or local governments—that apply in the manner prescribed to aid them in developing or adapting their systems to the new HIT enrollment standards.

Section 1562. [Technical and conforming amendments.]

[EDITOR'S NOTE: These language changes insure compatibility between this Act and the Public Health Service Act.]

Section 1563. The Senate finds that, based on Congressional Budget Office estimates, this Act will reduce federal deficits, extend the solvency of the Medicare Health Insurance Trust Fund, and increase the surplus in the Social Security Trust Fund. Savings realized in the Community Living Assistance Services and Supports (CLASS) program shall be reserved for that program and not used for other purposes of this Act.

TITLE II.
ROLE OF PUBLIC PROGRAMS

Subtitle A. Improved Medicaid Access

Section 2001. As amended by Section 10201 of this Act and Section 1004 of the Reconciliation Act, beginning January 1, 2014, a State plan under Title XIX of the Social Security Act (Medicaid) shall make medical assistance available to individuals under age 65 who are not covered under Title XVIII (Medicare) and whose modified adjusted gross income does not exceed 133 percent of the poverty line for its family size. If such individuals have a child under age 19, they will not be enrolled until or unless the child is enrolled in the State plan or other equivalent coverage. States may opt to extend eligibility to individuals above 133 percent of the poverty line.

Eligible individuals shall be entitled to benchmark coverage that includes at a minimum hospital care, physician services, laboratory and x-ray services, well-baby and well-child care and other basic services as determined by the Secretary. Effective January 1, 2014, a benchmark benefits package must provide essential health benefits. Mental health and substance abuse coverage shall have coverage and financial parity with other benefits in group health plans.

As amended by Section 1201 of the Reconciliation Act, for newly covered individuals under this requirement, the federal matching assistance percentage (FMAP) shall be 100 percent for 2014 through 2016. For the newly covered, a State's FMAP will drop to 95 percent in 2017, 94 percent in 2018, 93 percent in 2019 and 90 percent after that.

[EDITOR'S NOTE: FMAP is the federal share of total Medicaid expenditures.]

Section 2002. In determining Medicaid eligibility, as amended by Section 1004 of the Reconciliation Act, the State shall use modified adjusted gross household income (per IRS Code of 1986) without reference to income disregards and assets or resources tests.

This requirement shall not apply to individuals eligible under a State plan waiver covering medically needy persons, persons age 65 or over, recipients of other federal assistance (e.g. Supplementary Security Income or SSI) and individuals

eligible for Medicare cost-sharing (e.g. for prescription drug coverage). In addition, the requirement shall not apply in determining eligibility of individuals for medical assistance in nursing facilities or home and community-based services furnished under a waiver or State plan amendment.

Section 2003. A State may not require as a condition of Medicaid eligibility that an individual or an individual's parent must apply for qualified employer-sponsored coverage.

Section 2004. Effective January 1, 2019, and as modified by Section 10201, Medicaid eligibility is extended to individuals under age 26 who were formerly in foster care for 6 months or more, whether or not consecutive.

Section 2005. This section concerned payments to Territories. As amended by Section 1204 of the Reconciliation Act, it was redesignated as Section 1323 of this Act. (See above.)

Section 2006. For a State recovering from disaster and facing a higher share of Medicaid costs, as modified by Section 10201, beginning January 1, 2011, the Medicaid federal matching assistance percentage (FMAP) shall be increased by 50 percent for the first applicable fiscal year and 25 percent over that figure for the second and succeeding years.

Section 2007. For the Medicaid Improvement Fund, any unobligated funds for fiscal years 2014 through 2018 are rescinded.

Subtitle B. Children's Health Insurance Program

Section 2101. Between October 1, 2013 and September 30, 2019, as modified by Section 10201, the FMAP for the Children's Health Insurance Program (CHIP; Title XXI of the Social Security Act) is increased by 23 percent. During that period, States may not impose eligibility standards that are more restrictive than those in effect on the date of enactment of this Act. As amended by Section 1004 of the Reconciliation Act, an applicant's modified adjusted gross income shall be used in determining eligibility. If funding is insufficient to cover some eligible children, States shall arrange for their coverage through an Exchange.

Section 2102. [Technical corrections.]

Subtitle C. Medicaid and CHIP Enrollment

Section 2201. A State shall establish an Internet website whereby individuals may apply for medical assistance electronically. Through such a website the State shall either enroll eligible individuals in Medicaid or CHIP or, if they are found ineligible, screen applicants for eligibility in a qualified health plan under an Exchange and determine if they qualify for premium assistance. Agreements may be established among the State Medicaid agency, State CHIP agency and an Exchange to streamline enrollment in the appropriate source of health care coverage.

Section 2202. A hospital participating in Medicaid may also choose to be an entity capable of determining, based on preliminary information, whether an applicant is eligible for Medicaid or CHIP. The hospital may provide assistance to the individual during a period of presumed eligibility.

Subtitle D. Medicaid Services Improvement

Section 2301. A State shall make payments to free-standing birth centers offering pre-natal labor, delivery and/or postpartum care through health care providers such as midwives and birth attendants.

Section 2302. A child's hospice care payments shall not waive his or her rights to Medicaid or CHIP services and payments for treatment of conditions related to the child's terminal illness.

Section 2303. A State may at its option provide coverage for family planning services and supplies to medically needy persons who are not pregnant and whose income eligibility does not exceed the level established for pregnant women under its medical assistance and child health insurance programs.

[EDITOR'S NOTE. Persons with income that is too high to qualify for Medicaid eligibility on that basis may, at the State's option, obtain eligibility as "medically needy" if their health care expenses leave their remaining income below the income eligibility threshold.]

Section 2304. [Technical language clarifying the definition of "medical assistance".]

Subtitle E. State Long-Term Services

Section 2401. Under a new Community First Choice option, as amended by Section 1205 of the Reconciliation Act, a State's Medicaid program may include home and community-based attendant services and supports as alternatives to institutional care (e.g. hospitals, nursing homes). The option is intended for low income individuals with disabilities who require assistance with activities of daily living (e.g. eating, bathing, dressing), instrumental activities of daily living (e.g. cooking, telephoning, shopping, etc.) or health-related tasks.

To the extent possible, home and community based services shall be consumer-controlled. A State's plan shall result from collaboration between the State and a Development and Implementation Council, the majority of whose members are elderly, persons with disabilities and their representatives. Funds may not be spent for room and board or for special education and related services. The federal medical assistance percentage applicable to a State for home and community-based services shall be increased by 6.0 percent.

The Secretary shall evaluate Community First Choice services to determine their effect on the ability of individuals to live independently; the impact on individuals' health; and the costs in comparison to the costs of institutional care. The Secretary shall publish a final report no later than December 31, 2015.

Section 2402. A State may provide additional home and community based services through a waiver allowable under Section 1915(i) of the Social Security Act to individuals with higher levels of need so long as the individuals' income does not exceed 300 percent of the Supplemental Security Income (SSI) benefit rate.

Section 2403. The Money Follows the Person demonstration is extended from 2011 through 2016. Minimum residence in an institution is reduced from six months to 90 consecutive days.

[EDITOR'S NOTE: The Money Follows the Person demonstration, established under the Deficit Reduction Act of 2005, eliminates barriers that prevent States from using sufficient Medicaid funds for home and community based services when a person moves from an institution to the community. The intent is to offset a systemic bias toward

institutional care and create a better balance between institutional and community-based care.]

Section 2404. For a five year period beginning January 1, 2014, a State's Medicaid rules for institutionalized persons that protect against spousal impoverishment shall be applied for persons receiving home and community based services.

Section 2405. For fiscal years 2010 through 2014, $10 million a year is appropriated for State Aging and Disability Resource Centers established under the Older Americans Act of 1965 as amended.

Section 2406. The Senate finds that, despite the 1990 report of the U.S. Bipartisan Commission on Comprehensive Health Care (Pepper Commission) and the 1999 U.S. Supreme Court decision in Olmstead versus L.C., long-term care to the elderly and persons with disabilities has not improved.

In 2007, 69 percent of Medicaid long-term care spending was for institutional care and only six States spent half or more of the Medicaid long-term care dollars on home and community-based care. In its 111th session, Congress should address long-term care and supports comprehensively and expand the availability of community-based care.

Subtitle F. Medicaid Prescription Drug Coverage

Section 2501. The minimum for manufacturers' rebates for prescription drugs—both single source and innovator multiple source drugs—is increased from 15.1 percent to 23.1 percent. Exceptions are drugs approved by the Food and Drug Administration for clotting factors and for outpatient pediatric conditions, where the increase is to 17.1 percent. The basic rebate percentage for non-innovator multiple source drugs is increased from 11 percent to 13 percent. Manufacturers shall make rebates with an upper limit of 100 percent of the average manufacturer price (AMP) for a drug dispensed to beneficiaries by a Medicaid managed care organization.

The increase in rebate amounts shall be used to reduce a State's share of expenditures for Medicaid and the corresponding federal matching share of total (i.e. federal and State) Medicaid expenditures.

[EDITOR'S NOTE. 1) A multiple source drug is one for which there is at least one other therapeutically equivalent (i.e. brand name) drug product. 2) An innovator multiple source drug is a multiple source drug that was initially marketed under a new drug application approved by the Food and Drug Administration. 3) A non-innovator multiple source drug is a generic product. 4) A single source drug is a covered outpatient drug produced and distributed under an FDA-approved new drug application.]

Section 2502. Certain previously excluded drugs are now covered, namely, FDA-approved over-the-counter agents for smoking cessation, barbiturates, and benzodiapezines.

Section 2503. In calculating the upper limit, federal reimbursement for drugs to pharmacies shall be no less than 175 percent of the weighted average (based on utilization) for average manufacturer prices.

Subtitle G. Medicaid Disproportionate Share Hospital (DHS) Payments

Section 2551. This section, as modified by Section 10201 of this Act and Section 1203 of the Reconciliation Act, provides for reductions in Disproportionate Share Hospital (DSH) payments. As amended by Section 1203 of the Reconciliation Act, DSH payments are reduced annually to achieve a total $14.1 billion aggregate reduction for the 2014-20 period. The Secretary shall develop a methodology applicable to all States that accomplishes these reductions.

[EDITOR'S NOTE: DSH payments are additional payments made to hospitals that serve a "disproportionate" number of low income and uninsured patients with special needs.

Subtitle H. Dual Eligible Beneficiaries

Section 2601. The time period for waivers under a State's medical assistance plan by which it may provide non-institutional long-term care, e.g. case management and home and community-based services, is extended to five years.

Section 2602. The Secretary shall establish a Federal Coordinated Health Care Office within the Centers for Medicare and Medicaid Services in order to better integrate benefits under Medicare and Medicaid and ensure that individuals eligible for both programs (i.e., dual eligibles) have access to all the items and services to which they are entitled.

Subtitle I. Medicaid Quality Improvement

Section 2701. No later than January 1, 2011, the Secretary shall publish a core set of core adult health quality measures for Medicaid eligible adults similar in manner to the existing set of core child health quality measures. States will be encouraged to report voluntarily on the quality of health care for Medicaid eligible adults. No later than January 1, 2014, and every three years thereafter, the Secretary shall report to Congress on this issue.

The Secretary shall establish a Medicaid Quality Measurement Program and shall periodically revise and update the core set of adult health quality measures as warranted. For each fiscal year 2010 through 2014, $60 million is appropriated for this initiative.

Section 2702. The Secretary shall prohibit payments to States making expenditures under their medical assistance plans for health care-acquired conditions. A healthcare-acquired condition is one for which an individual was diagnosed that could be identified by a secondary diagnostic code.

[EDITOR'S NOTE: The goal is to prevent assignment of a higher cost Diagnosis Related Group (DRG) code when a secondary code would be more appropriate.]

Section 2703. A State may at its option amend its Medicaid plan to include payments for a individual's health home. A health home is a program of coordinated care such that eligible individuals with chronic conditions can obtain home health services through a designated provider, a team of health care professionals working with the provider or a health team.

Covered chronic conditions include at a minimum mental health conditions, substance abuse disorders, asthma, diabetes, heart disease and being overweight (with a Body Mass index of BMI of 25 or greater). Beginning January 1, 2011, the Secretary may award planning grants to States to establish health homes.

A participating State shall develop methods for tracking savings from improved chronic care management. The Secretary shall evaluate the effectiveness of coordinated care through a health home with respect to hospital admissions, emergency room visits and admissions to skilled nursing

facilities. An evaluation report shall be submitted to the Congress no later than January 1, 2017.

Section 2704. The Secretary shall establish a demonstration program to evaluate the impact of bundled payments on integrated care to Medicaid beneficiaries whose episode of care includes hospitalization and concurrent physician services. The demonstration shall be conducted in up to eight states and run from January 1, 2012 through December 31, 2016. Participating hospitals must have robust discharge planning systems.

Section 2705. The Secretary shall establish a Medicaid Global Payment System demonstration project which employs a global capitated payment model. The demonstration will be conducted in no more than five States and operate in fiscal yeas 2010 through 2012.

Section 2706. The Secretary shall establish a Pediatric Accountable Care Organization demonstration project under which pediatric medical providers that qualify as accountable organizations may receive incentive payments for meeting performance guidelines. The demonstration shall run from January 1, 2012 through December 31, 2016.

Section 2707. The Secretary shall establish a Medicaid Emergency Psychiatric demonstration project. Under the demonstration payments may be made to a qualifying institution for mental diseases that renders medical assistance to a Medicaid beneficiary in order stabilize an emergency condition (e.g. suicidal or homicidal thoughts and/or gestures). The demonstration shall be conducted for three consecutive years. $75 million are appropriated in fiscal year 2011 and remain available for obligation through December 31, 2015.

Subtitle J. Medicaid Payment and Access Commission (MACPAC)

Section 2801. The Medicaid and CHIP Payment and Access Commission (MACPAC) shall review Medicaid and State Children's Health Insurance (CHIP) eligibility policies, enrollment and retention processes, coverage, and quality of care, as well as interactions between Medicare and Medicaid. Based on these reviews, the Commission shall submit reports to Congress, the Secretary and the States with its recommendations.

MACPAC shall consult with the Medicare Payment Advisory Commission or MedPAC (particularly regarding dual eligibles), States, and the Federal Coordinated Health Care Office established under this Act. MACPAC membership shall include health care professionals, third party payers, health care delivery experts, representatives of beneficiary groups (e.g. pregnant women, elderly, persons with intellectual disabilities, etc.) and representatives of State Medicaid and CHIP agencies.

Subtitle K. American Indians and Alaska Natives

Section 2901. No cost sharing shall be required of Indians with income at or below 300 percent of the federal poverty line who are enrolled in a qualified health plan offered through the individual market under an Exchange.

Section 2902. Medicare reimbursement to Indian hospitals and clinics for the provision of Part B (Medical Insurance) items and services is extended indefinitely beyond the original five year period that began January 1, 2005.

Subtitle L. Maternal and Child Health Services

Section 2951. As a condition of federal assistance for Maternal, Infant and Early Childhood Home Visiting Programs, States shall conduct a statewide needs assessment within six months of enactment. The assessment shall identify at-risk communities as indicated by premature births, low birth weight, infant mortality, poverty, crime, substance abuse, domestic violence, high school dropout rates, unemployment or child maltreatment. It shall include the State's capacity to meet such needs, including early child home visitation.

The Secretary is authorized to make grants to eligible entities—normally a State, Indian Tribe, Tribal Organization, Urban Indian Organization, U.S. Territory— for early childhood home visitation programs that promote maternal and prenatal health, infant health, child health and development, parenting skills, and reductions in child abuse. If a State has not applied for or been approved for a grant by fiscal year 2012, the Secretary may award grants to qualified nonprofit entities.

An eligible entity shall develop quantifiable 3-year and 5-year benchmarks for measuring improvements due to such programs. Priority for services shall be given to families in need as identified by the statewide assessment, or with the following characteristics: low income, pregnant women below age 21, history of child abuse or neglect and substance abuse, users of tobacco products, children of low academic achievement, children with developmental disabilities, members of the Armed Forces with multiple deployments outside the U.S.

No later than March 31, the Secretary shall submit to Congress an evaluation of the home visiting program. Appropriations for the program are $100 million, $250 million, $350 million, $400 million, and $400 million for fiscal years 2010, 2011, 2012, 2013 and 2014 respectively.

Section 2952. The Secretary is encouraged to continue activities on postpartum depression and psychosis, including basic research, epidemiological studies, screening and diagnostic techniques, clinical studies, and information and education programs.

It is the sense of Congress that the National Institute of Mental Health may conduct a longitudinal study in the period

from fiscal year 2010 through 2019 on the mental health consequences of resolving a pregnancy, including carrying the pregnancy to term and either parenting or giving the child up to adoption; miscarriage; or aborting.

The Secretary may make grants to eligible public or nonprofit entities for the delivery of services that deal with adverse postpartum conditions.

Section 2953. As modified by Section 10201, for fiscal years 2010 through 2014, the Secretary shall allot funds to each State under a formula to assist in achieving reduced pregnancy rates and birth rates among youth populations (ages 10 through 19). The minimum allotment per State shall be $250,000.

Unexpended funds from State allotments may be awarded as grants to local organizations including faith-based organizations. The total appropriation for this initiative is $75 million for each fiscal year. The initiative shall be administered by the Administration for Children and Families in DHHS.

Grants to States and/or local organizations shall be used for personal responsibility education programs that cover abstinence and contraception, as well as selected adulthood preparation subjects like healthy relationships, adolescent development, financial literacy, parent-child communication, educational and career success, and healthy life skills.

The Secretary shall reserve $10 million from appropriated funds to support innovative youth pregnancy prevention strategies and services for vulnerable youth populations, e.g. youth in foster care, homeless youth, pregnant women and mothers under age 21 and their partners. Funds shall also be reserved for Indian tribes and tribal organizations and for program support activities like research, training, and dissemination of information.

Section 2954. Appropriations for the funding of abstinence education programs are provided for fiscal years 2010 through 2014.

Section 2955. Transition planning for children aging out of foster care and independent living programs shall include information on the importance of designating an individual to make health care decisions on behalf of a child who is unable

to participate in such decisions and who does not have or does not want a relative to do so.

TITLE III.
QUALITY AND EFFICIENCY OF HEALTH CARE

Subtitle A. Health Care Delivery System

PART I—LINKING MEDICARE PAYMENT TO QUALITY

Section 3001. As amended by Section 10335, beginning October 1, 2012, the Secretary shall implement a value-based purchasing program for hospitals. Under the program, incentive payments may be made to hospitals for discharges that meet the program's performance standards.

Performance measures shall cover at least the following five conditions: acute myocardial infarction, heart failure, pneumonia, surgeries, and healthcare-associated infections. The measures shall be related to the Hospital Consumer Assessment of Healthcare Providers and Systems Survey. Hospital readmissions are excluded.

The base operating payment for each Diagnosis Related Group (DRG) shall be reduced by 1.0 percent, 1.25 percent, 1.50 percent, 1.75 percent and 2.0 percent respectively for fiscal years 2013, 2014, 2015, 2016, and 2017 and succeeding years. The reduced amounts shall be used for value-based incentive payments.

Thus, for a hospital meeting or exceeding performance standards, the reduced base operating payment amount for a Diagnosis Related Group (DRG) shall be increased for each discharge. Hospitals achieving the highest performance scores shall receive the largest value-based incentive payments.

The Secretary shall make information regarding the performance of individuals hospitals under the program publicly available on the Hospital Compare Internet website. The Secretary shall provide for appropriate risk adjustment to maintain incentives for hospitals to treat patients with severe illnesses or conditions. The Secretary shall submit a report to Congress by January 1, 2016 that includes proposals for improving the program.

[EDITOR'S NOTE: The risk adjustment aspect is aimed at reducing what is called "creaming" or "cherry-picking" where high success rates are due mainly to treating easier cases.]

The Government Accountability Office shall assess the impact of the program on the quality of care, Medicare expenditures, and quality performance in safety net hospitals and in small rural and urban hospitals. A final report is due by July 1, 2017.

No later than two years after enactment, the Secretary shall establish a value-based purchasing demonstration program for critical access hospitals. The three-year demonstration will test innovative methods for measuring and rewarding quality of care in such hospitals. The Secretary shall submit a report to Congress no later than 18 months after the demonstration with recommendations on establishment of a permanent program for such hospitals.

[EDITOR'S NOTE: A critical access hospital is a small (25 bed maximum) rural based community hospital able to provide acute and long-term care services and 24-hour emergency care services to Medicare beneficiaries who otherwise would have to travel at least 35 miles for such services. Instead of being subject to Medicare's Prospective Payment System (PPS) designated hospitals are eligible for cost-based reimbursement. There are approximately 1300 critical access hospitals nationwide.]

Section 3002. The Physician Quality Reporting Initiative, which provides incentive payments to physicians who report quality data to Medicare, is extended through 2014. If an eligible health care professional fails to submit data satisfactorily on quality measures for covered services, the fee schedule for such services in that year will be reduced. The applicable reduction percentages are 1.5 percent in 2015 and 2 percent in subsequent years. No later than January 1, 2102, the Secretary shall develop a plan for integrating physician reports on quality measures with required electronic health records (EHR) reports.

Section 3003. Beginning in 2012, under the Physician Feedback Program, the Secretary shall use Medicare claims data to provide individual confidential reports to physicians or groups of physicians on how their use of resources compares with other physicians treating similar patients. The Secretary may include quality data in such reports. The Secretary shall make appropriate adjustments for factors like socio-economic and demographic characteristics, ethnicity, health status of individuals, and geographic adjustments in payment rates. The

methods, data adjustments and aggregate physician reports shall be made publicly available.

Section 3004. For rate years beginning in 2014, annual updates to the standard federal discharge rate shall be reduced by 2 percent or any long-term care hospital that does not submit required data on quality measures to the Secretary. Similar requirements apply to inpatient rehabilitation hospitals and hospice programs. The data submitted from these institutions shall be made publicly available.

Section 3005. Beginning in 2014, cancer hospitals exempt from the Prospective Payment System (PPS) are required to submit data on quality measures.

Section 3006. The Secretary shall submit to Congress a value-based purchasing plan for skilled nursing facilities such that Medicare payments to such facilities are based on measures of quality and efficiency. A similar type of plan shall be developed for home health agencies and, as amended by Section 10301, for ambulatory surgical centers. Reports on these plans are due to Congress on by October 1, 2011.

Section 3007. For physician fee schedules under Medicare, the Secretary shall develop a payment modifier that provides for differential payments to physicians or groups of physicians based on the quality of care. Quality shall be evaluated according to composite of measures of quality and costs with appropriate risk adjustments for factors like socio-economic and demographic characteristics, ethnicity, and health status of individuals. The payment modifier shall take into account the circumstance of physicians in rural areas and underserved communities. The payment modifier will be phased in with full implementation by January 1, 2017.

Section 3008. Beginning in 2015 and with respect to hospitals in the top quartile for the rate of certain common and high cost hospital acquired conditions, Medicare payments for patients discharged with such conditions shall be 99 percent of the amount that would otherwise be paid.

The Secretary shall conduct a study of healthcare acquired conditions under other facilities such as inpatient rehabilitation facilities, long-term care hospitals, hospital outpatient departments, inpatient hospitals excluded from the PPS system, skilled nursing facilities, ambulatory surgical centers,

and health clinics. The study shall analyze how expanding policies regarding healthcare acquired conditions would affect quality, patient safety and spending under Medicare. The Secretary shall submit the study's report with recommendations to Congress by January 1, 2012.

PART II—IMPROVED HEALTH CARE QUALITY

Section 3011. Through a collaborative process with State agencies and a variety of other stakeholders, and as amended by Section 10302, the Secretary shall develop a national strategy for improving the delivery of health care services, patient health outcomes and population health. The national strategy shall be submitted to the Congress by January 1, 2011 and updated annually thereafter.

Section 3012. The Secretary shall convene an Interagency Working Group on Healthcare Quality to foster collaboration among federal departments and agencies in the efforts and resources devoted to quality improvement. The Working Groups shall submit a report annually to Congress.

Section 3013. The Secretary, in consultation with the Director of the Agency for Health Care Research and Quality and the Administrator for the Centers for Medicare and Medicaid Services, shall expand and update quality measures in accordance with the national strategy. As amended by Section 10303, the Secretary shall develop provider-level outcome measures for physicians and hospitals.

To the extent practicable, the Centers for Medicare and Medicaid Services shall adjust payments to hospitals based on their rates of hospital-acquired infections. Under contract to the Secretary, the Institute of Medicine shall develop new clinical practice guidelines. Other grants, contracts or intergovernmental agreements may be awarded to eligible entities for the development and evaluation of quality measures.

For each fiscal year from 2010 through 2014, $75 million is authorized to be appropriated for this purpose.

[EDITOR'S NOTE. Through authorization of appropriations, this Act sets an upper limit on the dollar amount. Separate legislation is needed for actual appropriations, which can be lower but not higher than the authorized amount.]

Section 3014. Under contract with the Secretary, a consensus-based entity shall convene multi-stakeholder groups to review quality performance measures. The entity shall submit the input of the stakeholder groups to the Secretary no later than February 1 of each year beginning in 2012. In making a determination on quality performance measures, the Secretary shall take into account measures that have or have not been endorsed by the entity.

[EDITOR'S NOTE. A multi-stakeholder group is a voluntary collaborative of organizations representing a broad group of stakeholders interested in or affected by a quality measure.]

Periodically, but no less often than every three years, the Secretary shall review quality measures with a view to maintaining, modifying or phasing them out. Funding for the program in the amount of $20 million is transferred from Medicare trust funds to the Centers for Medicare and Medicaid Services for each fiscal year 2011 through 2014.

Section 3015. As amended by Section 10305, the Secretary shall collect, aggregate and analyze data on quality and resource allocation from healthcare information systems. The Secretary shall create an overall framework for public reporting of performance information, including consistent data collection and analysis methods. For this purpose the Secretary may award grants to or contract with eligible entities. To receive a grant or contract, an entity must provide a match of $1 for every $5 in federal funds. The Secretary shall make quality performance information available to the public on standardized websites.

PART III—NEW PATIENT CARE MODELS

Section 3021. As amended by Section 10306, there is established a Centers for Medicare and Medicaid Innovation within the Centers for Medicare and Medicaid Services for the purpose of testing innovative payment and service delivery models that reduce expenditures without sacrificing quality of care.

One example is the making of comprehensive payments to Healthcare Innovation Zones, where groups of providers—teaching hospital, physicians, other clinical entities—deliver integrated and comprehensive services to applicable individuals

while training future healthcare professionals. Another example is the creation of community-based health teams that support small-practice medical homes for primary care and chronic care management.

For fiscal year 2010, $5 million is appropriated for the design, implementation and evaluation of innovative models. For fiscal years 2011 through 2019, $10 billion is appropriated for testing specific payment and service delivery models. The same amount is appropriated for subsequent ten-year periods. The Secretary shall submit a report with recommendations to Congress in 2012 and not less than every two years thereafter.

Section 3022. No later than January 1, 2012, the Secretary shall establish a Medicare shared savings program that fosters high quality and efficient service delivery under Parts A and B. Groups of service providers and suppliers will manage and coordinate care for Medicare fee-for-service beneficiaries under an Accountable Care Organization (ACO).

The ACO shall serve at least five thousand beneficiaries. Providers and suppliers of services shall continue to receive fee-for-service payments under Medicare Parts A and B. As amended by Section 10307, full or partial capitation models or other models as approved by the Secretary may be used for testing purposes.

An ACO shall receive additional payments for shared savings if it meets quality performance standards and if average per capita expenditures for Medicare beneficiaries, adjusted for beneficiary characteristics, are at least a given percentage (established by the Secretary) below an applicable benchmark.

The amount of the difference between actual ACO expenditures and the benchmark shall be considered savings and a percentage of that amount, again as determined by the Secretary, shall be shared with the ACO. Sanctions may be imposed on ACOs, including termination from the program, for avoiding patients at risk in order to reduce costs.

Section 3023. The Secretary shall establish a pilot program of integrated care for an episode of care involving a hospitalization. For the demonstration, bundled payments will be made for one or more of eight conditions as selected by the Secretary. Payments shall be comprehensive, covering all applicable and appropriate services for an episode of care.

Applicable and appropriate services include acute care services, physician services, outpatient and emergency department) services, post-acute services (e.g. home health, skilled nursing, rehabilitation) and other services approved by the Secretary. As amended by Section 10308, the demonstration shall include continuing care as well as acute care hospitals.

An instrument like the Continuity Assessment Record and Evaluation (CARE) shall be used to evaluate the beneficiary's condition and help in selecting the clinically appropriate site for care. The program shall be established by January 1, 2013 and continue for five years or longer if the Secretary so determines. The Secretary shall evaluate the program's effect on quality measures, health outcomes, access to care, and expenditures. If the pilot program is judged successful, the Secretary shall submit an expansion plan by January 1, 2016.

Section 3024. As amended by Section 3024, the Secretary shall establish a demonstration program wherein home-based primary care teams provide comprehensive care across all treatment settings to high-need beneficiaries with chronic illnesses and functional dependencies (e.g. needing assistance with daily activities like eating, bathing, dressing, toileting and walking).

The demonstration aims at reducing hospital admissions, readmissions, emergency room visits and costs while improving health outcomes, efficiency of care, and beneficiary and caregiver satisfaction levels.

The Secretary shall establish per capita spending targets based on what would have been spent absent the demonstration and shall make incentive payments to a practice whose actual expenditures fall below the projected target levels. An independence-at-home medical practice includes physicians and nurse practitioners who are part of a larger medical care team that provides home-based primary care on a 24/7 basis to beneficiaries with chronic conditions.

An agreement with a practice shall be limited to three years. At least 200 beneficiaries shall be served by an individual practice for each year of the demonstration. The total number of beneficiaries served under the demonstration shall not exceed 10,000. The demonstration shall begin no later than January 1, 2012. Funding for the program in the amount

of $5 million is transferred from Medicare trust funds to the Centers for Medicare and Medicaid Services for each fiscal year 2010 through 2105. The Secretary shall submit an evaluation report to Congress.

Section 3025. For a fiscal year beginning on or after October 1, 2012, the Secretary shall employ an adjustment factor by which base Diagnosis-Related Group (DRG) payments to hospitals are reduced to account for excess readmissions. Within two years of enactment, the Secretary shall implement a program of patient safety organizations to assist eligible hospitals in reducing their readmission rates.

Section 3026. The Secretary shall establish a Community-Based Care Transitions Program under which eligible entities provide high-risk Medicare beneficiaries with transition services from hospital t community. Eligible entities include hospitals with high readmission rates and community-based organizations. An eligible hospital must partner with a community-based organization. The entity shall arrange timely post-discharge follow-up services. Funding for the program in the amount of $500 million is transferred from Medicare trust funds to the Centers for Medicare and Medicaid services for fiscal years 2011 through 2015.

Section 3027. The Gainsharing Demonstration project is extended from December 31, 2009 through September 30, 2011. The final report is due March 31, 2013.

[EDITOR'S NOTE. Under the Gainsharing Demonstration, as authorized in the Deficit Reduction Act of 2005, a limited number of hospitals and physicians collaborate to improve quality and efficiency. From the resulting savings, the hospital remunerates physicians (gainsharing payments) that represent a share of the savings.]

Subtitle B. Improving Medicare

PART I—INSURING BENEFICIARY ACCESS TO SERVICES

Section 3101. This section modifies the factor used for physician payment updating. It is repealed by Section 10310 of the Act.

Section 3102. The Medicare physician fee schedule takes into account differences between local practice fee schedules and the national average. The floor for the geographic adjustment is extended to January 1, 2011. As amended by Section 1108 of the Reconciliation Act, the local geographic index is modified to reflect one-half the difference between the relative costs of local wage and rent expenses and the national average for 2010-11.

The Secretary shall evaluate current methods for establishing practice expense geographic adjustments and, not later than January 1 2012, make appropriate adjustments across fee schedule areas.

Section 3103. The exceptions process for Medicare therapy caps is extended to December 31, 2010.

[EDITOR'S NOTE. This refers to medically necessary exceptions on expense caps for certain types of therapy.]

Section 3104. The period for which qualified rural hospitals are reimbursed for certain clinical laboratory services is extended through 2010.

Section 3105. The period for which bonus payments for ground and air ambulance services in rural and other areas is extended through 2011. Section 10311 requires implementation of the extension on January 1, 2010.

Section 3106. As further amended by Section 10312, the period in effect for certain payment rules for long-term care hospitals established under the Medicare, Medicaid and SCHIP Extension Act of 2007 is extended from three to five years. The moratorium on the establishment of certain hospitals and facilities is extended from three to five years.

Section 3107. The mental health add-on to the physician fee schedule, by which the payment rate for psychiatric services is increased by five percent, is extended through 2010.

Section 3108. On or before January 1, 2011, similar to a clinical nurse specialist, a physician assistant is permitted to order post-hospital extended care services.

Section 3109. Certain pharmacies are exempt from accreditation requirements if their Medicare billings are less than five percent of total billings and they are enrolled suppliers of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS). However the Secretary may void the exemption by applying an alternative accreditation requirement for such pharmacies.

Section 3110. A special enrollment period of twelve months for Medicare Part B is established for disabled TRICARE beneficiaries, their spouses, widows and dependents.

Section 3111. The payment formula for dual energy x-ray absorptiometry tests for bone density is restored to 70 percent of the 2006 Medicare rate.

Section 3112. Funding for the Medicare Improvement Fund is zeroed out.

Section 3113. The Secretary shall conduct a two-year demonstration whereby separate payments are made for complex diagnostic laboratory tests (e.g. for gene protein expression, topographic genotyping, cancer chemotherapy sensitivity assay) under Medicare Part B. No later than two years after completion demonstration, the Secretary shall submit to Congress an evaluation report with recommendations.

Section 3114. The payment rate for certified nurse midwives is increased from 65 percent to 100 percent of the rate paid to physicians.

PART II—RURAL PROTECTIONS

Section 3121. For adjustments downward in Medicare payments for certain outpatient services, hospitals in rural areas and sole community hospitals shall be held harmless.

[EDITOR'S NOTE. "Hold harmless" in this context means not affected by the downward adjustments.]

Section 3122. Reasonable cost reimbursements for certain clinical laboratory services in rural areas as provided for in the 2003 Medicare Prescription Drug, Improvement and Modernization Act (P.L. 108-173) are reinstated.

Section 3123. As amended by Section 10313, the initial five-year rural community hospital demonstration program under the 2003 Medicare Prescription Drug, Improvement and Modernization Act is extended by five years. For the extension period, the number of States with low population densities that are participating is increased to twenty and the number of rural hospitals participating is increased to thirty. The demonstration tests the feasibility of establishing rural hospitals.

Section 3124. The payment methodology program for small rural Medicare-dependent hospitals under the Social Security Act, Title XVIII, is extended by one year through fiscal year 2012.

Section 3125. The program of additional Medicare payments for low-volume hospitals under the Social Security Act, Title XVIII, is extended through fiscal year 2102. As amended by Section 10314, the definition of low-volume hospital is broadened and the number of applicable discharges is increased to 1,600.

Section 3126. The number of eligible counties is expanded and physician services are newly included for the demonstration project on rural community health integration models under the Section 123 of the 2008 Medicare Improvements for Patients and Providers Act.

Section 3127. By January 1, 2011, the Medicare Payment Advisory Commission (MEDPAC) shall submit to Congress a report on the adequacy of Medicare payments to suppliers and providers of services and items in rural areas.

Section 3128. [Technical correction regarding payments to critical access hospitals.]

Section 3129. The Medicare rural hospital flexibility program (Flex Grant Program) under the Social Security Act,

Title XVIII, is revised so that funds in grants to rural hospitals may be used to support reforms like value-based purchasing, accountable care organizations (ACO), and bundling of payments.

PART III—PAYMENT ACCURACY

Section 3131. As amended by Section 10315, adjustments are made in the prospective payment system for home health services to reflect the number and intensity of visits, mix of services, average costs of providing care per episode and other factors deemed relevant by the Secretary. The adjustments will be phased in over a four-year period beginning in 2014. Outlier payments are capped at ten percent. There is an add-on for rural home health agencies through 2015.

[EDITOR'S NOTE: Outliers are variations outside the normal range in the amount and type of care provided. They may be due to severity of illness or other factors.]

The Medicare Payment Advisory Commission (MEDPAC) shall conduct and study and report to Congress by January 15, 2015 on the impact of these adjustments with respect to access to and quality of care, the number and mix of home health agencies (e.g. urban, rural, profit, nonprofit).

As amended by Section 10315, the Secretary shall report to Congress by March 1, 2014 on adjustments to home health prospective payments considering the costs of providing care to low income Medicare beneficiaries in medically underserved areas and in treating severe illnesses. Based on the study, the Secretary may conduct a demonstration project to determine how payment adjustments would affect the provision of care in underserved areas and the treatment of severe illnesses.

Section 3132. The Secretary shall collect additional data and information on hospice claims, cost reports and other mechanisms. Based on such data, no later than October 1, 2013, the Secretary shall by regulation implement revisions to payments for routine home care and other services under hospice. The Secretary shall adopt MEDPAC recommendations regarding recertification of individuals for care extending beyond the authorized 180-day period.

Section 3133. As amended by Section 10316 of this Act and Section 1104 of the Reconciliation Act, payments to Medicare

disproportionate share hospitals (DSH) are revised to better account empirically for uncompensated costs and to make adjustments in payments based on the percent of uninsured patients and related factors.

[EDITOR'S NOTE: DSH payments are additional payments made to hospitals that serve a "disproportionate" number of low income and uninsured patients with special needs.]

Section 3134. The Secretary shall regularly examine services whose payment codes may be misvalued and make appropriate adjustments based on factors like changes in practice expenses, codes for new technologies and services, and codes that are often billed multiple times for a single treatment. The Secretary shall determine the relative value of codes considering work elements (e.g. time, mental effort, professional judgment, technical skill, stress due to risk), and shall make appropriate adjustments to fee schedules under the codes.

Section 3135. As amended by Section 1107 of the Reconciliation Act, in calculating the practice expense part of advanced imaging services, the presumed rate of utilization for imaging equipment is raised from 50 percent to 75 percent from 2011 on. Reduced expenditures attributable to such utilization rates shall be reflected in fee schedules.

Section 3136. For power-driven wheelchairs, the percentage of the total price reflected in monthly payment amounts is increased to from 10 percent to 15 percent for the first three months and from 6.0 percent to 7.5 percent for the remaining months.

Section 3137. No later than December 31, 2011, the Secretary shall submit to a Congress a report with a plan to reform Medicare's hospital wage index system. As amended by Section 10317, the reclassification of hospitals (e.g. as psychiatric, rehabilitation, children's, cancer, etc.) under the 2003 Medicare Modernization Act (P.L. 108-173) is extended through fiscal year 2010.

The hospital wage index used in fiscal year 2009 shall be applied in determining hospital wage classifications. However, the Secretary may use the average wage data of certain hospitals whose reclassification is extended only if so doing results in a higher wage index for those hospitals.

Section 3138. The Secretary shall conduct a study to determine if certain cancer hospitals have higher costs for outpatient services than other hospitals and if so to make appropriate adjustments in the outpatient prospective payment system (OPPS).

Section 3139. Reimbursement for biosimilar biological products under Medicare Part B shall a include a 6 percent add-on over the average sales price of a brand product.

[EDITOR'S NOTE. A biologic is an agent like a drug, vaccine, or antitoxin that is synthesized from living organisms.]

Section 3140. The Secretary shall establish a three-year Medicare Concurrent Care demonstration program under which Medicare beneficiaries in up to fifteen participating hospice programs may receive other items and services under Medicare. The Secretary shall evaluate the effect of the demonstration on patient care and quality of life as well as cost-effectiveness and submit a report to Congress.

Section 3141. In calculating the floor of the Medicare hospital wage index, the Secretary shall apply budget neutrality on a national rather than a State-specific basis.

Section 3142. The Secretary shall conduct a study to determine if there is a need for additional payments to urban Medicare-dependent hospitals. The Secretary shall submit a report to Congress no later than nine moths after enactment of this Act.

Section 3143. Nothing in this Act shall result in the reduction of guaranteed home health benefits under Medicare.

Subtitle C. Medicare Advantage (Part C) Provisions

Section 3201. This section, which provided criteria and rules for determining Medicare Advantage payments, was repealed by Section 1102 of the Reconciliation Act. (See below.)

[EDITOR'S NOTE. As distinct from original Medicare, which pays for covered services, companies offering Medicare Advantage plans receive a fixed or capitated amount for each enrollee and strive to keep costs below the capitated amount.]

Section 3202. Medicare Advantage plans are prohibited from imposing cost-sharing (e.g. deductibles, co-payments) on beneficiaries that is greater than the cost-sharing required under Medicare's original fee-for-service program. As amended by Section 1102 of the Reconciliation Act, monthly rebates shall be made by Medicare Advantage plans to beneficiaries using a formula that includes average per capita cost savings, new benchmark phase-in proportions and plan quality ratings. Rebates shall be used to reduce beneficiary cost-sharing, provide wellness and preventive health benefits and cover additional services (e.g. eye exams, dental care).

Section 3203. The section provided for coding intensity adjustments to improve payment accuracy to Medicare+Choice organizations. This section was repealed by Section 1102 of the Reconciliation Act. (See below.)

Section 3204. The annual 45 day period starting January 1 that gives beneficiaries the option of changing enrollment from Medicare Advantage to original Medicare fee-for-service and to enroll in Medicare Part D (prescription drug coverage) is modified to permit more time for processing paperwork and eliminate duplicate enrollment periods for Medicare Advantage plans.

Section 3205. Legislative authority for Medicare Advantage plans for special needs individuals (special needs plans or SNP) is extended through 2013. Beginning in 2013, dual eligible SNP plans are required to contract with State Medicaid programs. Such plans must be approved by the National Committee for Quality Assurance. The Secretary shall periodically evaluate and modify as necessary the risk adjustment system to account for higher medical care and coordination costs of services to SNP beneficiaries.

[EDITOR'S NOTE: "Dual eligibles" refers to persons eligible for both Medicare and Medicaid.]

Section 3206. The period during which the Secretary may enter into reasonable cost reimbursement contracts where other health plan options are available is extended through 2012.

Section 3207. Under a technical correction, service area extensions for Medicare Advantage plans authorized by CMS can be made applicable to employer-sponsored Medicare Advantage fee-for-service plans.

Section 3208. This section extends permanently the senior housing facility demonstration project under which participating Medicare Advantage plans restrict enrollment to beneficiaries in continuing care retirement communities (CCRC). The plans must have participated in the demonstration for at least one year.

Section 3209. The Secretary may deny bids from Medicare Advantage organizations and prescription drug plans that significantly increase cost-sharing or decrease benefits under Medicare Parts A, B and D.

Section 3210. The Secretary shall request the National Association of Insurance Commissioners (NAIC) to encourage the use of appropriate physician services under Medicare Part B by updating standards for benefit packages including requirements for nominal cost-sharing.

Subtitle D. Prescription Drug Plans (Part D)

Section 3301. Under Medicare Part D, a coverage gap discount program is established. Under the new program, eligible Medicare beneficiaries receive a 50 percent discount on brand name drugs while they are in the donut hole.

[EDITOR'S NOTE. Under prior law, once spending for covered drugs reached a certain amount (e.g. $2,800) through deductibles and copayments, the beneficiary had to pay for subsequent costs out of pocket. This is the coverage gap or "donut hole" which this section addresses. When out-of-pocket spending reaches an upper limit (e.g. $4,500), Medicare coverage resumes. Also see Section 3315 below.]

Section 3302. The subsidy for the Medicare Part D premium for low income beneficiaries is calculated without regard to Medicare Advantage rebates or quality bonus payments.

Section 3303. If the amount of the monthly premium for a subsidy-eligible individual is de minimis, the Medicare prescription drug plan (PDP) or Medicare Advantage – Prescription Drugs (MA-PD) may waive the premium.

[EDITOR'S NOTE. This provision enables more Part D plans to qualify as zero-premium plans eligible for Medicare's low-income subsidy for low income beneficiaries. A low income individual is one whose income is below 150 percent of the poverty line for the applicable family size.]

Section 3304. In the case of a couple eligible for a low-income subsidy under Part D, a redetermination of eligibility is delayed for one year after the death of one spouse.

Section 3305. If a subsidy-eligible individual is reassigned from one plan to another plan, within thirty days of reassignment, the Secretary shall provide the individual with information on the differences in the drug formularies and on the individual's right to appeal or file a grievance regarding coverage determination.

Section 3306. $45 million is provided to Area Agencies on Aging, Aging and Disability Resource Centers, and the National Center for Benefits Outreach and Enrollment for health insurance education and outreach to low-income individuals.

Section 3307. PDP sponsors and MA-PD plans shall be required to cover drugs in certain categories and classes determined by the Secretary to be of clinical concern. Until the Secretary makes such a determination, PDP sponsors and MA-PD plans shall cover all drugs in six classes (viz., anticonvulsants, antidepressants, antineoplastics, antipsychotics, antiretrovirals, and immunosuppressants for transplant rejection).

Section 3308. The Part D subsidy is reduced for certain individuals whose income exceeds a certain threshold. The Social Security Administration uses modified adjusted gross income amount computed from IRS tax returns to determine Part B premium amounts. The Secretary shall forward the base beneficiary premium for Part D with which Social Security will also determine any appropriate Part D premium increase.

Section 3309. Cost sharing for dual eligibles is eliminated for individuals and couples receiving home and community-based services under a State's Medicaid waiver.

Section 3310. PDP sponsors and MA-PD plans shall adopt techniques that reduce wasteful dispensing of drugs to residents of long-term care nursing facilities.

Section 3311. The Secretary shall develop and maintain an effective PDP and MA-DP complaint system.

Section 3312. Each PDP sponsor shall develop a single, uniform exceptions and appeals process.

Section 3313. The Inspector General of DHHS shall report to Congress on how the prices of Part D covered drugs compare to State Medicaid payments for covered outpatient drugs.

Section 3314. The costs of drugs incurred by AIDS drug assistance programs and the Indian Health Service shall count toward the annual out-of-pocket threshold under Part D.

Section 3315. This section, which reduced the coverage gap for 2010, was repealed by Section 1101 of the Reconciliation Act of 2010. Section 1101 instead provides a $250 rebate to individuals who fall into the donut hole in 2010 and provides a 75 percent discount by 2020 and thereafter for brand name and generic drugs.

Subtitle E. Medicare Sustainability

Section 3401. As amended by Section 10319 of this Act and Section 1105 of the Reconciliation Act, revisions are made to how market basket updates are calculated for Medicare payments and a productivity factor where lacking and as appropriate is included. In general projected market basket percentage increases (e.g. as based on changes to the Consumer Price Index for all urban consumers) are reduced but can be offset by productivity gains.

[EDITOR'S NOTE. A market basket is a mix of goods and services that collectively comprise the basis on which payment is made.]

The modifications apply to in-patient acute care hospitals, long-term care hospitals, skilled nursing facilities, in-patient rehabilitation facilities, home health agencies, psychiatric hospitals, hospice care, dialysis, outpatient hospitals, ambulance services, ambulatory surgical centers, laboratory services, durable medical equipment, prosthetic devices, and certain other items under Part B (e.g. medical supplies, therapeutic shoes, parenteral and enteral equipment, supplies and nutrients, electromyogram devices, etc.).

Payment reductions are imposed on psychiatric hospitals that fail to submit timely data on quality measures as prescribed by the Secretary.

Section 3402. A adjustment is made to how Medicare Part B (Medical Insurance) premiums are calculated for higher income individuals by freezing 2010 income levels until 2019.

Section 3403. As amended by Section 10320 of this Act, a 15-member Independent Payment Advisory Board is created with a goal to improve health care quality and reduce excess cost growth under Medicare. The Secretary, Administrator of the Centers for Medicare and Medicaid Services and the Administrator of the Health Resources and Services Administration shall serve as ex officio, nonvoting members.

For selected years the Chief Actuary at the Centers for Medicare and Medicaid Services shall project per capita growth rates under Medicare and compare them to targeted growth rates. In years when Medicare cost growth is determined to be unsustainable, the Board's recommendations on how to reduce

per capita growth rates shall take effect unless Congress through its fast-track process comes up with an alternative that achieves the same level of savings.

The Board shall submit annual recommendations on quality and cost containment to the President, Congress and private entities. In so doing, the Board shall coordinate with the Medicare Payment Advisory Commission and the Medicaid and CHIP Access Commission. The Secretary shall review and comment on the Board's proposals or, if the Board fails to submit a proposal by an applicable deadline, shall submit a proposal instead. In 2020 and beyond, the Board's binding proposals are limited to every other year if growth in Medicare spending is lower than overall health care spending.

The Board is prohibited from making proposals that ration care, raise taxes, increase Part B premiums, reduce Part B premium supports for low-income individuals, or alter Medicare benefit, eligibility or cost-sharing standards.

A 10-member Consumer Advisory Council is established to advise the Board on the impact of proposals on consumers. The Comptroller General shall submit reports periodically to Congress on Medicare payments, rates and coverage policies. $15 million is appropriated for the Board in fiscal year 2012 with subsequent appropriations based on increases in the Consumer Price Index.

Subtitle F. Health Care Quality Improvements

Section 3501. The Center for Quality Improvement and Patient Safety within the Agency for Healthcare Research and Quality shall support research into quality improvement practices. Such support can be accomplished through contracts or other mechanisms, including establishment of a Quality Improvement Network Research Program. The Center shall disseminate its findings widely and, through grants and contracts, shall support technical assistance to health care institutions and providers on ways to foster quality improvement.

Section 3502. Through grants to and contracts with eligible entities, the Secretary shall establish community-based interdisciplinary health teams to make capitated payments to primary care providers and to render ongoing, team-based support to primary care practices.

Health teams shall support patient-centered medical homes that give safe, high-quality care through evidence-informed medicine, information technology, expanded access to care, wellness and prevention activities, and 24-hour care management during transitions from one care setting to another (e.g. hospital to community). Section 10321 clarifies that health teams can include nurse practitioners and other primary care providers.

Section 3503. Through grant and contract awards, the Center for Quality Improvement and Patient Safety shall support medication management services by licensed pharmacists for the treatment of chronic diseases. The Secretary shall evaluate and report to Congress on the effectiveness of such services including whether patients improved their adherence to medication regimens, maintained better health and reduced their hospitalizations and emergency room visits.

Section 3504. By no fewer than four contracts or competitive grants, the Secretary, acting through the Assistant Secretary for Preparedness and Response, shall support pilot projects for the development and evaluation of innovative regionalized models of emergency care and trauma systems. Applicants must match $1 in cash or in-kind for every $3 of federal funds. The Secretary shall give priority to medically underserved areas. The Secretary shall also support research

into pediatric and overall emergency medical care systems and emergency medicine through the National Institutes of Health, Agency for Healthcare Research and Quality, Centers for Disease Control and Prevention and Health Resources and Services Administration.

Section 3505. The Secretary shall award grants to eligible entities to further the core mission of trauma centers, defray substantial uncompensated costs, and provide emergency relief to support continued availability of trauma services. Eligible entities for such grants include Indian Health Service, Indian tribal and urban Indian trauma centers.

The Secretary shall provide funds to States so that States can make grants to eligible entities for trauma center services. Eligible entities for State grants include a public or nonprofit center or consortium, a safety net public or nonprofit center or a hospital in a underserved area that seeks to establish new trauma services.

Section 3506. The Secretary shall establish a program to improve patients' understanding of their medical treatment options (including tradeoffs). Patients, caregivers and authorized representatives shall be given education "decision aid" tools to help in deciding the most appropriate course of treatment given scientific evidence, circumstances, patients' beliefs and preferences.

The Secretary shall make grants to establish Shared Decisionmaking Resource Centers that give technical assistance to providers and disseminate best practices and other information. The Secretary shall award grants to health care providers to develop shared decisionmaking techniques.

Section 3507. The Food and Drug Administration shall determine whether adding quantitative summaries of prescription drug benefits and risks in a standardized format to promotional labeling and advertisements would improve health care decisionmaking.

Section 3508. The Secretary shall award demonstration grants to academic institutions for the purpose of developing, testing and integrating quality improvement and patient safety into the clinical education of health care professionals. A non-federal contribution of $1 in cash or in-kind is required for every $5 in federal grant funds.

Section 3509. Within the Office of the Secretary there shall be established an Office on Women's Health, as well as a Coordinating Committee on Women's Health and an National Women's Health Information Center—all aimed at improving prevention, treatment and research for women in health programs. Similar offices of women's health shall be established in other agencies of DHHS, including the National Institutes of Health, Centers for Disease Control and Prevention, Agency for Healthcare Research and Quality, Health Resources and Services Administration and food and Drug Administration.

Section 3510. As modified by Section 10201, the patient navigator demonstration program is reauthorized.

[EDITOR'S NOTE. Under the program, trained patient navigators assist patients in overcoming barriers in the health care system and assist in the coordination of health care services for individuals for whom there is an abnormal finding of cancer or other chronic disease.]

Section 3511. Authorization is given to appropriate such funds as necessary to carry out activities under this subtitle.

Subtitle G. Guaranteed Medicare Benefits

Section 3601. Nothing in this act shall result in a reduction of benefits guaranteed under Title XIX of the Social Security Act (Medicare).

Section 3602. Nothing in this act shall result in a reduction of benefits guaranteed to participants in Medicare Advantage plans.

TITLE IV.
CHRONIC DISEASE PREVENTION

Subtitle A. Modernizing Disease Prevention and Public Health Systems

Section 4001. Within the U.S. Department of Health and Human Services, the President shall establish a National Prevention, Health Promotion and Public Health Council, which is chaired by the Surgeon General and whose members are selected Cabinet Secretaries and heads of other agencies and.

As amended by Section 10401, the Council will develop a national strategy for disease prevention, health promotion and public health. It shall report annually to the President and relevant congressional committees on progress toward meeting the national strategy goals. There shall also be established a non-federal 25-member Advisory Group on Prevention, Health Promotion, and Integrative and Public Health, whose members shall include a diverse group of licensed health professionals.

Section 4002. There shall be established a Prevention and Public Health Fund to expand investment in prevention and public health activities and to reduce overall health care costs. $500 million is authorized to be appropriated in fiscal year 2010, with increases of $250 million a year through 2014 and $2 billion in 2015 and thereafter.

Section 4003. Within the Agency for Healthcare Research and Quality, there exists a Preventive Services Task Force, an independent panel of non-federal experts, whose purpose is to provide recommendations and guidelines on clinical preventive services to primary care practitioners based on the latest scientific evidence.

The Task Force is mandated to coordinate with the Community Preventive Services Task Force and the Advisory Committee on Immunization Practices to assure a tight nexus between clinical and community prevention strategies.

[EDITOR'S NOTE. For preventive measures like, for example, colorectal screening or smoking cessation, a clinical approach focuses on individual patients while a community-based approach uses strategies to reach large population groups.]

Section 4004. Through a public-private partnership, the Secretary conduct a prevention and health promotion media campaign. Topics could include emphasis on nutrition, exercise and smoking cessation, among others. The Secretary shall provide information to States and health care providers regarding preventive and obesity-related services. Through public awareness campaigns, States shall educate Medicaid enrollees on the availability of such services.

Subtitle B. Clinical Preventive Services

Section 4101. The Secretary shall award grants for the establishment of school-based health centers. Preference is given to centers that serve a large number of children enrolled in Medicaid or the Children's Health Insurance Program (CHIP). The centers shall provide comprehensive primary care including mental health services and substance abuse prevention services.

$50 million a year is appropriated for fiscal years 2010 through 2013. A non-federal cash or in-kind match equal to 20 percent of the grant funds is required from the applicant. Section 10402 adds vision services to a list of services for which referrals should be provided.

Section 4102. The Centers for Disease Control and Prevention shall establish a five-year national public education campaign on oral healthcare and education. The campaign shall be targeted toward specific population groups, such as children, pregnant women, parents, the elderly, and racial and ethnic minorities.

The CDC shall award grants to eligible entities to demonstrate the effectiveness of dental caries management. Eligible entities include federally-qualified health centers, hospital clinics, State or local health departments, and Indian Health Service dental programs, among others. Oral health components shall be added into the National Health and Nutrition Examination Survey (NHANES) and Medical Expenditures Panel Survey.

Section 4103. Medicare coverage is extended to include an annual wellness visit that provides for a health risk assessment, an individual's medical and family history, a five to ten year screening schedule, a personalized health and prevention plan. For the beneficiary, any deductibles or co-payments are eliminated. As clarified by Section 10402, a beneficiary's eligibility for Medicare wellness and prevention services shall take effect once coverage begins under Part B and continues every twelve months thereafter.

Section 4104. No coinsurance or deductible shall be required for services under the personalized prevention plan and any covered service receiving a grade of A or B by the U.S. Preventive Services Task Force. Medicare shall cover 100

percent of those costs. Section 10406 clarifies that beneficiaries do not have to make coinsurance payments for services in all settings.

Section 4105. The Secretary is authorized to modify Medicare's coverage of any preventive service that is consistent with recommendations of the U.S. Preventive Services Task Force. The Government Accountability Office shall conduct a study of the use and payment for Medicare covered preventive services.

Section 4106. A State's option under Medicaid to cover diagnostic, screening, preventive and rehabilitation services is expanded to include clinical preventive services given a grade of A or B by the U.S. Preventive Services Task Force and immunizations recommended by the Advisory Commission on Immunization Practices (ACIP). States that cover these services and immunizations and prohibit cost-sharing will receive a one percent increase in the federal medical assistance percentage (FMAP). This provision takes effect January 1, 2013.

[EDITOR'S NOTE. FMAP is the share of total Medicaid expenditures in a State that is borne by the federal government. It varies in accordance with a statutory formula, ranging from approximately half (California) to three-quarters (Mississippi).]

Section 4107. Under their Medicaid program, States are required to provide pregnant women with counseling and pharmacotherapy services for tobacco use cessation. Cost-sharing for such services is eliminated.

Section 4108. Under grants awarded by the Secretary, States shall help Medicaid beneficiaries to improve their health and wellness with emphasis on a) not using tobacco products, b) controlling their weight, c) lowering their cholesterol, d) lowering their blood pressure, and e) preventing the onset of diabetes or, for diabetics, improving diabetes management. States shall evaluate the effectiveness of their program along with lessons learned. The Secretary shall conduct an independent evaluation of the overall program and shall submit final report to the Congress no later than July 1, 2016.

Subtitle C. Healthier Communities

Section 4201. The Centers for Disease Control and Prevention shall award Community Transformation grants to State and local governments and community-based organizations to foster community preventive health activities. These activities relate to weight, nutrition, physical activity, tobacco use, emotional well-being, overall mental health and other factors. Section 10403 ensures that at least 20 percent of the grants will go to rural and frontier areas.

Section 4202. The Centers for Disease Control and Prevention shall award 5-year pilot program grants to State and local health departments and Indian tribes to provide public health community interventions, screenings and referrals for persons aged 55 through 64. The Secretary shall evaluate the program annually to measure changes in the prevalence of uncontrolled chronic disease risk factors (e.g. for heart disease, stroke, diabetes and other conditions) among new Medicare enrollees or persons nearing enrollment age.

The Centers for Medicare and Medicaid Services shall evaluate existing wellness and prevention programs sponsored by the Administration on Aging. Based on such evaluation, the Secretary shall develop a plan for promoting healthy lifestyles and chronic disease self-management for Medicare enrollees. $50 million is transferred from Medicare trust funds to the CMS for these activities.

Section 4203. The Architectural and Transportation Barriers Compliance Board shall promulgate regulatory standards to assure that medical diagnostic equipment is accessible to and usable by persons with disabilities.

Section 4204. The Secretary may contract with manufacturers to buy vaccines for adults. States may purchase additional quantities of adult vaccines at the price negotiated by the Secretary.

Under a demonstration program, the Centers for Disease Control and Prevention shall award grants to States to improve the provision of recommended immunizations for children, adolescents and adults. No later than four years after enactment of this act, the Secretary shall submit to Congress a report on the effectiveness of the demonstration.

The Government Accountability Office shall conduct a study on the ability of Medicare beneficiaries aged 65+ to access routinely recommended vaccines covered under Part D.

Section 4205. A restaurant that is part of a chain with twenty or more locations and using the same name shall disclose clearly and conspicuously the calorie content of standard menu items and the recommended daily calorie intake as specified by the Secretary through regulation. Upon request, restaurants shall also make available to consumers in written form additional nutrition information (e.g. cholesterol, sodium, carbohydrates, sugars, fiber, protein, calories from fat).

Section 4206. The Secretary shall implement a pilot program for not more than ten community health centers under which individualized wellness plans are developed for at-risk populations who use those centers. Wellness plans shall cover such areas as nutrition, physical activity, tobacco and alcohol use, stress management, dietary supplements, and plan compliance.

Section 4207. Under an amendment to the Fair Labor Standards Act of 1938, an employee shall be given a reasonable break time and private space to express breast milk for her nursing child for a year after birth. Exempted are employers with fewer than fifty employees.

Subtitle D. Prevention and Public Health Innovation

Section 4301. The Centers for Disease Control and Prevention shall provide funding for research into prevention (including community-based prevention), the translation of recommended interventions from academic to real world settings, and strategies for delivering public health services in real world settings. Research shall focus on high priority areas as identified in the National Prevention Strategy or Healthy People 2020.

Section 4302. This section sets forth data collection requirements such that federally conducted or supported surveys and other information programs include data on race, ethnicity, primary language, disability status, underserved rural and frontier areas and other factors that may account for health disparities.

Section 4303. The Centers for Disease Control and Prevention shall provide employers with technical assistance, consultation, tools, and other resources in support of employers' wellness programs. The CDC shall conduct a national survey to assess worksite health policies and programs.

The CDC shall establish an Epidemiology and Laboratory Capacity Grant Program. Grants shall be awarded to qualifying State and local health departments and tribal jurisdictions to improve surveillance of and response to infectious diseases and other conditions of public health importance.

Emphasis shall be given to strengthening laboratories' epidemiologic capacity, expanding the use of electronic systems for transmitting test results, improving information systems and developing prevention and control strategies. $190 million is authorized to be appropriated each year for 2010 through 2013.

Section 4305. This section authorizes a Conference on Pain convened by the Institute of Medicine in recognition of pain as a significant public health issue. Through the Pain Consortium, the National Institutes of Health is encouraged to expand an aggressive program of basic and clinical research into the causes of and treatments for pain.

To foster interagency collaboration and coordination, the Secretary shall establish an Interagency Pain Research

Coordinating Committee. The Secretary is authorized to provide grant and other support for programs to educate and train health care professionals in pain care.

Section 4306. $25 million is appropriated for a childhood obesity demonstration program for fiscal years 2010 through 2014.

Subtitle E. Miscellaneous Provisions

Section 4401. [This section, which calls for better methods to estimate the costs and results of prevention programs, is eliminated by Section 10405.]

Section 4402. The Secretary shall evaluate federal health and wellness initiatives to determine their effectiveness with respect to the health status of the public and in particular the federal workforce. The evaluation shall include measures of absenteeism, productivity, workplace injury, and medical costs.

TITLE V.
HEALTH CARE WORKFORCE

Subtitle A. Purpose and Definitions

Section 5001. The purpose is to assess the capacity of the healthcare workforce to deliver services to all individuals with emphasis on underserved groups and to expand the supply of qualified health care workers.

Section 5002. For purposes of this title, definitions are provided for the following terms: allied health professional, healthcare career pathway, institution of higher education, low income individual, State workforce investment board, local workforce investment board, postsecondary education, physician assistant education program, area health education center, area heath education center program, clinical social worker, cultural competency, direct care worker, federally qualified health center, frontier health professional health shortage area, graduate psychology, health disparity population, health literacy, mental health service professional, one-stop delivery system, paraprofessional child and adolescent mental health worker, racial and ethnic minority group, racial and ethnic minority population, rural health clinic, accelerated nursing degree program, bridge or degree completion program.

Subtitle B. Healthcare Workforce Innovations

Section 5101. There is established a 15-member National Healthcare Workforce Commission. The commission's purpose is to identify and make recommendations to Congress and federal agencies on effective polices and practices that improve the recruitment, education, training and retention of the healthcare workforce.

The Commission shall take into account the needs of a diverse population, changes in technology and other environmental factors. Members shall be appointed by the Comptroller General to three-year terms. Section 10501 includes ophthalmologists, optometrists as healthcare workers, highlights primary care careers as a priority area and adds small business representatives to the Commission's membership.

Section 5102. A competitive health care workforce development grant program is established under which State partnerships can plan and implement strategies for health care workforce development at the State and local levels. The Health Resources and Services Administration shall administer the grant program. An eligible partnership shall be a State workforce investment board with appropriate membership composition.

Applicants will compete for one-year planning grants followed by two-year implementation grants. State partnerships must reserve at least 60 percent of the federal grant to award smaller grants on a competitive basis to regional partnerships focused on health care workforce development. A no-federal match of 15 percent for planning grants and 25 percent for implementation grants is required. $150 million is authorized to be appropriated for the program for 2010.

Section 5103. The Secretary shall establish a National Center for Health Workforce Analysis. The Center shall analyze the health care workforce and related issues and shall coordinate as practicable with the National Health Care Workforce Commission.

[EDITOR'S NOTE. This codifies in law an existing center in the Health Resources and Services Administration.]

Through grants and contracts, The Center shall in turn establish State and regional centers that support health workforce data collection and analysis. Entities eligible for such grants and contracts include a State, State workforce investment board, public health or health professions school, academic health center, or other appropriate public or private non-private organization. Additional funds shall be awarded for longitudinal studies of individual health care careers. $7.5 million is authorized to be appropriated to the National Center and $4.5 million for State and regional centers for years 2010 through 2014.

Section 5104. As added by Section 10501, a federal interagency task force is established to assess and improve access to health care in Alaska.

Subtitle C. Increasing the Supply of Health Care Workforce

Section 5201. The federal primary care student loan program is modified by easing the criteria for qualifying, shortening the payback periods, and decreasing the interest rate penalty for noncompliance.

Section 5202. The nursing student loan program is modified by increasing loan amounts and updates the years for schools to establish and maintain loan programs.

Section 5203. The Secretary shall establish a pediatric specialty loan repayment program whereby the Secretary shall make payments on loan principal and interest not to exceed $35,000 a year on behalf of specialists who practice in a health professional shortage or medically underserved area or who serve a medically underserved population. Eligible individuals must serve for no less than two years and provide a pediatric medical subspecialty, pediatric surgical subspecialty, or mental and behavioral health care, including substance abuse treatment.

Section 5204. The Secretary shall establish a public health workforce loan repayment program to help remedy shortages of qualified professionals in public health agencies. On behalf of an individual who agrees contractually to relocate to a priority service area for at least three years, the Secretary shall make a loan repayment incentive amount up to $35,000 a year for each year of obligated service.

Section 5205. The Secretary shall establish an allied health professionals loan repayment program whereby the Secretary shall make loan repayments on behalf of health professionals employed at public health agencies or in health care settings (including acute care and ambulatory care facilities) located in a health professional shortage area, medically underserved area or who serve a medically underserved population.

Section 5206. The Secretary may award grants to or contract with accredited academic institutions for the purpose of giving scholarships to mid-career professionals in public health and allied health professions who enroll in degree or professional training programs. $60 million is authorized for appropriation in 2010 and such sums as may be necessary from 2011 through 2015.

Section 5207. Appropriations for the National Health Service Corps are authorized from fiscal year 2010 and subsequent years.

Section 5208. The Secretary shall award grants for the development and operation of nurse-managed clinics. Such clinics shall provide wellness and primary care services to medically underserved populations and be associated with schools, colleges and universities, federally qualified health centers or nonprofit health and social service agencies. A $50 million appropriation is authorized for 2010 and such sums as may be necessary for 2011 through 2014.

Section 5209. The cap on the number of members in Commissioned Corps of the U.S. Public Health Service is eliminated.

Section 5210. In addition to the Regular Corps, there is established in the Commissioned Corps a Ready Reserve Corps for service in national emergencies.

Subtitle D. Healthcare Workforce Education and Training

Section 5301. The Secretary may award grants to or contract with eligible entities to develop primary care training programs. Eligible entities include accredited hospitals, schools of medicine or osteopathic medicine, academically affiliated physician assistant training programs, or other qualified public or nonprofit entity. Qualified entities will implement accredited training programs and provide traineeships and fellowships to participants.

Qualified entities will develop special programs for physicians who plan to teach in or conduct research on training programs in family medicine, internal medicine, and pediatrics training programs. Entities will develop physician assistant training programs and "train the trainers" programs.

They will plan or sponsor demonstration programs that train participants in new competencies such as providing care in patient-centered medical homes. They will develop joint degree programs that foster interdisciplinary and inter-professional graduate training in public health and other health professions. There is a five-year award period for such grants and contracts.

The Secretary may award grants or contract with accredited schools of medicine or osteopathic medicine to improve clinical teaching and research in primary care training programs or foster interdisciplinary recruitment, training and faculty development. Awards shall be for a five-year period.

For the above purposes, $125 million is authorized to be appropriated for 2010 and such sums as necessary for 2011 through 2014.

Section 5302. The Secretary shall award grants to accredited institutions of higher education to train direct care workers who are employed in long-term care settings like nursing homes, assisted living facilities, intermediate care facilities, and home and community-based arrangements. $10 million is authorized to be appropriated for fiscal years 2011 through 2013.

Section 5303. The Secretary shall support dental training programs by making grants to or contracting with schools of dentistry, hospitals, or other qualified public or nonprofit

entity. Grant or contract recipients shall implement or participate in approved training programs, provide financial assistance to enrollees, develop oral health training programs for dentistry teachers, and operate a faculty loan repayment program. The grant or contract award period is five years. $30 million is authorized for appropriation in 2010 and such sums as necessary for 2011 through 2015.

Section 5304. The Secretary may award grants to fifteen eligible entities in support of a demonstration to establish training programs for alternative dental health care providers in rural and other underserved areas. Alternative dental health care providers may be community dental health coordinators, dental hygienists, primary care physicians, dental therapists and dental health aides.

The demonstration projects shall begin no later than two years after enactment and conclude within seven years of enactment. Eligible entities include among others institutions of higher education, public-private partnerships, federally qualified health centers, Indian Health Service facilities, tribes or tribal organizations, public health clinics, and public hospitals. The Institute of Medicine shall evaluate the demonstration.

Section 5305. Through grants and contracts, the Secretary shall support geriatric education centers. Centers shall offer fellowships to faculty members of medical schools and other health professions schools for supplemental training in geriatrics, chronic care management and long-term care for. Courses shall include material on depression, medicine management, and dementia. Periodically, at no or nominal cost, courses shall be offered to family caregivers and direct care providers. Annual appropriations of $10.8 million for fiscal years 2011 through 2014 are authorized.

To foster greater interest among a variety of health professionals, the Secretary shall award grants and contracts to eligible individuals pursuing advanced degrees in geriatric care. Eligible individuals include nurses, clinical social workers, pharmacists, and graduate psychology students. Recipients agree to teach or practice in geriatric care, chronic care management or long-term care for five years minimum after completion of the award period.

Eligibility for Geriatric Academic Career Awards is expanded. Awards shall be made to board certified or board eligible individuals in internal medicine, family practice, psychiatry, and dentistry, and allied health professions who have completed an approved training program in geriatrics and who have a non-tenured faculty appointment. Award recipients agree to spend at least 75 percent of their professional time in teaching clinical geriatrics.

Traineeships are established for individuals who are preparing for advanced education degrees in geriatric nursing, long-term care, gero-psychiatric nursing and related areas.

Section 5306. The Secretary may award grants to institutions of higher education to recruit and train individuals for undergraduate and graduate degrees, internships and residencies in mental health and behavioral health, including substance abuse prevention and treatment. Awards may be used for training in the fields of social work, graduate-level psychology, and child and adolescent mental health. $35 million is authorized to be appropriated for fiscal years 2010 through 2013.

Section 5307. The section expands programs administered by the Health Resources and Services Administration for developing research, demonstrations, and model curricula for training in cultural competency, prevention, public health proficiency, and aptitude for working with individuals with disabilities. Such training is intended for use in health professions schools and continuing education programs. The Secretary shall evaluate the adoption and implementation of such training.

Section 5308. This section strengthens the ability of accredited nurse midwifery programs to receive advanced nurse education, practice and retention grants under section 811 of the Public Health Service Act.

Section 5309. Section 831 of the Public Health Service Act is strengthened by authorizing the Secretary to make grants to eligible entities for nurse education, career advancement programs, internships, residencies, and retention strategies. Eligible entities include accredited schools of nursing, health care facilities and partnerships of such schools and facilities.

Section 5310. Faculty members at nursing schools are added as being eligible for loan repayment and scholarship programs.

Section 5311. To increase the number of teaching nurses, a nurse faculty loan repayment program administered by the Health Resources and Services Administration is established. Under the program the government will make loan repayments on behalf of nurses with debt who pursue nurse education careers. Participating nurses agree to serve as full-time faculty members at accredited nursing schools for at least four years of a six year period following completion of their degree program.

Section 5312. Appropriations are authorized for nursing programs under Parts B, C, and D of the Public Health Service Act.

Section 5313. The Director of the Centers for Disease Control and Prevention is authorized to make grants to eligible entities to promote positive health behaviors and outcomes in medically underserved areas through the use of community health workers.

[EDITOR'S NOTE. Community health workers serve as liaisons between the community and healthcare agencies and provide culturally appropriate education and guidance on health and nutrition to community residents.]

Eligible entities include public agencies, public health departments, private nonprofit organizations, free clinics, hospitals, federally qualified health centers, and consortiums of the preceding entities. Section 10501 clarifies the definition, roles and functions of community health workers.

Section 5314. To remedy workforce shortages in key areas of public health, funding by the Centers for Disease Control and Prevention is authorized to support epidemiology fellowship training programs, laboratory fellowship training programs, the Public Health Informatics Program, and expansion of the Epidemic Intelligence Service.

Section 5315. A United States Public Health Sciences Track is authorized under the guidance and direction of the Surgeon General with advice from the National Health Care Workforce Commission. The Track shall be located at academic health centers in regions selected by the Surgeon General. Degree

programs for medical, physician assistant, behavioral and mental health, public health, dental and nursing students shall include emphasis on team-based service, public health, epidemiology, and emergency preparedness and response. Students receive tuition remission and stipends and agree, for each year of schooling, to devote at least two years of service in the U.S. Commissioned Corps of the U.S. Public Health Service. Funding for the Track will come from the $1.3 billion Public Health and Social Services Emergency Fund.

Section 5316. As added by Section 10501, the Secretary shall establish a training demonstration program for family nurse practitioners. Grant recipients will provide new nurse practitioners with clinical training to enable them to serve as primary care. providers in federally qualified health centers (FQHC) and nurse-managed health clinics (NMHC).

Subtitle E. Health Care Workforce Support

Section 5401. Under Title VII of the Public Health Service Act, the Secretary may award grants to or contract with health professions schools and other entities to operate programs of excellence in the health professions for under-represented minority individuals. Under this section the program is reauthorized with increased appropriations ($50 million for fiscal years 2010 through 2015) and modifications to centers of excellence grant allocation formulas.

Section 5402. Faculty loan repayment and fellowship programs under Title VII of the Public Health Service Act are expanded. The authorization level for appropriations for scholarships and other educational assistance for disadvantaged students is increased. Section 10501 adds schools for physician assistants as eligible for the program.

Section 5403. The Secretary shall award grants to develop new area health education centers (AHEC) and maintain existing centers. Eligible entities are schools of medicine and osteopathic medicine.

AHECs shall recruit persons from underrepresented minority populations and rural areas into the health professions. They shall support innovative training curricula and emphasize the delivery of high quality care, especially primary care, in underserved areas for health disparity populations. They shall develop other strategies to meet healthcare workforce needs.

Annual appropriations of $125 million for fiscal years 2010 through 2014 are authorized. Subject to specific waiver provisions, a non-federal match of 50 percent is required. An additional $5 million is authorized for appropriation to support health care professionals in isolated underserved communities through enhanced distance learning education, continuing education, conferences, and electronic and telelearning activities.

Section 5404. The use of nurse diversity grants is expanded to include stipends for students in bridge or degree completion programs, scholarships or stipends for accelerated nursing degree programs, pre-entry and advanced education preparation, and retention activities.

Section 5405. There is established in the Agency for Healthcare Research and Quality a Primary Care Extension Program under which primary care providers are educated about preventive medicine, health promotion, chronic disease management, mental and behavioral health services, and evidence-based therapies and techniques. Providers will be better able to incorporate such elements into their practices and to work with extension agents, i.e. community-based health workers.

The AHRQ shall award competitive grants to States for the establishment of State-level or multi-level Primary Care Extension Program Hubs. Such Hubs shall consist minimally of the State health department, plus (if different) the State's Medicaid and Medicare agencies, and a health professions school that trains primary care providers. Other appropriate entities (e.g. State licensing agency) may be included in a Hub.

Hubs shall fund local primary care extension agencies. Local extension agencies will aid primary providers in implementing patient-center medical homes, develop primary care learning communities, offer training and technical assistance to community health teams, and collaborate with other organizations in meeting local healthcare workforce needs.

To administer the program, AHRQ will award two-year planning grants and six-year implementation grants. $120 million is authorized to be appropriated for fiscal years 2011 and 2012 and such sums as necessary fiscal year 2013 and 2014.

Subtitle F. Primary Care and Other Workforce Improvements

Section 5501. Between January 1, 2011 and January 1, 2016, for the services of a primary care practitioner and for major surgeries by a general surgeon in health professional shortage areas, an additional incentive payment shall be made that equals ten percent of the normal payment amount. Section 10501 eliminates the requirement for a budget neutrality adjustment.

Section 5502. The Secretary shall develop a prospective payment system (PPS) for Medicare-covered services, including preventive services, furnished at federally qualified health centers (FHQC). Section 10501 stipulates that the type, duration and intensity of services shall be factored in to payments and establishes an annual FQHC market basket update.

Section 5503. Under Title XVIII of the Social Security Act, the Secretary can assist hospitals with payments for the costs of graduate medical education. However, under this new Act, if there are unfilled medical residencies relative to approved limits for the three most recent cost reporting periods and certain exceptions are not applicable (e.g. hospitals in rural areas with fewer than 250 beds are exempt), the Secretary shall reduce a hospital's approved limit.

The Secretary shall use the unfilled slots to increase the limit of other hospitals for the training of primary care physicians. The Secretary shall give preference to States with low physician to population ratios and to States where the highest proportion of people live in health profession shortage areas.

Section 5504. For purposes of federal funding, if a hospital covers the costs of stipends and fringe benefits, the time of an intern or resident spent on patient care activities in non-provider settings can be counted toward full-time equivalent (FTE) participation in programs of indirect medical education (IME) and/or direct graduate medical education (DMGE).

Section 5505. The time spent by a resident or intern at didactic conferences and seminars shall be counted toward full-time equivalent participation in IME or DMGE programs. Section 10501 clarifies that the Secretary is not required to reopen

certain settled cost reports in applying Medicare's graduate education rules on payments for didactic training.

Section 5506. In the case of hospitals that have closed within two years prior to this Act, the Secretary shall redistribute their approved medical residency slots to other hospitals, subject to certain criteria (e.g. initial preference is given to hospitals in the same core-based statistical area).

Section 5507. The Secretary, in consultation with the Secretary of Labor, shall award demonstration grants to eligible entities to provide eligible low-income individuals with opportunities for education, training and career advancement to meet healthcare workforce needs. Eligible individuals include TANF recipients plus other individuals as specified by the applicant. Participants receive financial aid, child care, case management and other supportive services.

[EDITOR'S NOTE. TANF is Temporary Aid for Needy Families, the federal welfare program.]

Entities eligible for a grant include a State, Indian tribe or tribal organization, institution of higher education, workforce investment board, registered apprenticeship program sponsor or community-based organization. Eligible entities shall consult with the State TANF program administrators, State and local workforce investment board and State apprenticeship agency.

The Secretary shall also award demonstration grants to not more than six States to develop core training competencies and certification programs for personal or home care aides.

$85 million is appropriated each year from funds in the Treasury not otherwise appropriated for fiscal years 2011 through 2014. Of this amount $5 million is reserved for the personal or home care aides demonstration. Both demonstrations are to be independently evaluated and interim and final reports submitted to Congress. Finally, family to family health information centers are extended through fiscal years 2011 and 2012.

Section 5508. The Secretary may award grants for not more than three years to teaching health centers to establish new accredited or expanded primary care residency programs. Such programs include family medicine, internal medicine,

pediatrics, obstetrics, gynecology, psychiatry, dentistry, and geriatrics.

Authorized appropriations are $25 million for fiscal year 2010, $50 million for fiscal years 2011 and 2012, and such sums as necessary thereafter. Up to 50 percent of the time spent by members of the Commissioned Corps in primary care teaching shall count as time spent in full-time clinical practice as required under the individual's contract.

$230 million are appropriated for fiscal years 2011 through 2015 for direct and indirect expenses of qualifying teaching health centers related to training primary care residents in new or expanded programs.

Section 5509. The Secretary shall establish a graduate nurse education demonstration program under which five eligible hospitals may receive payment for costs associated with providing qualified clinical training to advance practice nurses. $50 million a year for fiscal years 2012 through 2015 is appropriated for the demonstration out of Treasury funds not otherwise appropriated.

Subtitle G. Access to Health Care Services

Section 5601. Authorized appropriations for community health centers are increased by approximately $1 billion a year from fiscal years 2010 through 2015 and thereafter by a formula that takes into account per patient costs and the total number of patients served.

Section 5602. Through establishment of a negotiated rulemaking committee and in consultation with relevant stakeholders, the Secretary shall development criteria and a comprehensive methodology for the designation of medically underserved populations and health professions shortage areas.

Section 5603. The Wakefield Emergency Medical Service Program for Children is reauthorized and expanded. The program provides emergency medical services to children in need of trauma care and critical care treatment.

Section 5604. Through grants and contracts, the Substance Abuse and Mental Health Administration in DHHS shall establish demonstration projects under primary and specialty care are co-located at community-based and behavioral health settings to serve special populations. $50 million is authorized to be appropriated for fiscal year 2010 and such sums as necessary for fiscal years 2011 through 2014.

Section 5605. There is established a Commission on Key National Indicators. The Commission shall contract with the National Academy of Sciences to determine how best to establish a key national indicator system for the United States, whether through the Academy directly or through a private nonprofit Institute. The Academy shall report annually to the Commission on its activities.

Section 5606. As added by Section 10501, there is established a grant program whereby States may award grants to health care providers that serve a high percentage of medically underserved populations or other special populations. No Medicaid funds may be used for these grants.

Subtitle H. General Provisions

Section 5701. The Secretary shall submit a report to Congress annually on the activities carried out and their effectiveness under the amendments made by this Title.

TITLE VI.
TRANSPARENCY AND PROGRAM INTEGRITY

Subtitle A. Physician Ownership and Other Transparency

Section 6001. Under Medicare rules, as set forth in section 1877 of the Social Security Act, physicians may not make referrals to entities in which the physician or a member of the physician's immediate family has a financial interest (e.g. a clinical laboratory). Exceptions are made in the case of certain rural providers and physician-owned hospitals.

Under this new section, as amended by Section 10601, these exceptions are tightened. Under Section 1106 of the Reconciliation Act, exceptions on growth restrictions are made for a hospital that is not the sole hospital and serves the highest percentage of Medicaid patients in a county.

Section 6002. Manufacturers and group purchasing organizations of a covered drug, device, biological, or medical supply are required to report payments or other transfers of value (e.g. consulting fees, gifts, food, entertainment, investment interest, etc.) to covered physicians, non-medical professionals, group medical practice, or teaching hospitals. Failure to report is subject to civil penalties. Federal law preempts State laws on the matters in this section but not State requirements that go beyond this section.

Section 6003. For in-office ancillary services, under section 1877 of the Social Security referring physicians are required to inform patients in writing of all area providers of magnetic resonance imaging (MRI), computed tomography, positron emission tomography (PET), and other services the Secretary designates.

Additionally under this new section, the referring physician must make it clear in writing that the patient may receive such services from someone other than the referring physician, group practice to which the physician belongs or an individual under the supervision of the physician or other group practice member.

Section 6004. In addition to requirements under Section 6002, prescription drug manufacturers and distributors are required to report annually to the Secretary information on the

type and quantity of drug samples provided to requesting practitioners.

Section 6005. Pharmacy benefit managers (PBM) or health benefits plans that provide pharmacy benefit management services under Medicare or an Exchange must report to the Secretary information on the generic dispensing rate (i.e. percentage of prescriptions that were filled with generic drugs), including rebates, discounts, and price concessions, and shall identify differences in payments between health plans and PBMs and between PBMs and pharmacies.

Subtitle B. Nursing Home Transparency and Management

PART I—TRANSPARENCY OF INFORMATION

Section 6101. Skilled nursing facilities under Medicare and nursing facilities under Medicaid shall provide information on (a) each member of the facility's governing body, (b) each person or entity that is an officer, director, member, partner, trustee, or managing employee of the facility and (c) each person or entity that is an additional disclosable party.

A disclosable entity is an entity that exercises operational or financial control over part or all of the facility, leases or subleases property to the facility or provides management, clinical or financial consulting services. Upon request the information shall be released to the Secretary, the Inspector General of DHHS, the State, or the State's long-term care ombudsman.

Section 6102. Within 24 months after enactment of this Act, the Secretary, jointly with the Inspector General of DHHS, shall issue regulations regarding an effective compliance and ethics program for skilled and other nursing facilities. The program is aimed at preventing and detecting criminal, civil and administrative violations under this Act. The program shall be operational in nursing facilities within 36 months of enactment.

The Secretary shall evaluate the program and report its findings to the Congress. No later that December 31, 2011, the Secretary shall also establish an quality assurance and performance improvement (QAPI) program for nursing facilities, whether stand-alone or part of a chain of facilities.

Section 6103. At Medicare's Nursing Home Compare website, the Secretary shall make available data on skilled and other nursing facility staffing, links to State websites on survey and certification programs and other information, a standardized complaint form, summary information on substantiated complaints, and adjudicated instances of criminal violations by a facility or an employee. The Secretary shall also establish a consumer rights information page that includes guidance on choosing a nursing home, consumer rights and the services of a State's ombudsman program.

Section 6104. Cost reports for Medicare skilled nursing facilities shall include wage and benefit expenditures for direct care workers that shall be broken out at a minimum by registered nurses, licensed professional nurses, certified nurse assistants, and other medical and therapy staff. In consultation with other experts such as the Medicare Payment Advisory Commission, the Secretary shall use the cost report data to account annually for each facility's spending on direct care, indirect care, capital assets and administrative services.

Section 6105. The Secretary shall develop a standardized complaint form for use by a skilled or other nursing facility resident or someone acting on the resident's behalf for filing a complaint with a State's survey and certification agency or its ombudsman program. The State must establish a complaint resolution process.

Section 6106. The Secretary shall require skilled or other nursing facilities to submit electronically information on direct care staffing, including outside agency and contract staff, in a uniform format based on payroll and other auditable data.

Section 6107. Within two years of enactment, the Government Accountability Office shall conduct a study of the five-star quality rating system for skilled or other nursing facilities used by the Centers for Medicare and Medicaid Services and report to Congress on any needed improvements.

PART II—TARGETING ENFORCEMENT

Section 6111. In cases where a skilled or other nursing facility self-reports a deficiency and takes prompt corrective action, the Secretary may reduce any civil money penalty imposed by up to 50 percent, unless the deficiency results in significant harm, jeopardizes the health and safety of one or more residents or results in a resident's death. If a facility's appeal under a dispute resolution process is successful the penalty money will be returned. If not, a portion the proceeds may be used for activities that benefit the residents.

Section 6112. The Secretary shall carry out a two-year demonstration project for independent monitoring of interstate and large intrastate nursing facility chains. An independent monitor will operate under contract with the Secretary. The chains selected for participation may include those with serious safety and quality of care problems. The Secretary, in

consultation with the Office of the Inspector General, shall evaluate the demonstration and report to Congress the findings and recommendations, including whether an independent monitor should be made permanent.

Section 6113. No later than 60 days before the closure date, the administrator must notify in writing the Secretary, the State's ombudsman, residents and residents' legal representatives about the impending closure of the skilled or other nursing facility.

If the closure is due to Secretary's termination of the facility's participation in Medicare or Medicaid, the Secretary may set a different notification date. No new residents may be admitted and there must be a plan for the orderly transfer of to residents to other comparable facilities. Failure to comply can result in civil monetary penalties and other penalties.

Section 6114. The Secretary shall conduct two demonstration projects aimed at generating best practice models. One is designed for skilled or other nursing facilities that are involved in the culture change movement. The other aims at improved use of information technologies to improve resident care. The demonstrations shall conclude within three years and the Secretary shall report the results to Congress.

PART III—STAFF TRAINING

6121. Skilled and other nursing facilities are required to provide dementia management and abuse prevention training as part of pre-employment training for permanent, agency and contract staff and, if the Secretary so determines, as part of ongoing in-service training as well.

Subtitle C. Background Checks

Section 6201. The Secretary shall establish a nationwide program of national and statewide background checks for employees with direct patient access in long-term care facilities. Long-term care facilities include Medicare skilled nursing facilities, Medicaid nursing facilities, home health agencies, hospices, intermediate care facilities for the mentally retarded (ICF-MR) and other facilities designated by a State. The program shall be based on the pilot program conducted under the 2003 Medicare Prescription Drug Improvement and Modernization Act. The DHHS Inspector General shall conduct a nationwide evaluation of the program and report to Congress.

Subtitle D. Patient-Centered Outcomes Research

Section 6301. There is established a non-profit corporation, the Patient-Centered Outcomes Research Institute. The Board of Governors shall include the Director of the Agency for Healthcare Research and Quality and the Director of the National Institutes of Health plus 17 other members appointed by the Comptroller General.

The Institute will set research priorities and conduct or sponsor comparative outcomes research that takes into account the incidence, prevalence and burden of diseases, gaps in evidence on clinical outcomes, practice variations, health disparities, effects on national health care expenditures, patient needs and preferences, and strategies for national priorities in health care quality.

Section 10602 clarifies the rights of researchers on publication in peer-reviewed journals. Research findings shall not be construed as recommendations on health care policy, practice guidelines, coverage, or payment.

A Patient-Centered Outcomes Research Trust Fund is established in the Treasury Department. Appropriations to the Trust Fund are $10 million in fiscal year 2010, $50 million in fiscal year 2011, $150 million in fiscal year 2012 and, for the fiscal years 2013 through 2019, $150 million plus revenue from fees imposed on health insurance and self-insured plans.

Section 6302. The Federal Coordinating Council for Comparative Effectiveness Research terminates upon enactment of this Act.

Subtitle E. Medicare, Medicaid and CHIP Program Integrity

Section 6401. For enrollment of service providers and suppliers in Medicare, Medicaid and the Children's Health Insurance Program (CHIP), the Secretary shall implement procedures for screening (minimally, licensure checks), enhanced oversight, increased disclosure requirements, temporary moratoria on enrollments to prevent fraud, waste and abuse, and the adoption of compliance programs.

To increase oversight, Section 1304 of the Reconciliation Act authorizes the Secretary to withhold payment for 90 days for initial claims of durable medical equipment (DME) suppliers. Providers and suppliers would pay an enrollment fee, which, however is waived for physicians under Section 10603. States shall comply with federal screening, oversight and reporting requirements with respect to service providers and suppliers.

Section 6402. The Integrated Data Repository of the Centers for Medicare and Medicaid Services shall include at a minimum claims and payment data for Medicare, Medicaid, CHIP, health-related programs of the Department of Veterans Affairs and the Department of Defense, Social Security Administration, and Indian Health Service. The Secretary shall enter into data-sharing agreements with the heads of other agencies to identify fraud, waste and abuse.

The Secretary shall impose administrative penalties on individuals engaged in waste, fraud or abuse. Overpayments to individuals under any program in the date repository must be returned within 60 days after being identified. Medicare and Medicaid service providers and suppliers must include their national provider identifier on all enrollment applications and payment claims. The Secretary may withhold federal matching payments to States that do not report encounter data in a timely manner in the Medicaid Statistical Information System.

Providers and suppliers may be excluded from participation in Medicare and Medicaid for having included false information in enrollment applications. Certain providers and suppliers may be required to post surety bonds. The Secretary may withhold payment to suppliers of durable medical equipment where fraudulent activity is deemed a significant risk.

Under Section 1303 of the Reconciliation Act, an additional $250 million is appropriated over the next decade to the Health

Care Fraud and Abuse Account. Medicare and Medicaid Integrity program contractors shall provide the Secretary and Inspector General with summary statistics on number and amount of overpayments recovered, number of fraud referrals, and the return on investment for these activities. The DHHS Inspector General and the Attorney General (Department of Justice) shall have access to the IDR data for law enforcement and oversight responsibilities.

Section 6403. The Secretary shall maintain a national health care fraud and abuse data program and shall furnish data there from to the National Practitioner Data Bank. Information from the Data Bank may be shared with appropriate agencies, authorities and officials such as State licensing and certification agencies or State law or fraud enforcement agencies. The Secretary may charge a fee to cover the costs of such information sharing. Upon enactment of this Act, the Secretary shall cease operating the Healthcare Integrity and Protection Data Bank by the end of a specified transition period and shall transfer all the data collected to the National Practitioner Data Bank.

Section 6404. The maximum period for submission of Medicare claims is reduced to one calendar year from the date of service.

Section 6405. The ordering of durable medical equipment (DME) and, as clarified by Section 10604, home health services under Part A and B can be done only by physicians enrolled in Medicare or eligible professionals. To further combat waste, fraud and abuse, the Secretary may extend this requirement to other items and services under Medicare.

Section 6406. The Secretary may disenroll for up to one year a Medicare enrolled physician or supplier that fails to keep and provide access to written orders for durable medical equipment, home health services certification, or referrals for other items and services.

Section 6407. A face-to-face encounter (including through telehealth) is required before a physician can certify a patient's eligibility for home health services or durable medical equipment under Medicare. Section 10605 clarifies that the face-to-face encounter may be made by a physician, nurse practitioner, clinical nurse specialist, certified nurse-midwife, or physician assistant. The Secretary may extend the face-to-

face requirement to other Medicare items and services. The face-to-face encounter is also required for home health services certification under Medicaid.

Section 6408. Persons who fail to give timely access to documents or otherwise obstruct audits, investigations, evaluations, or other statutory functions are subject to civil monetary penalties of $15,000 a day for each day of failure. The making or using of false statements is subject to a $50,000 penalty for each violation.

Sanctions and civil monetary penalties may be imposed on Medicare Advantage and Part D plans that enroll individuals without their consent, transfer individuals from one plan to another in order to earn a commission, fail to comply with marketing restrictions, or employ or contract with an individual or entity that commits a violation.

Section 6409. The Secretary shall establish a self-referral disclosure protocol under which health care providers of services and suppliers may disclose an actual or potential violation of Section 1877 of the Social Security Act.

[EDITOR'S NOTE. In general, and with some exceptions, Section 1877 of the Social Security Act prohibits physicians from making referrals for Medicare-covered items or services to entities in which the physician or a member of the physician's family has a financial interest.]

Section 6410. Competitive bidding under Round 2 to provide durable medical equipment, prosthetics, orthotics and supplies under Medicare is expanded from the 79 largest metropolitan statistical areas to one hundred such areas and by 2016 to use or adjust as appropriate competitively bid prices in all areas whether in an original bid area or not.

Section 6411. Under the Centers for Medicare and Medicaid Services, the Recovery Audit Contractor program is expanded. States shall contract with one or more recovery audit firms to identify underpayments or overpayments made pursuant to Medicaid State plans or waivers and to collect overpayments. The Recovery Audit Contractor program is also expanded to Medicare Part C (Medicare Advantage) and Part D (prescription drug coverage) plans.

Subtitle F. Additional Medicaid Integrity Provisions

Section 6501. A State is required to terminate from its Medicaid program individuals or entities that have been terminated by Medicare or another State's Medicaid program.

Section 6502. A State shall exclude from participation in its Medicaid program an individual or entity if it owns, controls or manages another entity that has failed to repay overpayments within a specified time; is suspended, excluded or terminated from any Medicaid program; or is affiliated with any other such excluded entity.

Section 6503. An agency, clearinghouse or similar payee that submits claims on behalf of a Medicaid health care provider must register with the State and the Secretary.

Section 6504. States are required to submit additional data elements under the Medicaid Management Information System (MMIS) deemed by the Secretary to be necessary for program integrity, oversight and administration.

Section 6505. A State shall not pay for items and services provided under Medicaid to any financial institution or entity located outside the United States.

Section 6506. If a State has made an overpayment to an entity, and the overpayment is subject to an ongoing administrative or judicial process, the State shall have one year to recover or attempt to recover the overpayment before an adjustment is made in the federal share of Medicaid expenditures. However, if the initial overpayment was due to fraud, the adjustment in the federal share shall not be made until thirty days after a final judgment.

[EDITOR'S NOTE. Whatever the circumstances under Section 6506, the federal government's share of Medicaid expenditures should not cover overpayments.]

Section 6507. To control improper coding that leads to improper Medicaid payments, States must make sure that that their Medicaid Management Information Systems (MMIS) are compatible with Medicare's national correct coding initiative (NCCI).

Section 6508. States are required to implement Medicaid waste, fraud and abuse initiatives under this subtitle by January 1, 2011.

Subtitle G. Additional Program Integrity Provisions

Section 6601. Any person who knowingly makes a false statement or false representation of fact (e.g. regarding the plan's benefits or financial condition) in connection with the marketing of a multiple employer welfare arrangement (MEWA) is subject to criminal penalties.

[EDITOR'S NOTE. A MEWA is a plan that provides health and welfare benefits to the employees of two or more employers rather than a single employer. Depending on the actual arrangement, it may or may not be covered under the 1974 Employee Retirement Income Security Act (ERISA) as amended. Some promoters have falsely marketed plans as though they were ERISA-covered and not subject to State insurance regulation.]

Section 6602. [Clarifying definition that includes ERISA.]

Section 6603. the Secretary shall request the National Association of Insurance Commissioners (NAIC) to develop a model uniform report form that private health insurers can use to refer suspected fraud and abuse to the appropriate State agency.

Section 6604. The Department of Labor shall issue regulations and/or orders that prevent fraudulent MEWAs from avoiding liability under State law by claiming that they are covered instead by federal law.

Section 6605. The Secretary of Labor is authorized to issue a cease and desist order against a MEWA that appears to be fraudulent, a danger to public safety and welfare, or a likely source of imminent and irreparable public injury. Under such order, a MEWA will be forced to shut down operations until hearings are completed and the Department may seize the entity's assets if it is in a financially hazardous condition.

Section 6606. Before enrolling anyone, MEWAs are required to file federal registration forms and are subject to verification of their legitimacy.

Section 6607. The Secretary of Labor may issue a regulation that permits the sharing of confidential communications among a State insurance department, State attorney general, National Association of Insurance Commissioners, and U.S. Departments

of Labor, Treasury, Justice and Health and Human Services pursuant to an investigation, examination or inquiry undertaken by any of those parties.

Subtitle H. Elder Justice Act

Section 6701. This subtitle may be cited as the Elder Justice Act of 2009.

Section 6702. [Definitions.]

Section 6703. There is established in the office of the Secretary an Elder Justice Coordinating Council whose members are the heads of federal agencies administering programs related to elder abuse, neglect or exploitation. The Council shall receive input from an Advisory Board on Elder Abuse, Neglect and Exploitation, with 27 members selected from the general public who are knowledgeable in the Board's area of responsibility.

The Secretary, in consultation with the Attorney General, shall make four grants to for the establishment of stationary forensic centers and six grants for mobile forensic centers all with expertise in elder abuse, neglect or exploitation. The Secretary, in consultation with the Secretary of Labor, shall foster an increase in direct care workers in long-term care.

The Secretary shall award grants to eligible entities that offer training and various levels of certification to direct care workers and provide bonuses, benefits or other compensation to workers who achieve certification under the program. The Secretary shall award grants to long-term care facilities to offset costs in implementing Electronic Health Records (HER) technology. The Secretary shall adopt electronic standards for the exchange of clinical information among long-term care facilities.

The Secretary shall annually award grants to States for the purpose of enhancing adult protective services provided by the State and local governments. The Secretary shall also award grants to States to conduct demonstration programs that test methods for detecting and preventing elder abuse. The Secretary shall award grants to eligible entities to improve the capacity of long-term care ombudsman programs to deal with complaints about abuse and neglect.

The Secretary shall contract with an entity for the establishment of a National Training Institute for Federal and State Surveyors. The Institute shall improve the training of and support for surveyors regarding allegations of abuse, neglect,

or appropriation of property in Medicare or Medicaid certified nursing facilities.

Covered nursing facilities are required to report to the Secretary and one or more law enforcement agencies any reasonable suspicion of a crime committed against any individual who resides in or receives care from the facility. Facilities are subject to civil monetary penalties for retaliating against employees who file complaints about facility violations.

The Secretary shall investigate the feasibility of establishing a national nurse aide registry.

Subtitle I. Sense of the Senate Regarding Medical Malpractice

Section 6801. It is the sense of the Senate that alternatives to the civil litigation system should be tested by States to improve patient safety, reduce medical errors, more efficiently and fairly resolve disputes, and improve providers' access to liability insurance, all while preserving an individual's right to seek redress in court.

TITLE VII.
ACCESS TO INNOVATIVE MEDICAL THERAPIES

Subtitle A. Biologics Price Competition and Innovation

Section 7001. This subtitle may be cited as "Biologics Price Competition and Innovation Act of 2009".

[EDITOR'S NOTE. A biologic is an agent like a drug, vaccine, or antitoxin that is synthesized from living organisms.]

Section 7002. The Secretary, through the Food and Drug Administration, is required to license a biological product where the applicant can show that the product is biosimilar to an already licensed reference product; that it meets prescribed standards for safety, clinical effectiveness and interchangeability as the reference product; and the applicant consents to the inspection of its manufacturing facility.

Approval of a biosimilar or interchangeable product is prohibited until at least twelve years after licensure approval for the initial reference product. The Secretary's risk evaluation and mitigation authority under the Federal Food, Drug and Cosmetic Act shall be applied to the licensed biological products. Certain provisions of the Act shall apply to pediatric studies of biological products.

The Secretary may not make a determination of interchangeability for a second biological product relative to the reference product until at least twelve months after commercial marketing of the first approved biosimilar product. The Secretary may issue guidance with respect to the licensure of biological products. He Secretary shall develop recommendations for Congress for the review of biosimilar biological product applications for the first five fiscal years after fiscal year 2012.

Section 7003. The Secretary of the Treasury, in consultation with the Secretary of Health and Human Services, shall for each fiscal year determine the savings to the federal government resulting from enactment of this subtitle.

Subtitle B. More Affordable Medicines for Children and Underserved Communities

Section 7101. As amended by Section 2302 of the Reconciliation Act, this section extends participation in the 340B program to certain children's hospitals, cancer hospitals, critical access and sole community hospitals and rural referral centers. Orphan drugs are exempted from the required discounts for new participants under the 340B program.

[EDITOR'S NOTE. 1) Section 340B of the Public Health Service Act authorizes the Secretary to negotiate agreements with manufacturers for discounts and rebates on covered drugs under State Medicaid plans. 2) An orphan drug is one developed specifically to treat a rare medical condition.]

Section 7102. As amended by Section 2302 of the Reconciliation Act, this section imposes new auditing, reporting, dispute resolution and other requirements on the Secretary, pharmaceutical manufacturers, and covered entities to assure the integrity of the 340B program (e.g. with respect to alleged overcharges for discounted drugs).

Section 7103. Within eighteen months of enactment of this Act, the Government Accountability Office shall submit a report to Congress on whether individuals served by 340B-covered entities are receiving optimal health care services and what it recommends to improve the 340B program.

TITLE VIII.
COMMUNITY LIVING ASSISTANCE SERVICES AND SUPPORTS

Section 8001. This title may be cited as the "Community Living Assistance Services and Supports Act" or "CLASS Act".

Section 8002. As amended by Section 10801, this title establishes a public national voluntary insurance program for community living assistance services and supports aimed at enabling individuals with functional disabilities to remain independently in their homes and communities. From at least three alternatives, and taking into account the advice of the CLASS Independence Advisory Council, the Secretary shall designate one plan as the CLASS Independence Benefit Plan. This Plan is the one that best balances benefits and prices in an actuarially sound manner while optimizing the long-term sustainability of the program.

Annual premiums to be paid by enrollees shall be based on an actuarial analysis that insures solvency over a 75 year period. After ten years of CLASS program operation, and if the program is sustainable from annual premiums and interest, the Secretary may decrease reserves in the CLASS Independence Fund. There is a five-year vesting period for eligibility for benefits.

Benefits are triggered by a determination by a licensed health care practitioner that an enrollee has significant ongoing cognitive impairment or inability to carry out a certain number of activities of daily living (e.g. eating, bathing, dressing, toileting, transferring) without substantial assistance. Cash benefit levels are scaled according to the degree of functional limitation but overall average at least $50 a day. No taxpayer funds are used to pay for benefits.

TITLE IX.
REVENUE PROVISIONS

Subtitle A. Revenue Offset Provisions

Section 9001. As amended by Section 10901, an excise tax is imposed on high-cost employer-sponsored health care coverage providers. As amended by Section 1401 of the Reconciliation Act, the tax is 40 percent on coverage that is above a threshold of $10,200 for an individual and $27,500 for a family. The tax is levied on plan administrators and health insurance companies and applies to premiums in excess of the threshold. Stand-alone vision and dental coverage plans are excluded from the tax. The threshold is indexed through 2019 using the Consumer Price Index for All Urban Workers (CPI-U).

The threshold level is increased for plans covering retirees aged 55+ and individuals in high risk professions (e.g. law enforcement, fire protection, etc). Under Section 10901, longshore workers count are treated as being engaged in a high-risk profession. Additional adjustments can be made for firms with higher health care costs due to the age or gender of their workers and for unexpected high premium growth before 2018. The tax becomes effective in 2017.

Section 9002. Employers are required to include the value of benefits provided under their health care coverage plans on each employee's W-2.

Section 9003. Comparable language for defining qualified medical expenses for prescription medicine or drugs is inserted into the Internal Revenue Code for Health Savings Accounts (HSA), Archer Medical Savings Accounts (MSA), health Flexible Spending Arrangements (FSA) and Health Reimbursement Arrangements (HRA).

Section 9004. The tax on distributions (i.e. withdrawals) not used for qualified medical expenses is increased from 10 to 20 percent for HSAs and from 15 to 20 percent for MSAs.

Section 9005. As amended by Section 10902, the contribution to health FSAs is limited to $2,500 in 2013 and indexed for subsequent years at CPI-U. Additional amendments on effective dates are made by Section 1403 of the Reconciliation Act.

Section 9006. Businesses that pay $600 or more a year to corporate and non-corporate providers of property and services are required to report the information to each provider and to the IRS.

Section 9007. As amended by Section 10903, charitable nonprofit hospitals are subject to certain requirements covering periodic community health care needs assessments, financial assistance, emergency medical care; charges, billing and collections.

Section 9008. An annual fee is imposed on manufacturers and importers of branded prescription pharmaceuticals. As amended by Section 1404 of the Reconciliation Act, the fee for the sector is $2.5 billion for 2011-12, $2.8 billion for 2013, $3.0 billion for 2014-16, $4.0 billion for 2017, $4.1 billion for 2018, and $2.8 billion thereafter. The fee is allocated among covered firms in the sector according to each firm's market share.

Section 9009. As amended by Section 10904, an excise tax is imposed on manufacturers and importers of medical devices. As amended by Section 1405 of the Reconciliation Act, the tax is 2.3 percent of the sales prices and is deductible for federal income tax purposes. Eyeglasses, contact lenses, hearing aids and other items determined by the Secretary to be retail purchases for individual use are exempt from the tax.

Section 9010. As amended by Section 10905, an annual fee is imposed on health insurance providers. As amended by Section 1406 of the Reconciliation Act, the fee is $8.0 billion in 2014, $11.3 billion in 2015-16, $13.9 billion in 2017, and $14.3 billion in 2018. For subsequent years the fee is the amount for the preceding year increased by the rate of premium growth.

The fee is allocated among covered entities across the health insurance provider sector according to each entity's market share. Exempted are nonprofits where more than 80 percent of revenue is received from government programs that target low-income, elderly or disabled populations. The fee becomes effective in 2013.

Section 9011. The Secretary of Veterans Affairs shall conduct a study of how fees imposed on manufacturers of pharmaceuticals and medical devices and on health care providers affect veteran's health care costs and their access to

medical devices and prescription drugs. A report to Congress is due by December 31, 2012.

Section 9012. This section eliminates the tax deduction for the federal subsidy received by employers that maintain prescription drug plans for their retirees who are eligible for Medicare Part D coverage. As amended by Section 1407 of the Reconciliation Act, the effective date is December 31, 2012.

Section 9013. Effective in 2103, the threshold to claim the itemized deduction for medical expenses is raised from 7.5 percent to 10 percent of adjusted gross income. However, seniors age 65+ can use the 7.5 percent threshold through 2016.

Section 9014. This section applies to insurers where 25 percent or more of gross premium income is derived from health insurance plans that meet this Act's requirements for minimum essential coverage. Such insurer's corporate tax deduction for executive compensation is capped at $500 thousand per person for a taxable year. This applies to all officers, employees, directors, and other workers providing services for or on behalf of a covered health insurance provider.

Section 9015. As amended by Section 10906, the hospital insurance tax rate is increased by 0.9 percent for individual taxpayers earning more than $200,000 a year and couples filing jointly who earn more than $250,000. As amended by Section 1402 of the Reconciliation Act, the hospital insurance tax rate includes an additional 3.8 percent tax on investment income, that is, interest, dividends, annuities, royalties, and rents not derived in the ordinary course of business. Exempted from this provision are Chapter S corporation gains, partnership income, and individual taxpayers earning more than $200,000 a year and couples filing jointly who earn more than $250,000.

Section 9016. Nonprofit Blue Cross-Blue Shield organizations with a medical loss ratio of 85 percent or higher may take a deduction for 25 percent of claims and expenses, a deduction for 100 percent of premium reserves and other tax benefits.

Section 9017. This section is repealed by Section 10907, which instead imposes an excise tax of 10.0 percent on indoor tanning services.

Subtitle B. Other Provisions

Section 9021. For tax purposes, gross income does not include the value of qualified Indian health care benefits such as benefits or services provided by or through the Indian Health Service or accident or health insurance provided by an Indian tribe to a member.

Section 9022. Simplified cafeteria plans are established so that small businesses can provide tax-free benefits to employees.

[EDITOR'S NOTE. A cafeteria plan is one in which employee premiums are paid through pre-tax salary reduction arrangements that are not subject to federal, State or Social Security taxes. This also reduces the employer's share under the Federal Insurance Contributions Act (FICA), Federal Unemployment Tax Act (FUTA) and workmen's compensation insurance premiums.]

Section 9023. A temporary two-year tax credit is established—but capped overall at $1 billion—to encourage investment in the discovery of new therapies to prevent, diagnose, and treat acute and chronic diseases.

Section 9024. As added by Section 10908, payments made by any State loan repayment program or loan forgiveness program are excluded from a taxpayer's calculation of gross income for tax purposes, if such program is aimed at increasing the availability of health care services in underserved or health professional shortage areas.

Section 9025. As added by Section 10909, the tax credit and adoption assistance exclusion ($13,170 in 2009) is increased by $1,000. The tax credit is made refundable.

TITLE X.
QUALITY, AFFORDABLE HEALTH CARE FOR ALL

Subtitle A. Provisions Relating to Title I

Note: Some sections of Title X modify or repeal certain sections in Titles I-IX. These changes are included within the relevant sections of Titles I-IX. Only new provisions unrelated to the previous titles are described here.

Section 10101. Amendments to Subtitle A.
Section 10102. Amendments to Subtitle B.
Section 10103. Amendments to Subtitle C.
Section 10104. Amendments to Subtitle D.
Section 10105. Amendments to Subtitle E.
Section 10106. Amendments to Subtitle F.
Section 10107. Amendments to Subtitle G.

Section 10108. Employers of employer-sponsored plans with minimal essential coverage are required to offer qualified employees free choice vouchers to purchase a health plan through the Exchange. Employees would qualify of their contribution to the employer plan would lie between 8.0 and 9.8 percent of their income. Voucher recipients are not eligible for tax credits. The 8.0 percent figure shall be indexed to reflect the rate of premium growth from year to year.

Section 10109. The Secretary, in consultation with standard-setting stakeholders, the National Committee for Vital and Health Statistics, the Health Information Policy Committee and the Health Information Technology Standards Committee, to develop uniform standards where possible for health care administrative and financial transactions.

Subtitle B. Provisions Relating to Title II

PART I—MEDICAID AND CHIP

Section 10201. Amendments to Title II of this Act, specifically Sections 2001, 2004, 2005, 2006, 2101, 2551, and 2953 and Title XIX of the Social Security Act.

Section 10202. States are given incentives to offer home and community based services (HCBS) as alternatives to nursing home care through a State balancing incentives program. Under the program the federal matching assistance percentage (FMAP) for Medicaid is increased for rebalancing in favor of HCBS over nursing home care.

Section 10203. Title XXI of the Social Security Act is amended to make appropriations to the Children's Health Insurance Program (CHIP) through fiscal year 2015 and revise certain other CHIP provisions.

PART II—PREGNANT AND PARENTING TEENS AND WOMEN

Section 10211. [Definitions of terms.]

Section 10212. The Secretary, in cooperation with the Secretary of Education, shall establish a Pregnancy Assistance Fund, under which competitive grants will be awarded to States to assist pregnant and parenting teens and women.

Section 10213. A State may use Pregnancy Assistance Fund grants to enable institutions of higher education to offer pregnant or parenting student services. An institution receiving such assistance must provide a 25 percent non-federal share. Institutions may use funds to help pregnant or parenting teens to complete high school or other intervention services, to provide family housing and child care, post-partum counseling and other services. Funds may also be used to assist pregnant women who are victims of sexual assault, domestic violence, stalking or related risks to health and safety.

Section 10214. Annual authorized appropriations are $25 million for the years 2010 through 2019.

PART III—INDIAN HEALTH CARE IMPROVEMENT

Section 10221. Appropriations are authorized for the Indian Health Care Improvement Act, for programs to increase the Indian health care workforce, develop new health care delivery models, promote wellness, improve access to care and prevent suicide among Indian youth.

Subtitle C. Provisions Relating to Title III

Section 10301. Amendment to Section 3006.
Section 10302. Amendment to Section 3011.
Section 10303. Amendment to Section 3013.
Section 10304. [Technical amendment.]
Section 10305. Amendment to Section 3015.

Section 10306. Amendment to Section 3021.
Section 10307. Amendments to Section 3022.
Section 10308. Amendments to Section 3023.
Section 10309. Amendments to Section 3024.
Section 10310. Amendment repealing Section 3101.

Section 10311. Amendments to Section 3105.
Section 10312. Amendments to Section 3106.
Section 10313. Amendments to Section 3123.
Section 10314. Amendment to Section 3125.
Section 10315. Amendments to Section 3131.

Section 10316. Amendment to Section 3133.
Section 10317. Amendments to Section 3137.
Section 10318. [Technical amendment.]
Section 10319. Amendments to Section 3401.
Section 10320. Amendments to Section 3403.

Section 10321. [Technical amendment.]
Section 10322. Amendments to Section 3401.

Section 10323. A new Section 1881 is added to the Social Security Act under which Medicare coverage is extended to individuals with medical conditions resulting from exposure to environmental hazards. Covered are diagnoses of pleural thickening, pleural plaques, mesothelioma, and other asbestos-related conditions. The Secretary shall establish one or more pilot programs to determine the best ways to deliver comprehensive, cost-effective care to affected individuals. Competitive grants shall be awarded to eligible entities or early detection of medical conditions related to environmental hazards.

Section 10324. Under amendments to Section 1886 of the Social Security Act, protection is provided to frontier States by setting a floor under the wage index for hospitals and physicians. The area wage adjustment factor may not fall below 1.00. A frontier State is one in which at least half of its

counties have a population density of less than six people per square mile.

Section 10325. Implementation of the Resource Utilization Groups, Version 4 (RUGS-IV) is postponed until October 1, 2011. The implementation of Version 3.0 of the Minimum Data Set (MDS) shall go forward as planned on October 1, 2010.

[EDITOR'S NOTE. The RUGS system is used by the Centers for Medicare and Medicaid Services to calculate Medicare payments to skilled nursing facilities. This is done by adjusting payments for a facility's casemix, that is, groupings of patients based on their individual outcomes, quality of care, and resource use. The key source of information is the Minimum Data Set, a resident assessment instrument.]

Section 10326. The Secretary shall conduct separate pilot programs to test value-based purchasing for the following providers: psychiatric hospitals, long-term care hospitals, rehabilitation hospitals, PPS-exempt cancer hospitals, and hospice programs.

Section 10327. Under amendments to Section 1848 of the Social Security Act, additional incentive payments shall be made to eligible physicians who submit data on quality measures to the Secretary through a Maintenance of Certification program and who, more frequently than is required for their specialty, successfully complete a Maintenance of Certification program.

Section 10328. Section 1860-D4 of the Social Security Act (regarding Medicare Part D – Prescription Drug Coverage) is amended it to require that prescription drug plan sponsors shall offer medication therapy management services. The primary goal is to increase adherence to prescription medications. Enrollment is automatic but beneficiaries may opt out.

Section 10329. The Secretary shall develop a methodology for measuring health plan value.

Section 10330. The Secretary shall develop a plan and budget for modernizing the computer and data systems of the Centers for Medicare and Medicaid Services.

Section 10331. The Secretary shall develop a "Physician Compare" website with comparative data and information on

physicians enrolled in Medicare and other eligible professionals who participate in the Physician Quality Reporting Initiative. No later than January 1, 2019, the Secretary may establish a demonstration program under which financial incentives are provided to Medicare beneficiaries who receive services from high quality physicians.

Section 10332. For purposes of evaluating the performance of providers and suppliers, the Secretary shall make certain Medicare data available to qualified and eligible evaluation entities. The data are extracts of claims data under Medicare Parts A, B and D, made available in a manner that protects beneficiaries' privacy and meets other requirements.

Section 10333. The Secretary through the Health Resources and Services Administration may make grants to eligible entities for the purpose of establishing community-based collaborative care networks. Such networks are consortia of health care providers with a joint governance structure that provide comprehensive and integrated care to low income populations.

Section 10334. The Office of Minority Health is transferred from the Public Health Service to the Office of the Secretary of Health and Human Services. The Office of Minority Health will monitor and evaluate health quality of care among minority populations. The National Center on Minority Health and Health Disparities is elevated to being an institute within the National Institutes of Health.

An Office of Minority Health will be established within individual agencies of the Department of Health and Human Services, including the Centers for Disease Control and Prevention (CDC), Health Resources and Services Administration (HRSA), Substance Abuse and Mental Health Services Administration (SAMHSA), Agency for Healthcare Research and Quality (AHRQ), Food and Drug Administration (FDA), and Centers for Medicare and Medicaid Services (CMS).

Section 10335. Technical amendment to Section 1886 of the Social Security Act that excludes measures of readmissions from the hospital value-based purchasing program.

Section 10336. The Government Accountability Office shall evaluate the impact of the bundled prospective payment system (PPS) for end-stage renal disease treatment.

Subtitle D. Provisions Relating to Title IV

Section 10401. Amendments to Section 4001.
Section 10402. Amendments to Section 4101.
Section 10403. Amendments to Section 4201.
Section 10404. Technical amendment to Section 4303.
Section 10405. Eliminates Section 4401.
Section 10406. Amendment to Section 4104.

Section 10407. This section may be cited as the "Catalyst to Better Diabetes Care of 2009". The Secretary, in collaboration with the Centers for Disease Control and Prevention, shall prepare every two years a diabetes "report card" for the nation and, to the extent possible, for each State. The Secretary and the CDC shall foster training and education for physicians on the proper completion of birth and death certificates, including data on diabetes and other chronic diseases. The Institute of Medicine shall study the impact of diabetes on the practice of medicine and the appropriateness of medical education on diabetes for licensure and board certification.

Section 10408. The Secretary shall establish a five-year grant program under which grants are made to Eligible employers to provide their employees with access to comprehensive workplace wellness programs. Eligible employers are for-profit and nonprofit organizations with fewer than 100 employees working 25 or more hours a week. Appropriations of $200 million are authorized.

Section 10409. This section may be cited as the "Cures Acceleration Network Act of 2009". The Cures Acceleration Network within the National Institutes of Health may award grants and contracts to accelerate the development of high need cures through new medical products and behavioral therapies. The Network shall work with the Food and Drug Administration to expedite the approval process for new products and therapies.

To advise the Director of the National Institutes of Health, there shall be established a Cures Acceleration Network Review Board consisting of 24-members appointed by the Secretary and several ex-officio members representing the NIH, FDA, Department of Defense, Department of Veterans Affairs, and National Science Foundation. An appropriation of $500 million

is authorized for fiscal year 2010 and such sums as necessary thereafter.

Section 10410. This section may be cited as the "Establishing a Network of Health-Advancing National Centers of Excellence for Depression Act of 2009" or "ENHANCED Act of 2009". The Substance Abuse and Mental Health Administration shall award competitive grants to eligible entities to establish centers of excellence for the treatment of depressive disorders.

Up to thirty such centers may be established by September 30, 2016. Eligible entities include institutions of higher education and public or private nonprofit research organizations. One center shall be designated as a national coordinating center and shall oversee and coordinate the work of all centers. $100 million are authorized for appropriation for each fiscal year from 2011 through 2015 and $150 million for fiscal years 2016 through 2020.

Section 10411. This section may be cited as the "Congenital Heart Futures Act". The Centers for Disease Control and Prevention are authorized to expand the infrastructure that tracks the epidemiology of congenital heart disease and to organize the data into a nationally representative, population-based surveillance system. To accomplish this a grant may be made to a public or private non-profit entity with specialized experience in congenital heart disease. The National Heart, Lung and Blood Institute may expand, intensify and coordinate research and related activities on congenital heart disease.

Section 10412. Public access defibrillation programs under the Automated Defibrillation in Adam's Memory Act are reauthorized and extended through 2014.

Section 10413. This section may be cited as the "Young Women's Breast Health and Education Requires Learning Young Act of 2009". The Centers for Disease Control and Prevention shall conduct a national education campaign to increase young women's knowledge of breast health and risk factors associated with breast cancer. Under grants to eligible entities, there shall be national multimedia campaigns oriented to young women and health care professionals on breast health and detection and treatment of breast cancer. The Centers for Disease Control and Prevention shall conduct research on the prevention of cancer in young women.

Subtitle E. Provisions Relating to Title V

Section 10501. This section makes technical amendments plus other changes. There is added Section 5104 (Alaska health care task force), and Section 5316 (nurse practitioner training). Faculty members at schools for physician assistants are added to the individuals eligible for federal loan repayment and scholarship programs.

This section also establishes a national diabetes prevention program through the Centers for Disease Control and Prevention. Grants shall be made to eligible entities for community-based diabetes prevention activities, training, outreach and evaluation. Eligible entities include State, local and Indian tribal public health agencies, nonprofit health care organizations, academic institutions and others as determined by the Secretary.

The requirement for a budget neutrality adjustment in Section 5501 is repealed. Section 5505 is amended. A new Section 5606 (State grants) is added.

The Health Resources and Services Administration (HRSA) shall establish a new grant program for the recruitment of students most likely to practice medicine in rural underserved communities. Entities eligible for a grant are schools of allopathic or osteopathic medicine.

HRSA shall also award grants and contracts to eligible entities to provide graduate medical training in preventive medicine specialties. Eligible entities include schools of public health; medicine or osteopathic medicine; public or private nonprofit hospitals; State, local and tribal health departments; and consortia of two or more such entities.

If a waiver is granted, members of the National Health Service Corps who serve in medically underserved areas may meet their service obligation through half-time rather than full-time clinical practice. In such cases, the Corps member agrees to either double the time of the service period or accept a minimum service time of two years with an award equal to half the amount paid for full-time service.

Section 10502. $100 million is appropriated to the Department of Health and Human Services for construction, renovation or debt service for a health care facility engaged in

research, inpatient tertiary care, or outpatient clinical services. To be eligible the facility must be affiliated with a public university that houses a State's sole medical or dental school.

Section 10503. A Community Health Center Fund is established to be administered through the Office of the Secretary in the Department of Health and Human Services. Funds shall be used for investment in community health centers and the National Health Service Corps. Among other uses, funds may be used for the construction and renovation of community health center facilities.

As amended by Section 2303 of the Reconciliation Act, fiscal year appropriations to the Fund for community health centers are as follows: 2011-$1 billion; 2012-$1.2 billion; 2013-$1.5 billion; 2014-$2.2 billion; 2015-$3.6 billion. For 2011-2105, $1.5 billion are appropriated for facility improvement. Fiscal year appropriations to the Fund for the National Health Service Corps are as follows: 2011-$290 million; 2012-$295 million; 2013-$300 million; 2014-$205 million; 2015-$310 million.

Section 10504. The Health Resources and Services Administration shall establish a three year demonstration program in up to ten States to provide uninsured persons with access to comprehensive health care services at reduced fees. Each participating State shall receive not more than $2 million for the three year project period. Funds shall be awarded by States to nonprofit public-private partnerships to implement the demonstration.

Subtitle F. Provisions Relating to Title VI

Section 10601. Amendments to Section 6001.
Section 10602. Amendments to Section 6301.
Section 10603. Amendments to Section 6401.
Section 10604. Amendments to Section 6405.
Section 10605. Amendments to Section 6407.

Section 10606. Under its sentencing guidelines, the U.S. Sentencing Commission shall increase penalties for federal health care offenses relating to a federal health care program. For example, revised sentencing guidelines for convicted persons shall provide for a two level increase in the offense level where losses due to fraudulent billing are between $1-7 million; a three level increase for losses between $7-20 million; and a four level increase for losses beyond $10 million. Federal subpoena authority relating to health care is strengthened.

Section 10607. The Secretary may award demonstration grants to States for up to a five year period to test and evaluate alternatives to the current system of medical tort litigation. The alternatives shall allow for resolution of disputes and promote a reduction in medical errors that enhances patient safety and quality of care. Patients may opt out of the tort reform alternative at any time. The Secretary shall evaluate the program and report the results to Congress with appropriate recommendations.

Section 10608. Under the Federal Tort Claims Act, medical malpractice insurance coverage is extended to free clinics.

Section 10609. The approval requirements for the labeling of generic drugs are modified.

Subtitle G. Provisions Relating to Title VIII

Section 10801. Amendments to Section 8002.

Subtitle H. Provisions Relating to Title IX

Section 10901. Amendments to Section 9001.
Section 10902. Amendments to Section 9002.
Section 10903. Amendments to Section 9007.
Section 10904. Amendments to Section 9009.
Section 10905. Amendments to Section 9010.
Section 10906. Amendments to Section 9015.
Section 10907. Replacement of Section 9017 with new provisions.

Section 10908. For tax purposes, payments under the National Health Service Corps repayment program and certain State repayment programs shall not be counted as part of an individual's gross income.

Section 10909. Amendments to Section 9025.

HEALTH CARE AND EDUCATION RECONCILIATION ACT OF 2010 (P.L. 111-152)

Note. Parts of this Reconciliation Act modify the Patient Protection and Affordable Care Act and are included in the relevant sections there. We summarize here only those sections of the Reconciliation Act that do not directly modify the Patient Protection and Affordable Care Act.

TITLE I.
COVERAGE, MEDICARE, MEDICAID AND REVENUES

Subtitle A. Coverage

Section 1004. The definition of income that is used to determine the tax credit, subsidy eligibility and individual responsibility for coverage requirement conforms to the one reported on IRS Form 1040 and current law on income tax filing thresholds.

Section 1005. There is established an Health Insurance Reform Insurance Fund within the Department of Health and Human Services to finance administrative costs of implementing this Act. $1 billion is appropriated to the Fund.

Subtitle B. Medicare

Section 1102. Medicare Advantage (MA) payments are frozen for 2011. In 2012 and thereafter, benchmarks that determine MA payments will be reduced, varying from 95 percent of Medicare spending for high cost areas to 115 percent for low cost areas. For high quality plans, benchmarks in any area may be increased by five percent. The changes will be phased in over three, five or seven years, depending on the reduced payment level. The Centers for Medicare and Medicaid Services may adjust risk scores for Medicare Advantage compared to fee-for-service if differences in data coding patterns are observed.

Section 1103. Medicare Advantage plans are mandated to spend at least 85 percent of revenue on medical costs or quality of care activities, rather than overhead and profit.

[EDITOR'S NOTE. More technically, .85 is the minimum medical loss ratio permitted to MA plans.]

Section 1109. Based on risk-adjusted spending for Medicare enrollees, hospitals located in the lowest quartile of counties shall receive an additional payment under Medicare's in-patient prospective payment system (PPS).

[EDITOR'S NOTE. The risk of Medicare spending that is higher or lower than the average is adjusted using factors like age, gender and race.]

Subtitle C. Medicaid

Section 1202. State Medicaid payment rates to primary care physicians for primary care services shall be not less than the Medicare rates for 2013-14. Federal funds shall cover 100 percent of the additional costs to States for meeting this requirement.

Subtitle D. Reducing Fraud, Waste and Abuse

Section 1301. To reduce fraud and abuse, community mental health centers that provide Medicare partial hospitalization services are subject to new restrictions. E.g. at least 40 percent of those served by the centers must not be eligible for Medicare.

Section 1302. To streamline Medicare's conduct of prepayment medical reviews, section 1874A(h) of the Social Security Act, which imposed certain conditions and limitations on those reviews, is repealed.

Subtitle E. Revenues

Section 1402. Subtitle A of the Internal Revenue Code of 1986 is amended to impose an unearned income Medicare contribution. In addition to existing payroll taxes, individuals earning over $200 thousand a year and couples earning over $250 thousand a year will be subject to a 3.8 percent tax on capital gains from investments.

[EDITOR'S NOTE. Despite the tax's title, the revenue does not go to the Medicare trust funds but rather to the general fund.]

Section 1408. An unintended application of the tax credit for cellulosic biofuel producers is eliminated by excluding fuels with excess water, sediment or ash content.

Section 1409. The economic substance doctrine is clarified. Economic substance is deemed to exist only if a transaction changes in a meaningful way a taxpayer's economic position and the taxpayer has a substantial purpose (apart from federal income tax effects) for the transaction. Tax underpayments attributed to a transaction that lacks economic substance are subject to a strict liability penalty of 40 percent—or 20 percent if the transaction was disclosed.

Section 1410. A one-time adjustment to corporate estimated income taxes is made for payments in 2014.

Subtitle F. Other Provisions

Section 1501. For fiscal years 2010-14, $500 million a year is appropriated for community colleges to develop or improve educational and career training programs under the Community College and Career Training grant program.

TITLE II.
EDUCATION AND HEALTH

Subtitle A. Education

PART I—STUDENTS AND FAMILIES

Sections 2101-2103. These sections increase the amounts of federal Pell Grants available to students, increase funding for historically black colleges and universities, and other minority-serving institutions, and continue funding for the College Access Challenge Grant Program authorized under the College Cost Reduction and Access Act.

PART II—STUDENT LOAN REFORM

Sections 2201-2213. The following are terminated: Federal Family Education Loan (FFEL) appropriations; federal loan insurance program; applicable interest rates; federal payments to reduce student interest costs; FFEL loans, unsubsidized Stafford Loans for middle income borrowers, and special allowances. The borrowers of two or more loans under certain federal programs may have those loans consolidated under a one-year temporary loan consolidation authority (July 1, 2010-11)

Subtitle B. Health

Section 2501. Amendments to Section 1251 of the Patient Protection and Affordable Health Care Act.

Section 2502. Amendments to Sections 7101 and 7102 of the Patient Protection and Affordable Health Care Act.

Section 2503. Amendment to Section 10503 of the Patient Protection and Affordable Health Care Act.

Appendix. TIMELINE FOR SELECTED HEALTH CARE REFORMS

2010

-Access to coverage for people with pre-existing conditions through high risk insurance pools (through 2013).
-Dependent coverage up to age 26.
-No lifetime limits on coverage and no rescission of existing coverage.
-Preventive services and immunizations for infants, children, adolescents and women.
-Tax credits for small employers up to 25 employees.

-Temporary reinsurance program by employers for non-Medicare eligible retirees.
-Rebates when premium revenue spent on services is below threshold.
-Justification required for health plan premium increases.
-Rebate of $250 to start elimination of Medicare Part D coverage gap (donut hole) by 2020.
- Medicare coverage for persons with health conditions due to environmental hazards.

-Improved care coordination for dual eligibles (Medicare and Medicaid).
-Annual market basket updates for hospital services.
-Restrictions on Medicare coverage of physician-owned hospitals.
-State option to cover childless adults under Medicaid.
-State option to provide family planning services under Medicaid.

-New Medicaid option to for CHIP coverage of State employees' children.
-Increases in the Medicaid drug rebate percentage.
-Expanded role for Medicaid and CHIP Payment and Access Commission.
-HHS regulations on Section 1115 waivers for Medicaid and CHIP.
-Authorization of FDA approval of generic versions of certain biologic drugs.

-Patient-Centered Outcomes Research Institute for comparative studies.
-Commissioned Regular Corps and Ready Reserve Corps established.

-Reauthorization of Indian Health Care Improvement Act.
-National workforce strategy to be prepared by Workforce Advisory Committee.
-Expanded training of healthcare professionals through scholarships and loans.

-New requirements for non-profit hospitals and tax for non-compliance.
-Deductibility of highly-paid executives limited to $500,000 for health care providers.
-Indoor tanning services taxed at 10%.
-Cellulosic biofuel tax credit excluded for unprocessed fuels.
-Clarification of economic substance doctrine for tax purposes.

2011

-CLASS, voluntary long-term care insurance program.
-Five-year grants to States to develop alternatives to tort litigation.
-No cost-sharing for Medicare covered preventive services.
-Comprehensive health risk assessment and prevention plan covered by Medicare.
-Grants up to five years for employers that establish wellness programs.

-National Prevention, Health Promotion and Public Health Council established.
-Chain restaurants and vending machines must disclose food items' nutritional content.
-Bonus payments for primary care physicians and surgeons in health shortage areas.
-Restructuring of Medicare Advantage payments.
-Medicare payments for hospitals in counties in lowest quartile for Medicare spending.

-Income thresholds for Medicare Part B premium subsidies frozen.
-Medicare Part D premium subsidy reduced for upper income individuals and couples.
-Innovation Center established in HHS' Center for Medicare and Medicaid Services.
-No federal Medicaid payments to States for health care acquired conditions.
-State Medicaid option for certain enrollees to designate a health home.

-Medicaid rebalancing initiative to increase community-based long term care.
-Community First Choice support option in Medicaid for people with disabilities.
-Development of a national quality improvement strategy.
-Community-Based Collaborative Care Network Program to help uninsured.
-New program to increase capacity of trauma centers.

-Additional funding for community health centers and National Health Service Corps.
-New programs for school-based health centers and nurse-managed clinics.
-Support for primary care residency programs in ambulatory care centers.
-Non-prescription drugs excluded from tax benefits under health savings accounts.
-Tax increased on HSA and Archer MSA for non-medical disbursements.

-New annual fees on pharmaceutical manufacturers.
-Simple cafeteria plan whereby small businesses can provide tax-free benefits to employees.

2012

-Medicare Part D cost-sharing equalized for community-based and institutional care.
-Accountable Care Organizations (ACO) share in Medicare cost savings.
-Medicare payments reduced for avoidable hospital readmissions.
-Market basket updates reduced for home health agencies, nursing homes and others.
-Medicare Independence at Home demonstration program.

-Value-based purchasing programs under Medicare for hospitals.
-Similar programs for nursing homes, home health agencies, ambulatory surgical centers.
-Bonus payments for high quality Medicare Advantage plans.
-Reduced rebates for Medicare Advantage plans.
-Medicaid demonstration program to test bundled payments for services.

-Medicaid demonstration program for global capitated payments to safety net hospitals.
-Sharing in cost-savings under Medicaid for pediatric care providers organized as ACOs.
-Medicaid payments to mental illness institutions for treating emergency conditions.
-More data on race, ethnicity, gender, language, disability and underserved areas.

2013

-Consumer Operated and Oriented Plan (CO-OP) program to set up non-profit insurers.
-Single set of operating rules for eligibility determination and claims status.
-Operating rules for electronic funds transfers, payments and remittances.
-Operating rules for health claims, enrollment, disenrollment, premiums and referrals.
-Penalties for failure of health insurance plans to comply with operating rules.

-Removal of cost-sharing for preventive services covered by Medicaid.
-Phase-in of federal subsidies for brand name drugs under Medicare Part D.
-Increased payment for primary care under Medicaid with 100% federal funding.
-Disclosure of financial relationships among physicians, hospitals, and other providers.
-Itemized tax deduction for medical expenses raised from 7.5% to 10.0%.

-Medicare Part A (hospital insurance) tax rate on wages increased for high incomes.
-Contributions to medical expenses accounts limited to $2,500/year adjusted for inflation.
-Excise tax of 2.3% on taxable medical devices.
-No tax deduction for employers getting Medicare Part D subsidy payments for retirees.

2014

-Penalty for failure of U.S. citizens and residents to have qualifying health coverage.

-Fee assessed on employers not offering health care insurance coverage.
-Creation of American Health Benefits Exchanges.
-Creation of Small Business Health Options (SHOP) Exchanges.
-Guaranteed issue and renewability of insurance coverage.

-Premium rating based solely on age, rating area, family composition, and tobacco use.
-Out of pockets limits reduced for incomes up to 400% of federal poverty line.
-Limits on deductibles for health plans in small group markets.
-Waiting period for coverage limited to 90 days.
-Essential health benefits package must meet certain criteria.

-At least two multi-state plans to be offered by each Exchange.
-State option to create Basic Health Plan for uninsured at 133-200% of poverty.
-Temporary reinsurance program to cover high risk individuals.
-New health plans required to meet operating rules and reporting requirements.
-Subsidies for those at 133-200% of poverty to buy insurance through Exchanges.

-Out of pocket amount reduced for Medicare Part D catastrophic coverage.
-Independent Payment Advisory Board established to control Medicare cost growth.
-Reduced payments to Medicare Disproportionate Share hospitals.
-Medical loss ratio no lower than .85 for Medicare Advantage plans.
-Medicaid expanded to non-Medicare individuals under age 65 up to 133% of poverty line.

-Reduced allotments to States for Medicaid Disproportionate Share hospitals.
-Higher spending caps for U.S. Territories.
-Rules regarding employer rewards to employees who participate in wellness programs.
-Pilot program in 10 States for wellness program rewards in the individual market.
-New fees imposed on health insurance sector.

-Movement toward value-based (vs. volume-based) purchasing for certain providers (e.g. hospices, ambulatory surgical centers, rehabilitation hospitals) through quality measures.

2015 and Beyond

-Multi-state insurance policy sales under health care choice compacts among States.
-Reduced Medicare payments to certain hospitals for hospital acquired conditions.
-Excise tax on insurers of certain high-valued employer-sponsored plans (in 2018).

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