



Health Policy Alternatives, Inc.

# SUMMARY OF PATIENT PROTECTION AND AFFORDABLE CARE ACT

Prepared by Health Policy Alternatives

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## NOTE FOR READERS

This summary of the Patient Protection and Affordable Care Act (PPACA, P.L. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (HCERA, P.L. 111-152), was prepared by Health Policy Alternatives. Except for a few selected provisions, this edition of the summary does not include Title V, Health Care Workforce. A revised summary with a complete Title V will be available in the near future. The summary includes revenue provisions except those unrelated to health care. The organization of the summary follows PPACA, with entirely new sections added by Title X of that law or by HCERA placed at the end of the related material in the summary. Changes made to existing sections of PPACA by Title X of that law or by HCERA are incorporated in the description of the pertinent section. We wish to acknowledge helpful assistance from Julie James in preparing the summary.

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# PATIENT PROTECTION AND AFFORDABLE CARE ACT

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Sec. 1409 of HCERA: Codification of economic substance doctrine and imposition of penalties.

Sec. 1410 of HCERA: Time for payment of corporate estimated taxes.

# SUMMARY OF PATIENT PROTECTION AND AFFORDABLE CARE ACT

## **TITLE I—QUALITY, AFFORDABLE HEALTH CARE FOR ALL AMERICANS**

### **HPA Explanation of application of insurance reforms to different types of coverage**

Although many of the title I provisions relating to insurance and related reforms are included as amendments to title XXVII of the Public Health Service (PHS Act), conforming amendments in sec. 1562(e) (renumbered as sec. 1563) apply these PHS Act provisions as if they were also included in the Employee Retirement Income Security Act (ERISA) and the Internal Revenue Code (IRC). Title XXVII of the PHS Act regulates group health plans, health insurance issuers providing group health coverage, coverage in the individual market, as well as some governmental plans. In addition to pensions, ERISA regulates welfare benefit plans that may provide, among other things, medical, surgical and other health benefits. ERISA applies to health benefit coverage offered through health insurance or other arrangements (e.g., self-funded plans). In general, ERISA regulates private sector employee benefit plans. The IRC regulates group health plans but does not regulate health insurers.

The requirements included in title I of PPACA vary in their application to the different types of coverage that are found in the private insurance market. The following definitions, which are based on definitions in sec. 1301 of the Act may be helpful:

*Group Health Plan:* Any plan, fund or program established or maintained by an employer or by an employee organization or by both, to the extent that the plan, fund or program was established or maintained to provide medical care (including items and services paid for as medical care) to employees or their dependents (as defined under the terms of the plan) directly or through insurance, reimbursement, or otherwise. “Group health plan” is generally used to include self-insured and fully insured plans. For certain provisions, the Act provides for an exemption for self-insured plans.

*Health Insurance Issuer:* An insurance company, insurance service, or insurance organization (including a health maintenance organization) which is licensed to engage in the business of insurance in a state and which is subject to state law which regulates insurance. An issuer does not include a group health plan.

*Health Insurance Coverage:* Benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise and including items and services paid for as medical care) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract offered by a health insurance issuer.

## **Subtitle A—Immediate Improvements in Health Care Coverage for All Americans**

### **Sec. 1001. Amendments to the Public Health Service Act (PHS)(as modified by sec. 10101 and sec. 2301 of HCERA).**

Redesignates certain existing sections of title XXVII of the PHS Act and inserts new provisions. New or revised PHS Act sections are identified below.

Note. See below sec. 1201 of the Act (sec. 2704 of the PHS Act) for the prohibition on preexisting condition exclusions with respect to enrollees in group or individual health insurance who are under 19 years of age. This provision is effective for plan years beginning on or after the date that is 6 months after enactment. Applies also for those under 19 to grandfathered group health plans for plan years beginning on or after 9/23/2010.

### **PHS Act sec. 2711. No lifetime or annual limits (as modified by sec. 10101 and sec. 2301 of HCERA).**

Amends the PHS Act to prohibit a group health plan and an issuer offering group or individual health insurance coverage from establishing lifetime limits on the dollar value of benefits for any participant or beneficiary; or impose annual limits on the dollar value of benefits for any participant or beneficiary.

Provides that prior to 1/1/2014, a group health plan or issuer offering group or individual coverage may only establish a restricted annual limit on the dollar value of benefits with respect to the scope of the essential benefit package (see §1302 below for a definition). In defining the term “restricted annual limit,” requires the Secretary to ensure that access to needed services is made available with minimal impact on premiums. Clarifies that this provision does not prevent a group health plan or health insurance issuer from placing annual or lifetime per beneficiary limits on specific covered benefits that are not essential health benefits to the extent that such limits are otherwise permitted under federal or state law.

Effective for plan years beginning on or after 9/23/2010. Applies also to grandfathered health plans for the first plan year on or after 9/23/2010 although the restriction on annual limits only applies to grandfathered group plans whereas the prohibition on lifetime limits applies to grandfathered individual and group plans.

### **PHS Act sec. 2712. Prohibition on rescissions (as modified by sec. 2301 of HCERA).**

Prohibits a group health plan and a health insurance issuer offering group or individual coverage from rescinding such plan or coverage with respect to an enrollee once the enrollee is covered, except in the case of a covered individual who has performed an act or practice that constitutes fraud or makes an intentional misrepresentation of material fact as prohibited by the terms of the plan or coverage. Provides that the coverage may not be cancelled without giving prior notice to the enrollee.

Effective for plan years beginning on or after 9/23/2010. Applies also to grandfathered health plans for the first plan year on or after 9/23/2010.

**PHS Act sec. 2713. Coverage of Preventive Health Services (as modified by sec. 10101).**

Requires that at a minimum, a group health plan and an issuer offering group or individual coverage provide coverage for and not impose any cost sharing requirements for: (1) evidence-based items or services that have in effect a rating of “A” or “B” in the current recommendations of the U.S. Preventive Services Task Force (USPSTF); (2) immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved; (3) with respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; 4) with respect to women, such additional preventive care and screening services not described in paragraph (1) above as provided for in comprehensive guidelines supported by the Health Resources and Services Administration for this purpose; and (5) for purposes of this Act and for purposes of any other provisions of law, the current recommendations of the USPSTF regarding breast cancer screening, mammography, and prevention shall be considered the most current other than those issued in or around November 2009.

Clarifies that this provision is not meant to prohibit a plan or issuer from providing coverage for services in addition to those recommended by the USPSTF or from denying coverage for services that are not recommended by the Task Force.

*Interval.* Requires the Secretary to establish a minimum interval between the date on which a recommendation or a guideline is issued and the plan year with respect to which the requirement is effective. Provides that the interval be no less than 1 year.

*Value-based insurance design.* Authorizes the Secretary to develop guidelines to permit a group health plan and an issuer offering group or individual coverage to utilize value-based insurance designs.

Effective for plan years beginning on or after 9/23/2010.

**PHS Act sec. 2714. Extension of dependent coverage (as modified by sec. 2301 of HCERA).**

Requires a group health plan and an issuer offering group or individual coverage that provides coverage of dependent children to continue to make such coverage available for an adult child until the child turns 26 years of age. Clarifies that this provision does not require a plan or issuer to make coverage available for a child of a child receiving dependent coverage. (§1251 below limits coverage of dependent children to those adult children without an employer offer of coverage for plan years beginning before 1/1/2014.) Requires the Secretary to issue regulations to define dependents for this purpose. Clarifies that this provision does not change “dependent” as used in the Internal Revenue Code (IRC) with respect to the tax treatment of the cost of coverage.

Effective for plan years beginning on or after 9/23/2010. Applies also to grandfathered health plans for the first plan year on or after 9/23/2010.

**PHS Act sec. 2715. Development and utilization of uniform explanation of coverage documents and standardized definitions (as modified by sec. 10101).**

Requires the Secretary, within 12 months of enactment, to develop standards for use by a group health plan and an issuer offering group or individual health insurance coverage,

in compiling and providing to applicants, enrollees and policyholders, a summary of benefits and coverage explanation that accurately describes the benefits and coverage under the applicable plan or coverage. Requires the Secretary to consult with the National Association of Insurance Commissioners (NAIC) and a working group composed of specified stakeholders. Requires that the standards for the summary of benefits and coverage meet specified requirements relating to appearance, language and contents. Requires the Secretary to periodically review and update, as appropriate, the standards developed under this section.

*Requirement to provide.* Within 24 months after enactment, requires issuers (including a group health plan that is not self-insured) offering coverage within the U.S. or, in the case of a self-insured group health plan, the plan sponsor or designated administrator of the plan, to provide (prior to any enrollment restriction), a summary of benefits and coverage explanation pursuant to the above standards to applicants, enrollees and policyholders or certificate policyholders at the time of application; an enrollee prior to the time of enrollment or reenrollment, as applicable; and a policyholder or certificate holder at the time of issuance of the policy or delivery of the certificate.

*Compliance.* Deems an entity specified above to be in compliance if the summary of benefits and coverage is provided in paper or electronic form.

*Notice of modifications.* Provides that if a group health plan or issuer makes any material modification in any terms of the plan or coverage (see §102 of ERISA) that is not reflected in the most recently provided summary of benefits and coverage, the plan or issuer must provide notice of such modification to enrollees not later than 60 days before the effective date of the modification.

*Preemption.* Provides that these standards preempt any related state standards that require a summary of benefits and coverage that provides less information to consumers than that required under this section, as determined by the Secretary.

*Failure to provide.* Provides that a covered entity (issuer, group health plan, etc.) that willfully fails to provide the information required is subject to a fine of not more than \$1,000 for each such failure. Provides that such failure with respect to each enrollee constitutes a separate offense.

*Development of standard definitions.* Requires the Secretary, by regulation, to provide for the development of standards for the definitions of terms used in health insurance coverage, including specified insurance-related terms and medical terms.

Effective 9/23/2010.

**PHS Act sec. 2715A. Provision of additional information (as modified by sec. 10101).**

Requires that plans not sold through the state Exchanges only be required to submit certain information required under the transparency in coverage provisions (e.g., claims payment, periodic financial disclosure and other disclosures as specified in §1311(e) below) to the Secretary and the state insurance commissioner, and make such information available to the public.

Effective 9/23/2010.

**PHS Act sec. 2716. Prohibition of discrimination based on salary (as modified by sec. 1562(e) (renumbered sec. 1563) and sec. 10101).**

Requires group health plans (other than self-insured plans) to satisfy the requirements of §105(h)(2) of the IRC relating to prohibition on discrimination in favor of highly compensated individuals. Provides that rules similar to the rules contained in paragraphs (3), (4) and (8) of §105(h) apply. (Note that 105(h) currently applies non-discrimination rules to self-insured group health plans and paragraphs (3), (4), and (8) require that these plans must benefit at least 70 percent of employees who are not highly compensated and that the benefits available to the highly compensated individuals are also provided for all other participants.)

Effective 9/23/2010.

**PHS Act sec. 2717. Ensuring the Quality of Care (as modified by sec. 10101).**

Requires the Secretary, within 2 years of enactment, and in consultation with experts in health care quality and stakeholders, to develop reporting requirements for use by a group health plan, and a health insurance issuer offering group or individual coverage, with respect to the plan or coverage benefits and health care provider reimbursement structures that: (1) improve health outcomes through implementation of activities such as quality reporting, effective case management, care coordination, etc.; (2) implement activities to prevent hospital readmissions through a comprehensive program for hospital discharge that includes patient-centered education and counseling, comprehensive discharge planning, and post discharge reinforcement by an appropriate health care professional; (3) implement activities to improve patient safety and reduce medical errors through the appropriate use of best clinical practices, evidence based medicine, and health information technology under the plan or coverage; and (4) implement wellness and health promotion activities. Provides examples of wellness and prevention programs.

*Reporting requirements.* Requires a group health plan and an issuer offering group or individual coverage to annually submit to the Secretary, and to enrollees, a report on whether the benefits under the plan or coverage satisfy the above quality elements. Requires the report to be made available during each enrollment period. Permits the Secretary to develop and impose appropriate penalties for non-compliance with the reporting requirements. Permits exceptions.

*Regulations, study and report.* Requires the Secretary to issue regulations within 2 years of enactment that provide criteria for determining whether a reimbursement structure meets the above requirements. Within 180 days after the regulations are issued, requires the Government Accountability Office (GAO) to review them and report to the Senate HELP and House Energy and Commerce Committees regarding the impact the activities under this section has had on the quality and cost of health care.

*Protection of second amendment gun rights.* Prohibits a wellness and health promotion activity implemented under the above provisions from requiring disclosure or collection of any information relating to the presence or storage of a lawfully possessed firearm or ammunition in the residence or on the property of an individual; or the lawful use, possession, or storage of a firearm or ammunition by an individual. Prohibits the Secretary from using any authorities under the bill for the collection of any information relating to records of lawful ownership or possession of a firearm or ammunition; the lawful use of a firearm or ammunition; or lawful storage of a firearm or ammunition.

Prohibits the Secretary from maintaining records relating to individual ownership or possession. Prohibits a premium rate from being increased, denying coverage and reducing a discount, rebate, or reward offered for participation in a wellness program on the basis of, or on reliance upon, the lawful ownership or possession of a firearm or ammunition; or the lawful use or storage of a firearm or ammunition. Prohibits a requirement on any individual to disclose any information under any data collection activity authorized under the bill relating to the lawful ownership or possession of a firearm or ammunition; or the lawful use, possession, or storage of a firearm or ammunition.

Effective 9/23/2010.

**PHS Act sec. 2718. Bringing down the cost of health care coverage (as modified by sec. 1562(e) (renumbered sec. 1563) and sec. 10101).**

Requires an issuer offering group or individual coverage (including a grandfathered plan but excluding a self-insured group health plan) to submit to the Secretary annually for each plan year a report concerning the ratio of the incurred loss (or incurred claims) plus the loss adjustment expense (or change in contract reserves) to earned premiums. Requires the report to include the percentage of total premium revenue, after accounting for collections or receipts for risk adjustment and risk corridors and payments of reinsurance, that such coverage expends on: reimbursement for clinical services provided under the coverage; activities that improve health care quality; and all other non-claims costs, including an explanation of the nature of such costs, and excluding federal and state taxes and licensing or regulatory fees. Requires the Secretary to make reports received available to the public on the Department of Health and Human Services (HHS) website.

*Ensuring that consumers receive value for their premium payments.* By 1/1/2011, an issuer offering group or individual health insurance coverage (including a grandfathered plan but excluding a self-insured group health plan) is required to provide an annual rebate to each enrollee, on a pro rata basis, if the ratio of the amount of premium revenue expended by the issuer on clinical services and quality improvement to the premium revenue (excluding federal and state taxes and licensing or regulatory fees and after accounting for payments or receipts for risk adjustment, risk corridors, and reinsurance) is less than 85% for large group coverage (or higher percentage if required under state law) or 80% in the small group and individual markets (or higher percentage if required under state law). Permits the Secretary to make an exception for individual coverage if the 80% minimum loss ratio would destabilize the market in a state. Requires the issuer to rebate to enrollees the amount by which the issuer's medical loss ratio is less than the required minimum.

Beginning 1/1/2014, requires the calculation of the rebate for a year to be based on the costs and revenues for the previous 3 years for the plan. In setting minimum loss ratio percentages, requires a state to seek to ensure adequate participation by issuers, competition in the market and value for consumers so that premiums are used for clinical services and quality improvements. Requires the Secretary to issue regulations and authorizes the Secretary to provide for appropriate penalties.

By 12/31/2010, and subject to the Secretary's certification, requires the NAIC to establish uniform definitions and standardized methodologies for calculating loss ratios, taking into account the special circumstances of smaller plans. Permits the Secretary to

adjust the rebate amount if the Secretary determines it appropriate on account of the volatility of the individual market due to the establishment of the state Exchange.

*Standard Hospital Charges.* Requires each hospital operating within the U.S., for each year, to establish (and update) and make public (in accordance with guidelines developed by the Secretary) a list of the hospital's standard charges for items and services provided by the hospital, including for Medicare diagnosis related groups (DRGs). [1001: 2718]

Effective for plan years beginning after 3/23/2010.

**PHS Act sec. 2719. Appeals process (as modified by sec. 10101).**

Requires a group health plan and a health insurance issuer offering group or individual coverage to implement an effective appeals process for appeals of coverage determinations and claims denials, under which the plan or issuer must, at a minimum, have an internal appeals process, provide notice to enrollees of the available internal and external appeals process and the availability of any consumer assistance or ombudsman to assist them (see "Health insurance consumer information" below); and allow an enrollee to review their file, present evidence and testimony as part of the appeal, and to receive continued coverage pending the outcome. Requires a group health plan or issuer offering group coverage to provide an internal claims and appeals process that initially incorporates the claims and appeals procedures (including urgent claims) in 29 CFR 2560.503-1 and update them in accordance with any standards established by the Secretary of Labor. Requires an issuer offering individual coverage and any other issuers not subject to the existing regulations to provide an internal claims and appeals process that initially incorporates the procedures set forth under applicable law (as of the date of enactment) and update them consistent with standards established by the Secretary.

*External review.* Requires that a group health plan and issuer offering group coverage: 1) comply with the applicable state external review process for such plans and issuers that, at a minimum, includes the consumer protections in the NAIC's Uniform External Review Model Act and is binding on such plans or 2) implement an effective external review process that meets minimum standards established by the Secretary through guidance and that is similar to the above process, if a) the state has no established external review process or b) a plan is self-insured, that is not subject to state insurance regulation. Permits the Secretary to deem the external review process of a group plan or issuer, in operation on the date of enactment, to be in compliance with the applicable process established above, as determined appropriate by the Secretary.

Effective 9/23/2010.

**PHS Act sec. 2719A. Patient Protections (as modified by sec. 10101).**

*Choice of health care professional.* Provides that if a group health plan or issuer offering group or individual coverage requires or provides for designation of a participating primary care provider, then the plan or issuer must permit the participant or enrollee to designate any participating primary care provider who is available to accept the individual.

*Coverage of emergency services.* Requires that if the plan or issuer provides or covers hospital emergency department services, it cover them as follows: 1) without the need for any prior authorization; 2) whether or not the provider is a participating provider; 3) in



the same manner as if there were no such requirements or any limitation on coverage that is more restrictive than if the providers had a contractual relationship; and 4) at the same cost-sharing requirements (with certain exceptions) as for in-network services. Adopts a prudent layperson standard for the definition of “emergency medical condition.” Defines “emergency service”, with respect to an emergency medical condition, as 1) a medical screening examination (as required under §1867 of the Social Security Act (SSA)) within the capability of the emergency department of a hospital including ancillary services routinely available to the emergency department to evaluate such condition and, 2) within the capabilities of the staff and facilities available at the hospital, such further medical examination and treatment as required under §1867 to stabilize the patient.

*Access to pediatric care.* Requires a plan or issuer to permit the participant or enrollee to designate a physician who specializes in pediatrics as the child’s primary care provider if such provider participates in the plan or issuer’s network.

*Access to obstetrical and gynecological care.* Prohibits a plan or issuer from requiring authorization or referral in the case of a female participant, beneficiary or enrollee who seeks coverage for obstetrical or gynecological care provided by a participating health care professional who specializes in obstetrics or gynecology. Requires that professional to agree to otherwise adhere to the plan’s or issuer’s policies and procedures, including those regarding referrals and obtaining prior authorization and providing services pursuant to a treatment plan (if any) approved by the plan or issuer. Applies to a group health plan or coverage that provides coverage for obstetric or gynecological care and requires the designation of a participating primary care provider by the enrollee, participant or beneficiary. This provision is not meant to waive any exclusions of coverage under the terms and conditions of the plan or coverage with respect to obstetrical or gynecological care or preclude the group health plan or issuer from requiring the obstetrical or gynecological provider to notify the primary care health care professional or the plan or issuer of treatment decisions.

Effective 9/23/2010.

## **Sec. 1002. Health insurance consumer information.**

### **PHS Act sec. 2793. Health Insurance Consumer Information.**

Requires the Secretary to award grants to states to enable them (or Exchanges operating in such states) to establish, expand, or provide support for: (1) offices of health insurance consumer assistance or (2) health insurance ombudsman programs. To be eligible, a state must designate an independent office of health insurance consumer assistance, or an ombudsman, that, directly or in coordination with state health insurance regulators and consumer assistance organizations, receives and responds to inquiries and complaints concerning health insurance coverage with respect to federal health insurance requirements and under state law. Requires a state that receives a grant to comply with specified criteria for carrying out grant activities.

*Duties.* Requires the office of health insurance consumer assistance or ombudsman to: (1) assist with the filing of complaints and appeals; (2) collect, track, and quantify problems and inquiries encountered by consumers; (3) educate consumers on their rights and responsibilities with respect to group health plans and health insurance coverage; (4) assist consumers with enrollment in a group health plan or health

insurance coverage by providing information, referral, and assistance; and (5) resolve problems with obtaining premium tax credits under section 36B of the Internal Revenue Code of 1986 (as added by the bill).

*Data collection.* Requires, as a condition of receiving a grant, an office of health insurance consumer assistance or ombudsman program to collect and report data to the Secretary on the types of problems and inquiries encountered by consumers. Requires the Secretary to utilize such data to identify areas where more enforcement action is necessary and to share such information with state insurance regulators and the Secretaries of Labor and Treasury for use in the enforcement activities of such agencies.

*Funding.* Appropriates to the Secretary \$30 million for the first fiscal year for which this section applies to carry out this section, and makes such amount available without fiscal year limitation. Appropriates for each fiscal year following the first such sums as may be necessary.

Effective 3/23/2010.

**Sec. 1003. Ensuring that consumers get value for their dollars (as modified by sec. 10101).**

**PHS Act sec. 2794. Ensuring that consumers get value for their dollars as modified by sec. 10101).**

*Initial premium review process.* Requires the Secretary, in conjunction with the states, to establish a process for the annual review, beginning with the 2010 plan year, of unreasonable increases (undefined) in premiums for health insurance coverage. Requires issuers to submit a justification to the Secretary and the relevant state for any unreasonable premium increase prior to the premium's implementation and to prominently post this information on their websites. Requires the Secretary to ensure the public disclosure of such information for all issuers.

*Continuing review.* As a condition of receiving a federal grant to assist with rate reviews (see below), requires a state, through its commissioner of insurance, to provide the Secretary with information about trends in premium increases in rating areas in the state and recommend, as appropriate, to the state Exchange where particular issuers should be excluded from participation in the Exchange based on excessive or unjustified premium increases.

*Monitoring by Secretary.* For plan years beginning in 2014, requires the Secretary, in conjunction with the states, to monitor premium increases of coverage offered through and outside of the Exchange. Requires the states to take into account any excess of premium growth outside as compared to the rate of growth inside the Exchange.

*Grants.* Requires the Secretary to give grants to states during the 5-year period beginning with FY 2010 to assist them in reviewing and, if appropriate under state law, approving premium increases and in providing information and recommendations to the Secretary. Appropriates \$250 million for the grants.

*Medical Reimbursement Data Centers.* Authorizes grants to the states to be used in establishing centers at academic or other nonprofit institutions to collect medical reimbursement information from health insurance issuers, to analyze and organize such

information, and to make such information available to such issuers, providers, health researchers, health policy makers and the general public. Specifies functions of the medical reimbursement data centers, including developing and updating fee schedules and other database tools that reflect market rates for medical services and geographic differences in those rates; using best available statistical methods and data processing technology to develop those fee schedules, etc. Requires a center to adopt bylaws to ensure against conflicts of interest. Clarifies that this provision does not compel health insurance issuers to provide data to the center.

*Allocation.* Requires the Secretary to establish a formula for determining the amount of any grant to a state. Requires the Secretary to consider the number of plans of coverage offered in each state and the population of the state. Limits any one state to no less than \$1 million or more than \$5 million for a grant year.

Effective 3/23/2010.

**Sec. 1004. Effective dates.**

Most immediate reforms take effect for plan years beginning on or after 9/23/2010. (The insurance reforms specified below generally apply as of 1/1/2014, although states may adopt small group market reforms prior to 2014 and certain provisions related to state flexibility apply later than 2014).

**Subtitle B—Immediate Actions to Preserve and Expand Coverage**

**Sec. 1101. Immediate access to insurance for uninsured individuals with a preexisting condition.**

Requires the Secretary, no later than 6/21/2010, to establish a temporary national high risk pool program to provide health insurance coverage for eligible individuals from the date of establishment until 1/1/2014.

*Administration.* Permits the Secretary to implement the program directly or through contracts with eligible entities, defined as state or nonprofit private entities. Requires, as a precondition for a state contract, that the state agree not to reduce the annual amount it expends for the operation of one or more state high risk pools below the prior level.

*Eligible individual.* Deems an individual to be eligible if he or she is a citizen or national or lawfully present; has not been covered under creditable coverage (as defined in §2701(c)(1) of the PHS Act (Health Insurance Portability and Accountability Act (HIPAA) provisions) as in effect on the date of enactment during the 6-month period prior to the date on which the individual is applying for coverage through the high- risk pool; and has a pre-existing condition, as determined in a manner consistent with guidance issued by the Secretary.

*Qualified high risk pool.* Requires a pool to provide to all eligible individuals coverage that does not impose any preexisting condition exclusion. Requires the issuer's share of total allowed costs of benefits under such coverage to be no less than 65% of such costs (i.e., enrollee cost-sharing does not exceed 35%) and an out-of-pocket (OOP) limit no greater than the applicable amounts for health savings account (HSA) qualified High Deductible Health Plans for the year involved, except that the Secretary may modify such limit if necessary to ensure the pool meets the actuarial limit of 65%. (In 2010, the HDHP OOP limits are \$5,950 for individual coverage and \$11,900 for family coverage.)

Requires also that the pool premium be established at a standard rate for a standard population and varies only for: whether the coverage is an individual or family plan, rating areas (as defined by the state), age (by no more than 4:1), and for tobacco use (by no more than 1:5 to 1).

*Protection against dumping risks by insurers.* Requires the Secretary to establish criteria for determining whether health insurance issuers and employment-based health plans have discouraged an individual from remaining enrolled in prior coverage based on the individual's health status. Requires such an issuer or health plan to reimburse the program for medical expenses incurred by the program for an individual who, based on criteria established by the Secretary, was encouraged to disenroll. Specifies criteria (e.g., provision of money or other financial consideration for disenrolling from the coverage). Provides that this sanction is not meant to exclude remedies for violations or to prevent states from applying or enforcing the sanctions or other provisions under law with respect to health insurance issuers.

*Oversight.* Requires the Secretary to establish an appeals process to enable individuals to appeal a determination under this section; and procedures to protect against waste, fraud, and abuse.

*Funding; termination of authority.* Appropriates to the Secretary \$5 billion to pay claims against (and the administrative costs of) the high risk pool that are in excess of the amount of premiums collected from eligible individuals enrolled in the pool. Makes funds available without fiscal year limitation. Provides that if the Secretary estimates for any fiscal year that the aggregate amounts available for the payment of the expenses of the pool will be less than the actual amount of such expenses, the Secretary must make such adjustments as are necessary to eliminate such deficit.

*Termination of authority.* In general, terminates risk pool coverage of eligible individuals on 1/1/2014. Requires the Secretary to develop procedures to provide for the transition of eligible individuals enrolled in health insurance coverage offered through a high risk pool into qualified health plans offered through an Exchange. Requires the procedures to ensure that no lapse occurs in coverage and authorizes the Secretary to extend coverage after the termination of the risk pool involved, if the Secretary determines it necessary to avoid such a lapse.

*Limitations.* Authorizes the Secretary to stop taking applications for participation in the high risk pool program to comply with the funding limits.

*Relation to state laws.* Provides that the standards established under this section supersede any state law or regulation (other than state licensing laws or state laws relating to plan solvency) with respect to qualified high risk pools which are established in accordance with this section.

Effective 3/23/2010.

**Sec. 1102. Reinsurance for early retirees (as modified by sec. 10102).**

Requires the Secretary, within 90 days of enactment, to establish a temporary reinsurance program to provide reimbursement to assist participating employment-based plans with the cost of providing health benefits to eligible retirees (55 years of age or older, not eligible for Medicare and not an active employee). An eligible plan is one

maintained by one or more employers (including state or political subdivisions or instrumentalities thereof), former employers or employee associations, or a voluntary employees' beneficiary association, board of individuals appointed to administer a plan or a multiemployer plan, that provides health benefits to retirees. Provides that in order to participate in the reinsurance program, the employment-based health benefits plan must implement programs and procedures to generate cost-savings with respect to participants with chronic and high-cost conditions. Terminates the program on 1/1/2014.

*Participation and claims.* Requires that an eligible plan apply for the reinsurance to the Secretary. Requires the plan to submit claims for reimbursement to the Secretary documenting actual costs of the items and services for which claims are being made. Requires each claim to be based on actual amount expended for the retiree or spouse, surviving spouse or dependent, and to take into account any negotiated price concessions obtained by the plan. Includes cost-sharing costs paid by the retiree, spouse, etc.

*Program payments and limit.* Requires the Secretary to reimburse valid claims for 80% of the portion of the costs exceeding \$15,000 but less than \$90,000. Requires such amounts to be adjusted annually based on the medical care component of the CPI.

*Use of payments.* Requires the payments to the plans to be used to lower costs borne directly by participants and beneficiaries for health benefits provided under the plan in the form of premiums and cost-sharing. Requires the Secretary to develop a mechanism to monitor the appropriate use of the payments. Provides that payments received under this subsection shall not be included in determining the gross income of an employer, employee organization or other entity that is maintaining or currently contributing to a participating employment-based plan.

*Appeals and program protections.* Requires the Secretary to: (1) establish an appeals process to permit plans to appeal a determination of the Secretary with respect to submitted claims and (2) establish procedures to protect against fraud, waste and abuse. Requires the Secretary to audit claims data to ensure compliance.

*Funding.* Appropriates to the Secretary \$5 billion to carry out the reinsurance program. Provides that the funds will be available without fiscal year limitation. Authorizes the Secretary to stop taking applications for participation in the program based on the availability of the \$5 billion in total funding.

Effective on date of enactment.

**Sec. 1103. Immediate information that allows consumers to identify affordable coverage options (as modified by sec. 10102).**

Requires by 7/1/2010 that the Secretary, in consultation with the states, establish a mechanism, including a website, through which a resident of any state may identify affordable coverage options in that state. Requires the website, to the extent practicable, to provide ways for residents to receive information on at least: (1) health insurance coverage offered by issuers, other than coverage that provides reimbursement for treatment or mitigation of a single disease or condition or an unreasonably limited set of diseases or conditions (as determined by the Secretary); (2) Medicaid; (3) child health insurance program (CHIP); (4) a state high risk pool, if offered, and coverage under the federal high risk pool described above; and (5) coverage within the small group market

for small businesses and their employees, including reinsurance for early retirees, tax credits available under the Act, and other information specifically for small businesses regarding affordable health care options.

Requires the Secretary, within 60 days after enactment, to develop a standardized format to be used for the presentation of information (including on the website) relating to the above coverage options in a format that, at a minimum, requires the inclusion of information on the percentage of total premium revenue expended on nonclinical costs (see §2718 above relating to minimum medical loss ratios), eligibility, availability, premium rates, and cost-sharing and be consistent with the standards adopted for the uniform explanation of coverage (see §2715 above related to “Development and utilization of uniform explanation of coverage documents and standardized definitions”).

Permits the Secretary to carry out this section through contracts with qualified entities.

Effective on date of enactment.

**Sec. 1104. Administrative simplification (as amended by sec. 10109 of H.R. 3590).**

Amends the purposes section of the HIPAA administrative simplification provisions to provide that standards be uniform and that administrative simplification reduce clerical burden on patients, health care providers and health plans. Also adds electronic funds transfers as a transaction for which standards are to be developed.

*Requirements for financial and administrative transactions.* Requires that standards and operating rules, to the extent feasible, enable determination of an individual's eligibility and financial responsibility prior to or at the point of service of care; be comprehensive, be timely in support of a transparent claims and denial management process, and meet certain requirements with respect to data elements.

Further requires the Secretary to solicit, by 1/1/2012, and not less than every 3 years thereafter, input from specified entities on whether there could be greater uniformity in financial and administrative activities and items, as determined appropriate by the Secretary, and whether such activities should be considered financial and administrative transactions for which adoption of standards and operating rules would improve the operation of the health care system and reduce administrative costs. Specified entities include the National Committee on Vital and Health Statistics, the Health Information and Technology Policy Committee and the Health Information Technology Standards Committee and standard setting organizations and stakeholders, as determined appropriate by the Secretary. Specifies activities and items for which the Secretary must seek input such as whether the application process for enrollment of health care providers by health plans could be made electronic and standardized; whether standards and operating rules should apply to the health care transactions of auto insurance and workers' compensation, etc.

Requires the Secretary to task the ICD-9-CM Coordination and Maintenance Committee to convene a meeting, not later than 1/1/2011, to receive input from appropriate stakeholders regarding the crosswalk between the Ninth and Tenth Revisions of the ICD that is posted on the Center for Medicare and Medicaid Services (CMS) website and make recommendations about appropriate revisions to the crosswalk. Requires the Secretary to make the appropriate revisions and post any revised crosswalk on the CMS website. Requires any revised crosswalk to be treated as a code set for which a

standard has been adopted by the Secretary for purposes of §1173(c)(1)(B) of the SSA, under which the Secretary establishes code sets for data elements for transactions for which no code set is established. Provides for a process for handling subsequent crosswalks.

*Operating rules.* Requires the Secretary to adopt a single set of operating rules for financial and administrative transactions for which standards to enable electronic exchange are created under §1173 of the Social Security Act, with the goal of creating as much uniformity as possible in implementation of electronic standards. Operating rules to be consensus-based and reflect the necessary business rules affecting health plans and providers and the manner in which they operate under standards issued under HIPPA.

Directs the Secretary to consider recommendations for operating rules developed by a qualified nonprofit entity that focuses on administrative simplification, demonstrates a multi-stakeholder consensus process and meets other specified criteria.

*Review and recommendations.* The National Committee on Vital and Health Statistics (NCVHS) to advise the Secretary as to whether the nonprofit entity meets the specified requirements, review operating rules developed by the nonprofit entity; determine whether the rules are consistent with other existing standards and represent a consensus of stakeholders; evaluate whether the rules are consistent with electronic standards adopted for HIT, and make a recommendation to the Secretary regarding adoption. Following consideration of the rules developed by the nonprofit entity and the NCVHS recommendations and having ensured consultation with providers, the Secretary to adopt rules applying any standard or operating rule recommended by the NCVHS through an interim final rule, and consider public comments for 60 days after publication.

The operating rules for eligibility and health plan claims status transactions to be adopted by 7/1/2011, to be effective by 1/1/2013, and may allow for use of a machine readable identification card. Operating rules for electronic funds transfer and health care payment and remittance advice transactions to allow for automated reconciliation of the electronic payment with the remittance advice and be adopted by 7/1/2012 and effective by 1/1/2014. Operating rules for health claims or equivalent encounter information, enrollment and disenrollment in a health plan, health plan premium payments, and referral certification and authorization transactions, to be adopted by 7/1/2014 and effective by 1/1/2016.

*Compliance.* Additional requirements would be placed on health plans to comply with operating rules adopted by the Secretary. By 12/31/2013, plans required to file a certification statement with the Secretary and demonstrate that their data and information systems comply with applicable standards and operating rules for four transactions: electronic funds transfer, health plan eligibility, claims status, and health care payment and remittance advice. By 12/31/2015, systems compliance must be certified and documented for health claims or equivalent encounter information, enrollment and disenrollment from a health plan, premium payments, health claims attachments, and referral certification and authorization. Documentation to certify compliance to show that plans in full compliance with regulations and have completed end-to-end testing with partners such as hospitals and physicians. Health plans to

ensure that contractors meet compliance and documentation requirements. The Secretary may designate independent, outside entities to certify health plan compliance.

Health plans must file a statement with the Secretary certifying that data and information systems are in compliance with any amended standards and associated operating rules, and with new standards and rules for any financial and administrative transactions, upon the effective date of the new rules.

Secretary to conduct periodic audits to ensure plan compliance.

*Review and amendment of standards and operating rules.* By 1/1/2014, the Secretary to designate a review committee to evaluate updates to existing standards and operating rules. Committee may be the NCVHS or another. Committee to conduct hearings by 4/1/2014 and not less than biennially thereafter, and report to the Secretary by 7/1/2014 and biennially thereafter, with recommendations. Committee to recommend a single set of operating rules per transaction and to ensure coordination of recommendations with standards for electronic health record technology approved by the Office of the National Coordinator for Health Information Technology.

Any recommendations to be adopted by the Secretary within 90 days of the committee report through an interim final rule with 60-day comment period, effective 25 months later.

*Penalties.* A penalty fee for plans failing to meet the certification and documentation requirements for compliance to be imposed by 4/1/2014 and annually thereafter until a plan is certified. Fee set at \$1 per person covered by the plan for which data systems for major medical policies are not in compliance, for each day of non-compliance, up to a maximum of \$20 per covered life, with fees and maximum doubled in the case of a plan that has knowingly provided inaccurate or incomplete information. Fee increased annually by the percentage increase in national health expenditures. SEC filings to be used to determine number of covered lives.

The Secretary to establish a process for notice and dispute resolution before a penalty is assessed. Penalty fee to be collected by the Secretary of Treasury, using a list provided by the Secretary of HHS by 5/1/2014, and annually thereafter. Plans are to be notified of any penalty by August 1st with payment due by November 1st. Interest to apply to late payments.

*Promulgation of rules.* Directs the Secretary to issue a unique health plan identifier, based on input from the NCVHS. An interim final rule authorized to be effective no later than 10/1/2012.

Requires promulgation of a final rule to establish a standard for electronic funds transfers under §1173(a)(2)(J). May be an interim final rule and must be no later than 1/1/2012 to be effective 1/1/2014.

Requires promulgation of a final rule by 1/1/2012 establishing a standard and single set of operating rules for health claims attachments under §1173(a)(2)(B) consistent with the X12 Version 5010 transaction standards. May be done as interim final rule and to be no later than 1/1/2014 to be effective 1/1/2016.



*Expansion of electronic transactions in Medicare.* Amends Medicare law to require that not later than 1/1/2014, payment be made by electronic funds transfer or an electronic remittance in a form specified in ASC X12 835 Health Care Payment and Remittance Advice or a subsequent standard.

Effective on date of enactment.

**Sec. 1105. Effective date.**

Provides that this subtitle takes effects on date of enactment.

**Subtitle C—Quality Health Insurance Coverage for All Americans**

**PART I—HEALTH INSURANCE MARKET REFORMS**

**Sec. 1201. Amendment to the Public Health Service Act. (as modified by sec. 10103)**

**PHS Act sec. 2701. Fair health insurance premiums (as modified by sec. 10103).**

Limits the variation in premiums charged for health insurance coverage offered in the individual or small group market to: 1) whether such plan or coverage covers an individual or family; 2) rating area (as established by the state); 3) age, except that such rate shall not vary by more than 3 to 1 for adults and 4) tobacco use, except that such rate shall not vary by more than 1.5 to 1. Requires each state to establish 1 or more rating areas. Requires the Secretary to review these rating areas to ensure their adequacy for purposes of carrying out the requirements of this title. Permits the Secretary to establish the state's rating areas if he or she determines the areas not to be adequate, or that a state has failed to establish them. Requires the Secretary, in consultation with the NAIC, to define the permissible age rating bands for adults.

*Application of variations based on age or tobacco use.* Provides that with respect to family coverage under a group health plan or health insurance coverage, the rating variations permitted for tobacco use must be applied based on the portion of the premium that is attributable to each family member covered under the plan or coverage.

*Special rule for large group market.* Applies these rating rules to the large group market (except self-insured group health plans) in a state if the state permits issuers that offer coverage in the large group market to offer through the state Exchange.

Effective for plan years beginning on or after 1/1/2014.

**PHS Act sec. 2702. Guaranteed availability of coverage.**

Requires each issuer that offers health insurance coverage in the individual or group market in a state to accept every employer and individual in the state that applies for such coverage. Permits, however, an issuer, to restrict enrollment to open or special enrollment periods. Requires an issuer, in accordance with regulations issued by the Secretary, to establish special enrollment periods for qualifying events (under §603 of ERISA).

Effective for plan years beginning on or after 1/1/2014.

**PHS Act sec. 2703. Guaranteed renewability of coverage.**

Requires an issuer to offer health insurance coverage in the individual or group market and to renew or continue in force such coverage at the option of the plan sponsor or the individual, as applicable.

Effective for plan years beginning on or after 1/1/2014.

**PHS Act sec. 2704. Prohibition of preexisting condition exclusions or other discrimination based on health status (as modified by sec. 10103).**

Amends the PHS Act to prohibit a group health plan and a health insurance issuer offering group or individual health insurance coverage to impose any preexisting condition exclusion with respect to such plan or coverage.

Effective for plan years beginning on or after 1/1/2014. Applies prohibition on pre-existing condition exclusions with respect to enrollees who are under 19 years of age for plan years beginning on or after the date that is 6 months after enactment. Applies also for those under 19 to grandfathered group health plans beginning on or after the date that is 6 months after enactment (9/23/2010).

**PHS Act sec. 2705. Prohibiting discrimination against individual participants and beneficiaries based on health status.**

Prohibits a group health plan and an issuer offering group or individual coverage from establishing rules for eligibility (including continued eligibility) of any individual to enroll based on any of the specified health status-related factors of the individual or a dependent. (See also §1558 relating to protections for employees against discrimination based on qualifying for federal premium and cost-sharing subsidies.)

*Programs of health promotion or disease prevention.* Defines as a program offered by an employer designed to promote health or prevent disease and that meets specific requirements. Provides a safe harbor (i.e., is not discriminatory) for a wellness program if: (a) none of the conditions for obtaining a premium discount or rebate or other reward for participation is based on an individual satisfying a standard related to a health status factor; (b) participation in the program is made available to all similarly situated individuals and; (c) the below requirements are met. In the case of a wellness program in which any of the conditions for obtaining a premium discount or rebate or other reward for participation in a wellness program is based on an individual satisfying a standard related to a health status factor, it nonetheless still meets the nondiscrimination requirements if the below requirements are met. If none of the conditions for obtaining a premium discount or rebate or other reward are based on an individual satisfying a standard related to a health status factor (or if such a wellness program does not provide such a reward), it is not discriminatory if participation is made available to all similarly situated individuals. These latter programs include those that reimburse all or part of fitness center membership costs; a diagnostic testing program that provides a reward for participation and does not base any part of the reward on outcomes; programs that encourage preventive care related to a health condition through the waiver of the copayment or deductible for the costs of certain items or services related to a health condition (such as prenatal care or well-baby visits); a program that reimburse for the costs of smoking cessation programs without regard to whether the individual quits smoking; and programs that provide a reward to individuals for attending a periodic health education seminar.

*Wellness program subject to requirements.* Provides that if any condition for obtaining a premium discount, rebate, or reward is based on satisfying a standard related to a health status factor, the program nonetheless meets the bill's requirements if: 1) the reward (together with the reward for other plan wellness programs that require satisfaction of a standard related to a health status factor) does not exceed 30% of the cost of employee-only coverage (and if dependents may participate fully in the wellness program, such reward cannot exceed 30% of the cost of the coverage in which an employee or individual and any dependents are enrolled). Cost is determined based on the total amount of employer and employee contributions for the benefit package. The reward can be in the form of a discount or rebate of a premium or contribution, a waiver of all or part of a cost-sharing mechanism, the absence of a surcharge, or the value of a benefit that would otherwise not be provided under the plan. Permits the Secretaries of Labor, HHS and the Treasury to increase the reward available up to 50% of the cost of coverage if the Secretaries determine the increase to be appropriate. 2) The wellness program must be reasonably designed to promote health or prevent disease, i.e., it has a reasonable chance of improving the health of, or preventing disease in, participating individuals and it is not overly burdensome, is not a subterfuge for discriminating based on a health status factor, and is not highly suspect in the method chosen to promote health or prevent disease. 3) The plan gives individuals eligible for the program the opportunity to qualify for the reward at least once each year. 4) The full reward is made available to all similarly situated individuals. Specifies conditions that do not meet the similarly situated requirement.

*Existing programs.* Clarifies that programs established prior to enactment which complied with all applicable regulations and are operating on enactment are grandfathered for as long as the current regulations remain in effect.

*Wellness program demonstration project.* Requires the Secretary, by 7/1/2014, in consultation with the Secretaries of Treasury and Labor, to establish a 10-state demonstration project under which states apply the requirements for group health plan wellness programs described above to programs of health promotion offered by an issuer that offers coverage in the individual market. Beginning on 7/1/2017, permits the Secretary, in consultation with the Secretaries of Treasury and Labor, to expand the demonstration project to additional participating states if they find the demonstration program to be effective. Requires the states to maintain effort, i.e. that the state's proposed project not result in any decrease in coverage; and will not increase the federal costs in providing the affordability or cost-sharing credits established under this Act.

*Other requirements.* Participating states may permit premium discounts or rebates or the modification of otherwise applicable copayments or deductibles for adherence to, or participation in, a reasonably designed program of health promotion and disease prevention. Requires such states to ensure that requirements of consumer protection are met in programs of health promotion in the individual market; require verification from issuers that offer coverage in the individual market that premium discounts do not create undue burdens for individuals insured in that market; do not lead to cost shifting; and are not a subterfuge for discrimination. Requires participating states to ensure that consumer data are protected in accordance with HIPAA and to ensure and demonstrate to the satisfaction of the Secretary that the discounts or other rewards reflect the expected level of participation in the wellness program involved and the anticipated effect the program will have on utilization or medical claim costs.

*Report.* Within 3 years of enactment, requires the Secretary, in consultation with the Secretaries of Treasury and Labor, to report to the appropriate committees of Congress concerning the effectiveness of state wellness programs in promoting health and preventing disease; their impact on access to care and affordability of coverage for participants and non-participants of such programs; the impact of premium-based and cost-sharing incentives on participant behavior and the role of such programs in changing behavior; and the effectiveness of different types of rewards. Requires the Secretaries to gather relevant information from employers with wellness programs, including state and federal agencies.

*Regulations.* Clarifies that this provision does not prevent the Secretaries of Labor, HHS or the Treasury from promulgating regulations in connection with this section.

Effective for plan years beginning on or after 1/1/2014.

**PHS Act sec. 2706. Non-discrimination in health care.**

Prohibits a group health plan and an issuer offering group or individual health insurance coverage from discriminating with respect to participation under the plan or coverage against any health care provider who is acting within the scope of that provider's license or certification under applicable state law. Clarifies that this does not require a group health plan or issuer to contract with any provider willing to abide by the terms and conditions for participation established by the plan or issuer. Clarifies that this does not prevent a group health plan, an issuer, or the Secretary from establishing reimbursement rates that vary based on quality or performance measures. (See also §1558 below.)

Effective for plan years beginning on or after 1/1/2014.

**PHS Act sec. 2707. Comprehensive health insurance coverage.**

*Coverage for essential health benefits package.* Requires an issuer that offers health insurance coverage in the individual or small group market to ensure that such coverage includes the essential health benefits package (specified below under §1302).

*Cost-sharing under group health plans.* Requires a group health plan to ensure that any annual cost-sharing does not exceed the essential benefits limitations (specified below under §1302).

*Child-only plans.* Provides that if an issuer offers health insurance coverage in any level of essential benefits coverage (specified below under §1302), it must also offer such coverage in that level as a plan in which the only enrollees are individuals who, as of the beginning of a plan year, have not attained the age of 21.

*Dental Only.* Exempts dental-only plans from the requirements of this section.

Effective for plan years beginning on or after 1/1/2014.

**PHS Act sec. 2708. Prohibition on excessive waiting periods.**

Prohibits a group health plan and a health insurance issuer offering group coverage from applying any waiting period for benefits that exceeds 90 days. Effective for plan years beginning on or after 1/1/2014.

**PHS Act sec. 2709. Coverage for individuals participating in approved clinical trials (as modified by sec. 10103).**

If a group health plan or issuer offering group or individual coverage provides coverage to a qualified individual, then it: 1) may not deny the individual participation in a clinical trial; 2) may not deny or limit, or impose additional conditions on, the coverage of routine patient costs for items or services furnished in connection with participation in the trial; and 3) may not discriminate against the individual on the basis of the individual's participation in the trial. Excludes from the definition of "routine patient costs": 1) the investigational item, device or service; 2) items and services provided solely to satisfy data collection and analysis needs and that are not used in direct clinical management; and 3) a service clearly inconsistent with widely accepted and established standards of care for a particular diagnosis. Permits the plan or issuer to require the individual to participate in the trial through a participating provider if the provider will accept the individual as a participant in the trial. Nonetheless, the above protections apply in the event that the individual participates in an approved trial conducted outside the state in which the person resides.

Specifies who is a "qualified individual" and defines "approved clinical trial." Clarifies that this section is not meant to require a group health plan or issuer offering group or individual coverage to provide benefits for routine patient services out of network unless out of network benefits are otherwise provided under the plan or coverage.

*Construction.* Clarifies that nothing in this section is meant to limit a plan's or issuer's coverage with respect to clinical trials.

*Application to Federal Employees Health Benefits Program (FEHBP).* Applies this provision to health plans offered under FEHBP.

*Preemption.* Nothing in this section preempts state laws that require a clinical trials policy for state regulated plans that is in addition to the policy required under this section.

Effective for plan years beginning on or after 1/1/2014.

**PART II—OTHER PROVISIONS**

**Sec. 1251. Preservation of right to maintain existing coverage (as modified by sec. 10103 and sec. 2301 of HCERA).**

*No changes in existing coverage.* Provides that nothing in this Act requires an individual to terminate coverage under a group health plan or health insurance coverage in which they were enrolled on the date of enactment.

*Continuation of coverage.* With certain exceptions, provides that with respect to a group health plan or health insurance coverage in which an individual was enrolled on the date of enactment, the insurance market reforms and the immediate improvement requirements (as specified above), or any amendments to these provisions, do not apply to such plan or coverage, regardless of whether the individual renews such coverage after date of enactment.

*Exceptions:* The requirements for uniform coverage documents (§2715) and medical loss ratios (§2718) apply for plan years beginning on or after enactment. The prohibition

on lifetime limits (§2711), prohibition on rescissions (§2708), and the requirement to provide coverage for dependent children up to age 26 (§2714) applies beginning with the first plan year starting six months after enactment. The following provisions apply only to grandfathered group health plans: §2711 relating to annual limits and the provisions of §2704 relating to pre-existing condition exclusions as they apply to children under 19 years of age apply for plan years beginning with the first plan year starting six months after enactment. Provides that for plan years beginning before 1/1/2014, coverage of dependent adult children is limited to those adult children without an employer offer of coverage.

*Allowance for family members to join current coverage.* Permits family members to enroll in such plan or coverage if such enrollment is permitted under the terms of the plan in effect as of the date of enactment.

*Allowance for new employees to join current plan.* Permits a group health plan that provides coverage on the date of enactment to provide for the enrolling of new employees (and their families) in such plan and exempts them from the bill's otherwise applicable requirements.

*Effect on collective bargaining agreements.* Provides that in the case of coverage maintained pursuant to one or more collective bargaining agreements ratified before enactment, the requirements in this subtitle do not apply until the date on which the last of the collective bargaining agreements relating to the coverage terminates.

Effective 3/23/2010.

**Sec. 1252. Rating reforms must apply uniformly to all health insurance issuers and group health plans.**

Requires that any standard or requirement adopted by a state pursuant to this title, or any amendment made by this title, be applied uniformly to all health plans in each insurance market to which they apply. Provides also for uniform application of a state standard or requirement (that relates to the bill's federal standard or requirement or any amendment to it) that is not the same but which is also not preempted because it prevents the application of this title.

Effective for plan years beginning on or after 1/1/2014.

**Sec. 1253. Annual report on self-insured plans (as modified by sec. 10103).**

Beginning no later than 1 year after enactment, requires the Secretary of Labor to prepare an aggregate annual report, using Form 5500 data, that includes general information on self-insured group health plans as well as data from the financial filings of self-insured employers. Requires the Secretary to submit the reports to the appropriate committees of Congress.

Effective for plan years beginning on or after 1/1/2014.

**Sec. 1254. Study of large group market (as modified by sec. 10103).**

Requires the Secretary of HHS to conduct a study of the fully-insured and self-insured group health plan markets to compare characteristics and determine the extent to which new insurance market reforms are likely to cause adverse selection in the large group market or to encourage small and midsize employers to self-insure. Requires the

Secretary of HHS, in coordination with the Secretary of Labor to collect and analyze the extent to which self-insured plans can offer less costly coverage and why; claim denial rates, plan benefit fluctuations and impact of the limited recourse options on consumers; and any potential conflict of interest and its impact on the administration of the plan. Requires the report within 1 year of enactment be submitted to the appropriate committees of Congress.

Effective for plan years beginning on or after 1/1/2014.

**Sec. 1255. Effective dates.**

Provides that subtitle C (and amendments made by the subtitle) are effective for plan years beginning on or after 1/1/2014.

**Subtitle D—Available Coverage Choices for All Americans**

**PART I—ESTABLISHMENT OF QUALIFIED HEALTH PLANS**

**Sec. 1301. Qualified health plan defined (as modified by sec. 10104).**

Defines a Qualified Health Plan (QHP) as a plan that: (1) has in effect a certification (which may include a seal or other indication of approval) that it meets the Act's certification criteria issued or recognized by each Exchange through which such plan is offered; (2) provides the Essential Health Benefits package described below; and (3) is offered by a health insurance issuer that: (a) is licensed and in good standing to offer coverage in each state in which the issuer offers coverage under this title; (b) agrees to offer at least one QHP in the silver level and at least one plan in the gold level in each such Exchange; (c) agrees to charge the same premium rate for each QHP of the issuer without regard to whether the plan is offered through an Exchange or whether the plan is offered directly from the issuer or through an agent; and (iv) complies with the regulations developed by the Secretary and such other requirements as an applicable Exchange may establish. Provides that any reference in this title to a QHP is deemed to include a QHP offered through a CO-OP program or a multi-state plan, unless specifically provided for otherwise. Allows QHPs to provide coverage through a qualified direct primary care medical home plan that meets criteria established by the Secretary and if the services covered by the medical home plan are coordinated with the entity offering the QHP. Permits a QHP, including a multi-state QHP, to vary premiums by rating area (as defined in the Act).

Defines "Qualified Health Plan (QHP)" as a plan that meets the Act's requirements, and is certified as such. Excludes a group health plan or multiple employer welfare arrangement (MEWA) to the extent that the plan or arrangement is not subject to state law under §514 of the Employee Retirement Income Security Act of 1974 (ERISA).

Effective 3/23/2010.

**Sec. 1302. Essential health benefits requirements (As modified by sec. 10104).**

Defines the Essential Benefit package as coverage that: (1) provides for the essential health benefits defined below; (2) limits cost-sharing as required below; and (3) provides either the bronze, silver, gold, or platinum level of coverage. Requires the Secretary to define the essential health benefits, except that the benefits must include at least the following general categories and items and services covered within the categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn

care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; pediatric services, including oral and vision care. Requires Secretary to provide notice and an opportunity for public comment on definition of the essential benefits and any revisions.

*Limitation.* Requires the Secretary to ensure that the scope of the essential health benefits is equal to the scope of benefits provided under a typical employer plan, as determined by the Secretary. Requires the Secretary of Labor to conduct a survey of employer-sponsored coverage to determine the benefits typically covered by employers, including multiemployer plans, and report on such survey to the Secretary of HHS to inform the HHS determination. Requires the HHS Secretary to report to the appropriate committees of Congress containing a certification from the Chief Actuary of CMS that such essential health benefits meet this limitation.

*Required elements for consideration.* Requires the Secretary to: 1) ensure that the essential health benefits reflect an appropriate balance among the categories so that benefits are not unduly weighted toward any category; 2) not make coverage decisions, determine reimbursement rates, establish incentive programs, or design benefits in ways that discriminate against individuals because of their age, disability, or expected length of life; 3) take into account the health care needs of diverse segments of the population, including women, children, persons with disabilities, and other groups; 4) ensure that health benefits established as essential not be subject to denial to individuals against their wishes on the basis of the individuals' age or expected length of life or of the individuals' present or predicted disability, degree of medical dependency, or quality of life; 5) provide that a QHP not be treated as providing coverage for the essential health benefits unless the plan provides that: (a) coverage for emergency department services will be provided without imposing any requirement for prior authorization of services or any limitation on coverage where the provider does not have a contractual relationship with the plan for services that is more restrictive than the requirements or limitations that apply to emergency department services received from contracting providers; and (b) if such services are provided out-of-network, the cost-sharing requirement is the requirement that would apply if such services were provided in-network; 6) provide that if a stand-alone dental benefits plans is offered through an Exchange, another health plan offered through the Exchange will not fail to be treated as a QHP solely because it does not offer coverage of benefits offered through the stand-alone plan that are otherwise required for pediatric services (including oral and vision care); 7) periodically review the essential health benefits and provide a report to Congress and the public that contains: an assessment of access to the benefits and whether they need to be modified or updated to account for changes in medical evidence or scientific advancement; information on any modifications to address gaps in access or changes in the evidence base; an assessment of the potential of additional or expanded benefits to increase costs and the interactions between the addition or expansion of benefits and reductions in existing benefits to meet actuarial limitations described above. The Secretary is to periodically update the essential health benefits to address any gaps in access to coverage or changes in the evidence base the Secretary identifies in this review.

*Rule of construction.* Clarifies that nothing in this title prohibits a health plan from providing benefits in excess of the essential health benefits.



*Annual limitation on cost-sharing.* Limits cost-sharing incurred under a health plan for a plan year beginning in 2014 to the dollar amounts in effect for HSA-qualified high-deductible health plans for self-only and family coverage, respectively. [Note that in 2010, the maximum out-of-pocket limit is \$5,950 for an individual and for family coverage is \$11,900. These amounts are indexed annually for inflation.] For 2015 and later, the limitation in the case of self-only coverage will be the above dollar amount for self-only coverage increased by the product of that amount and the premium adjustment percentage for the calendar year (i.e., the percentage (if any) by which the average per capita premium for coverage in the U.S. for the preceding year exceeds the 2013 average per capita premium); and in the case of non self-only coverage, twice this amount.

*Annual limitation on deductibles for employer-sponsored plans.* Provides that in the case of a health plan offered in the small group market, the deductible under the plan not exceed \$2,000 for a single individual; and \$4,000 in the case of any other plan. Permits these amounts to be increased by the maximum amount of reimbursement reasonably available to a participant under a flexible spending arrangement (determined without regard to any salary reduction arrangement). Provides for indexing of these amounts to the product of the amounts and the premium adjustment percentage for the calendar year. Applies this limitation so as to not affect the actuarial value of any plan, including a plan in the bronze level. Clarifies that this does not permit a plan to require a deductible for preventive benefits (see §2713 above).

*Cost-sharing.* Includes deductibles, coinsurance, copayments, or similar charges; and any other expenditure required of an insured individual which is a qualified medical expense (within the meaning of §223(d)(2)) of the IRC with respect to essential health benefits covered under the plan. Does not include premiums, balance billing amounts for non-network providers, and spending for non-covered services.

*Levels of coverage.* The bronze plan must provide a level of coverage designed to provide benefits that are actuarially equivalent to 60% of the full actuarial value of the benefits provided under the plan. The silver plan must provide 70%; the gold plan 80%; and the platinum plan 90%. Requires under regulations issued by the Secretary that the level of coverage of a plan be determined on the basis that the essential health benefits be provided to a standard population (and without regard to the population for which the plan may actually provide benefits). Requires the Secretary to issue regulations under which employer contributions to an HSA may be taken into account in determining the level of coverage for a plan of the employer. Requires the Secretary to develop guidelines to provide for a de minimis variation in the actuarial valuations used in determining the level of coverage of a plan to account for differences in actuarial estimates.

*Catastrophic plan.* Provides that if a health plan does not provide a bronze, silver, gold, or platinum level of coverage, it shall be treated as qualified for any plan year if: (1) the only individuals who are eligible to enroll in the plan are individuals under the age of 30 before the beginning of the plan year or those with a certification in effect for that year that the individual is exempt from the individual responsibility requirement because other coverage is not affordable or because of the hardship exemption (see “Individual mandate” below); (2) the plan provides the essential health benefits except that it provides no benefits for any plan year until the individual has incurred cost-sharing expenses in an amount equal to the annual limitation (but not for preventive services)

described above for the plan year; and provides coverage for at least three primary care visits; and (3) it is only offered in the individual market.

*Child-only plans.* Provides that if a QHP is offered through a state Exchange for any level of coverage (i.e., bronze, silver, gold or platinum), the issuer is required to also offer a plan through the Exchange at that level in which the only enrollees are individuals who, as of the beginning of a plan year, have not attained the age of 21.

*Payments to Federally Qualified Health Centers (FQHCs).* Provides that if any item or service covered by a QHP is provided by a FQHC, the offeror of the plan is required to pay the FQHC at least the Medicaid reimbursement amount.

Effective 3/23/2010.

**Sec. 1303. Special Rules (as modified by Sec. 10104).**

*State opt out of abortion coverage.* Permits a state to prohibit abortion coverage in QHPs offered through an Exchange in that state if the state enacts a law to provide for such a prohibition. Permits a state to repeal such a law and provide for the offering of abortion coverage through the Exchange.

*Voluntary choice of coverage for abortion services.* Clarifies that nothing in this title (or any amendment made by it) requires a QHP to provide coverage of abortion services as part of its essential health benefits. Leaves the decision on whether to provide for elective abortions or abortions for which federal funds are permitted to the issuer of a QHP.

*Prohibition on the use of federal funds.* Prohibits a QHP that provides coverage of abortion services to use any amount attributable to any of the following for purposes of paying for such services: 1) The premium credit under (and the amount (if any) of the advance payment of the credit under §1412 of the Act; 2) any cost-sharing reduction under §1402 and the amount (if any) of the advance payment of the reduction. Provides that in the case of a plan which covers elective abortions, the issuer is required to collect from each enrollee in the plan a separate payment for the premium that excludes the cost of coverage for the abortion services and a separate amount equal to the actuarial value of the abortion coverage. Such amounts are to be kept in separate accounts and maintained for the separate purposes. Defines “actuarial value” to take into account the impact on overall costs of the inclusion of abortion coverage but may not take into account any cost reduction estimated to result from such services, including prenatal care, delivery or postnatal care; shall estimate the costs as if the coverage were included for the entire population covered and may not estimate the cost at less than \$1 per enrollee per month. Requires state insurance commissioners to ensure compliance with the requirement to segregate federal funds in accordance with generally accepted accounting requirements and guidance from the Office of Management and Budget (OMB) and guidance on accounting of GAO. Clarifies that such actions can be appealed in a court of competent jurisdiction.

*Rules relating to notice.* Requires plans to include in their benefit descriptions whether or not they cover abortion. Provides that the allocation of the premium into its components cannot be advertised or used in enrollment material by the issuer.

*Provider conscious protections.* Prohibits a QHP offered through an Exchange from discriminating against any health care provider or health care facility because of its unwillingness to provide, pay for, provide coverage of, or refer for abortions.

*Application of state and federal laws regarding abortion.* Clarifies that nothing in this Act preempts or has any effect on state laws regarding the prohibition or requirement of coverage, funding, or procedural requirements on abortions, including parental notification or consent. Clarifies that the following are not affected by this section: 1) federal conscience protections, laws regarding willingness or refusal to provide abortion; and abortion-related antidiscrimination laws; 2) the rights and obligations of employees and employers under Title VII of the Civil Rights Act of 1964 are not affected by this section; and 3) state or federal laws, including section 1867 of the SSA (EMTALA), requiring health care providers to provide emergency services.

Effective 3/23/2010.

**Sec. 1304. Related definitions (as modified by sec. 10104).**

Defines key terms, including “group market,” “individual market” and “large and small group markets.” Defines a “large employer” in connection with a group health plan to be one employing an average of at least 101 employees on business days during the preceding calendar year and who employs at least one employee on the first day of the plan year. Defines “small employer” as an employer with 1 to 100 employees. Prior to 1/2016, permits a state to define a small employer as 1 to 50 employees. Permits small employers that grow beyond the upper employee limit in the Small Business Health Options Program (SHOP Exchange) to continue to purchase coverage through the Exchange. Provides for rules for determining employer size. Defines a “state” to include the 50 states and the District of Columbia” (and not including Puerto Rico and other U.S. territories.)

Effective 3/23/2010.

**PART II—CONSUMER CHOICES AND INSURANCE COMPETITION THROUGH HEALTH BENEFIT EXCHANGES**

**Sec. 1311. Affordable choices of health benefit plans (as modified by sec. 10104).**

*Assistance to states to establish American Health Benefit Exchanges.* Appropriates to the Secretary an amount necessary to enable him or her to make awards, not later than one year after enactment, to states for the amount that the Secretary determines is needed. Requires the states to use the funds for activities (including planning activities) related to establishing an American Health Benefit Exchange. Permits the Secretary to renew a grant if the state is making progress (as determined by the Secretary) toward establishing an Exchange, implementing the related requirements, and meeting such other benchmarks as the Secretary may establish. Provides that no grants be awarded after 1/1/2015. Requires the Secretary to provide technical assistance to states to facilitate the participation of qualified small businesses in SHOP Exchanges.

*American Health Benefit Exchanges.* By 1/1/ 2014, requires each state to establish an American Health Benefit Exchange (Exchange) that facilitates purchase of QHPs, provides for the establishment of a Small Business Health Options Program (SHOP Exchange) to assist qualified employers who are small employers in facilitating enrollment of their employees in QHPs in the small group market, and meets other

requirements specified below. Requires that the state adopt and have in effect related federal requirements by that date. Permits a state to elect to provide only one Exchange in the state for providing both Exchange and SHOP Exchange services but only if the one Exchange has adequate resources to assist individuals and employers.

*Responsibilities of the Secretary.* Requires the Secretary of HHS, by regulation, to establish criteria for the certification of health plans as QHPs. Provides that to be certified by the Secretary as a QHP, a plan at a minimum must: 1) meet marketing requirements, and not employ marketing practices or benefit designs that have the effect of discouraging enrollment in the plan by individuals with significant health needs; 2) ensure a sufficient choice of providers and provide information to enrollees and prospective enrollees on the availability of in-network and out-of-network providers; 3) include within plan networks those essential community providers, where available, that serve predominately low-income, medically-underserved individuals, except that this does not require any health plan to provide coverage for any specific medical procedure; 4) be accredited with respect to local performance on clinical quality measures (e.g., Healthcare Effectiveness Data and Information Set (HEDIS), Consumer Assessment of Healthcare Providers and Systems (CAHPS)) as well as consumer access, utilization management, quality assurance, provider credentialing, complaints and appeals, network adequacy and access, and patient information programs by any entity recognized by the Secretary for the accreditation of health insurance issuers or plans; or receive such accreditation within a period established by an Exchange; 5) implement a quality improvement strategy as specified in the Act; 6) utilize a uniform enrollment form that qualified individuals and qualified employers may use (either electronically or on paper) in enrolling in QHPs offered through an Exchange; 7) utilize the standard format established for presenting health benefits plan options; 8) provide information to enrollees and prospective enrollees, and to each Exchange in which the plan is offered, on any applicable quality measures for health plan performance endorsed under §399JJ of the PHS Act, as added by the Act.

*Rule of construction.* Clarifies that the network requirements relating to essential community providers are not meant to require a QHP to contract with such a provider if the provider refuses to accept the generally applicable payment rates of the plan.

*Rating system.* Requires the Secretary to develop a system to rate QHPs offered through an Exchange in each benefits level on the basis of their relative quality and price. Requires the Exchange to include the quality rating in the information provided to individuals and employers through the Internet portal described below.

*Enrollee satisfaction system.* Requires the Secretary to develop an enrollee satisfaction survey system that would evaluate the level of enrollee satisfaction with QHPs offered through an Exchange, for each QHP that had more than 500 enrollees in the previous year. Requires the Exchange to include enrollee satisfaction information in the information provided to individuals and employers through the internet portal (see below) so that individuals can easily compare enrollee satisfaction between plans.

*Internet portals.* Requires the Secretary to continue to operate, maintain, and update the internet portal and to assist states in developing and maintaining their own such portal; and make available for use by Exchanges a model template for an internet portal that may be used to direct qualified individuals and qualified employers to QHPs, to assist them in determining Exchange eligibility and eligibility for a premium tax credit or cost-

sharing reduction, and to present standardized information (including quality ratings) regarding QHPs through an Exchange to assist consumers in making easy health insurance choices. Requires the template to include, with respect to each QHP offered through the Exchange in each rating area, access to the uniform outline of coverage the plan is required to provide under §2715 of the PHS Act (see “Transparency” above) and a copy of the plan's written policy.

*Enrollment periods.* Requires the Secretary to require an Exchange to provide for an initial open enrollment, as determined by the Secretary no later than 7/1/2012; annual open enrollment periods; special enrollment periods (as required under HIPAA) and other special enrollment periods similar to such periods under Medicare Part D; and special enrollments periods for Indians.

*Requirements.* Requires that an Exchange be a governmental agency or nonprofit entity that is established by a state; that an Exchange make available QHPs to qualified individuals and qualified employers; and that an Exchange not make available any health plan that is not a QHP. Requires each state Exchange to allow an issuer of a plan that only provides limited scope dental benefits to offer the plan through the Exchange (either separately or in conjunction with a QHP if the plan provides pediatric dental benefits meeting the requirements of §1302(b)(1)(J)) (see “Essential Benefits” above). Permits a state Exchange to make available a QHP, notwithstanding any provision of law, that may require benefits other than the essential health benefits. An exception applies with respect to state mandated benefits: A state may require that a QHP offer benefits in addition to the essential health benefits, but only if the state makes payments to an individual enrolled in a QHP in the state or on behalf of an individual directly to the QHP to defray the cost of any additional benefits which are not eligible for such credit or reduction.

*Functions of an Exchange.* Requires an Exchange, at a minimum, to perform specified functions including: 1) implement procedures for the certification, recertification, and decertification, consistent with guidelines set by the Secretary, of health plans as QHPs; 2) provide for a toll-free telephone hotline to respond to requests for assistance; 3) maintain a website through which enrollees and prospective enrollees of QHPs may obtain standardized comparative plan information; 4) assign a rating to each QHP offered through the Exchange in accordance with criteria developed by the Secretary; 5) utilize a standardized format for presenting health benefits plan options in the Exchange; 6) inform individuals of eligibility requirements for Medicaid, CHIP or any applicable state or local public program and, if through screening of the application an Exchange determines that such individuals are eligible for any of these programs, enroll the individuals in them; 7) establish and make available by electronic means a calculator to determine the actual cost of coverage after considering any tax credit or cost sharing assistance; 8) grant a certification attesting that, for purposes of the individual responsibility penalty (see below), an individual is exempt from the individual requirement or from the penalty because no affordable QHP is available through the Exchange, or the individual's employer or the individual meets the other exemptions; 9) transfer to the Treasury Secretary a list of individuals issued an exemption including taxpayer identification numbers; employees determined to be eligible for the premium tax credit; and the names and ID numbers of each individual who notifies the Exchange that they have changed employers and the individuals who have ceased coverage under a QHP during a plan year; and 10) establish the Navigator program (see below).

*Funding limitations.* Requires the state to ensure that the Exchange is self-sustaining beginning on 1/1/2015, including allowing the Exchange to charge assessments or user fees to participating issuers, or to otherwise generate funding, to support its operations. Prohibits an Exchange from utilizing any funds intended for the administrative and operational expenses of the Exchange for staff retreats, promotional giveaways, excessive executive compensation, or promotion of federal or state legislative and regulatory modifications. Requires an Exchange to consult with specified stakeholders (e.g., educated health care consumers, small business, state Medicaid offices) relevant to carrying out the required activities. Defines educated consumers as ones who are knowledgeable about the health care system and have backgrounds or experience in making informed decisions regarding health, medical and scientific matters. Requires an Exchange to publish the average costs of licensing, regulatory fees, and any other payments required by the Exchange, and its administrative costs, on a website to educate consumers on such costs. Requires this information to also include monies lost to waste, fraud, and abuse.

*Certification.* Permits an Exchange to certify a health plan as a QHP if the plan meets the above requirements for certification as promulgated by the Secretary and the Exchange determines that making available the health plan through the Exchange is in the interests of qualified individuals and qualified employers in the state or states in which such Exchange operates, except that the Exchange may not exclude a health plan on the basis that such plan is a fee-for-service plan; through the imposition of premium price controls; or on the basis that the plan provides treatments necessary to prevent patients' deaths in circumstances the Exchange determines are inappropriate or too costly.

*Premium considerations.* Requires an Exchange to, in turn, require health plans seeking certification to submit a justification for any premium increase prior to implementation of the increase. Requires QHPs to prominently post such information on their websites. Requires an Exchange to take this information, and the information and the recommendations provided to an Exchange by the state under §2794(b)(1) of the PHS Act (relating to patterns or practices of excessive or unjustified premium increases, as required above), into consideration when determining whether to make the plan available through the Exchange. Requires an Exchange to take into account any excess of premium growth outside the Exchange as compared to the rate of such growth inside the Exchange, including information reported by the states.

*Transparency in coverage.* Requires plans seeking certification by Exchanges to submit in plain language to the Exchange, Secretary, state insurance commissioner and the public information on claims payment policies, financial disclosures, enrollment, denials, rating practices, out-of-network cost-sharing, and enrollee rights. Requires such plans to provide information to enrollees on the amount of cost-sharing for a specific item or service in a timely manner at the request of the individual. Requires that this information be made available through a website and other means for individuals without Internet access. Requires the Secretary of Labor to update disclosure rules for group health plans to conform to these standards.

*Flexibility.* Permits an Exchange to operate in more than one state if each state permits such operation and the Secretary approves such regional or interstate Exchange. Permits Exchanges to enter into agreement with sub-Exchanges. Requires such a subsidiary Exchange to serve an area at least as large as a rating area (see "Premium

rating” above). Permits a state to authorize an Exchange to contract with an eligible entity to carry out 1 or more responsibilities of the Exchange. Defines an eligible entity as: (1) a person incorporated under, and subject to the laws of one or more states, with demonstrated experience on a state or regional basis in the individual and small group health insurance markets and in benefits coverage; and that is not an issuer or part of the same controlled group of corporations (or under common control with) as an issuer; or (2) the state Medicaid agency.

*Rewarding quality through market-based incentives.* Requires the Secretary, in consultation with experts in quality and stakeholders, to develop guidelines concerning quality strategies. Requires the periodic reporting to the applicable Exchange of the activities that a QHP has conducted to implement a quality strategy. Requires plans to annually report to the Secretary pediatric quality measures consistent with those measures developed for children enrolled in Medicaid or CHIP under section 1139A of the SSA. Defines a strategy as a payment structure that provides increased reimbursement or other incentives for: (1) improving health outcomes through implementation of specified activities (e.g., quality reporting, effective case management, care coordination); (2) implementation of activities to prevent hospital readmissions; (3) implementation of activities to improve patient safety and reduce medical errors through the appropriate use of best clinical practices, evidence based medicine, and health information technology under the plan or coverage; (4) implementation of wellness and health promotion activities; and (5) implementation of activities to reduce health disparities, including the use of language services, community outreach, and cultural competency training.

*Quality improvement.* Beginning on 1/1/2015, permits a QHP to contract with: (A) a hospital with greater than 50 beds only if such hospital: (1) utilizes a patient safety evaluation system as described in part C of title IX of the Public Health Service Act; and (2) implements a mechanism to ensure that each patient receives a comprehensive program for hospital discharge that includes patient-centered education and counseling, comprehensive discharge planning, and post discharge reinforcement by an appropriate health care professional; or (B) a health care provider only if the provider implements such mechanisms to improve health care quality as the Secretary may by regulation require. Permits the Secretary to establish reasonable exceptions to these requirements and, by regulation, adjust the size of hospitals to which this applies (i.e., number of beds).

*Navigators.* Requires an Exchange to establish a Navigator program to award grants to eligible entities. An eligible entity is one that demonstrates to the Exchange that it has or could readily establish relationships with employers and employees, consumers (including uninsured and underinsured consumers), or self-employed individuals likely to be qualified to enroll in a QHP. Lists entities that may qualify (e.g., trade, industry, and professional associations, chambers of commerce, unions, etc.). Requires a Navigator to conduct public education activities to raise awareness of the availability of QHPs; distribute fair and impartial enrollment information and the availability of premium tax credits and cost sharing reductions; facilitate enrollment; provide referrals to insurance consumer assistance or ombudsman (see “Health insurance consumer information” above) or any other appropriate state agencies, for any enrollee with a grievance, complaint, or question regarding their health plan, coverage, or a determination under such plan or coverage; and provide information in a manner that is culturally and

linguistically appropriate to the needs of the population being served by the Exchange(s).

*Navigator standards.* Requires the Secretary to establish standards for navigators including provisions to ensure that any private or public entity selected is qualified, and licensed if appropriate, to engage in the navigator activities and to avoid conflicts of interest. Prohibits a navigator from being a health insurance issuer or receive any consideration directly or indirectly from any health insurance issuer in connection with the enrollment of any qualified individuals or employees of a qualified employer in a qualified health plan. Requires the Secretary, in collaboration with states, to develop standards to ensure that information made available by navigators is fair, accurate, and impartial. Provides that grants be made from the operational funds of the Exchange and not federal funds received by the state to establish the Exchange.

*Applicability of mental health parity.* Provides that §2726 of the PHS Act (relating to mental health parity) applies to QHPs in the same manner and to the same extent as such section applies to health insurance issuers and group health plans.

*Conflict.* Prohibits an Exchange from establishing rules that conflict with or prevent the application of regulations promulgated by the Secretary under this subtitle (relating to quality coverage for all Americans).

Effective 3/23/2010.

**Sec. 1312. Consumer choice (as modified by sec. 10104).**

*Choice.* Permits a qualified individual to enroll in any QHP that is available to the individual and for which the individual is eligible. Permits a qualified employer to provide support for coverage of employees under a QHP by selecting the level of coverage to be made available to employees through an Exchange. Permits each employee to choose from the QHPs offered within that level of coverage.

*Payment of premiums by qualified individuals.* Permits a qualified individual enrolled in any QHP to pay the applicable premium to the plan's health insurance issuer.

*Single risk pool.* Requires an issuer to consider all enrollees in all of its health plans (other than grandfathered health plans) offered in the individual market, including those enrollees who do not enroll in plans through the Exchange, to be members of a single risk pool. Applies the same single risk pool requirement to all enrollees in the issuer's group coverage (other than grandfathered health plans). Permits a state to require its individual and small group within the state to be merged. Preempts a state law requiring grandfathered health plans to be included in a single pool for the individual or group market.

*Empowering consumer choice.* Permits an issuer to offer outside of an Exchange a health plan to a qualified individual or qualified employer. Permits a qualified individual to enroll in, or a qualified employer to select for its employees, a health plan offered outside of an Exchange. Provides that nothing in this title is meant to terminate, abridge, or limit the operation of any requirement under state law with respect to any policy or plan that is offered outside of an Exchange to offer benefits. Clarifies that nothing in this title is meant to restrict the choice of a qualified individual to enroll in a QHP or participate in an Exchange and nothing is meant to compel an individual to enroll or participate. Permits



a qualified individual to enroll in any QHP except that in the case of a catastrophic plan, a qualified individual may enroll only if the individual is under 30 years of age or because the individual's employer does not provide qualified coverage or it is determined to be unaffordable.

*Members of Congress in the Exchange.* Provides that notwithstanding any other provision of law, after the effective date of this subtitle, the only health plans that the federal government may make available to Members of Congress and congressional staff with respect to their service as a Member of Congress or congressional staff are those created under this Act (or an amendment made by this Act); or offered through an Exchange established under this Act (or an amendment made by this Act).

*No penalty for transferring to minimum essential coverage outside the Exchange.* Prohibits an Exchange, or a QHP offered through an Exchange, from imposing any penalty or other fee on an individual who cancels enrollment in a plan because he or she becomes eligible for minimum essential coverage (i.e. covered by Medicare, Medicaid, employer coverage, etc.) or such coverage becomes affordable.

*Enrollment through agents or brokers.* Requires the Secretary to establish procedures under which a state may allow agents or brokers to enroll individuals and employers in any QHPs in the individual or small group market as soon as the plan is offered through an Exchange and to assist individuals in applying for premium tax credits and cost-sharing reductions for plans sold through an Exchange.

*Qualified individuals and employers: access limited to citizens and lawful residents.* Provides that individuals and small employers are eligible to participate in the state Exchanges. Defines a qualified individual as one who is seeking to enroll in a QHP in the individual market offered through the Exchange and resides in the state of the Exchange (except for in the case of regional Exchanges). Excludes incarcerated individuals, other than those awaiting the disposition of charges.

Defines a qualified employer as a small employer that elects to make all full-time employees eligible for one or more QHPs in the small group market through an Exchange. (In §1304, the Act defines a small employer as an employer with 1 to 100 employees. Prior to 1/2016, permits a state to define small employer as 1 to 50 employees. Permits small employers that grow beyond the upper employee limit in the Exchange to continue to purchase coverage through the Exchange.) Beginning in 2017, a state may permit all issuers in the large group market to offer QHPs through the Exchange. Clarifies that this is voluntary for the issuer. Defines a large employer in this context to mean one that elects to make all full time employees eligible for one or more QHPs offered in the large group market through the Exchange.

Provides that if an individual is not, or is not reasonably expected to be for the entire period for which enrollment is sought, a citizen or national or an alien lawfully present in the U.S., the individual shall not be treated as a qualified individual and may not be covered under a QHP in the individual market that is offered through an Exchange.

Effective 3/23/2010.

**Sec. 1313. Financial integrity.**

*Accounting for expenditures.* Requires an Exchange to keep an accurate accounting of all activities, receipts, and expenditures and to annually submit to the Secretary a report.

*Investigations/audits/patterns of abuse.* Permits the Secretary, in coordination with the HHS Office of the Inspector General (OIG), to investigate the affairs of and examine properties and records of an Exchange, and may require periodic reports in relation to its activities. Requires full cooperation from the Exchange. Subjects an Exchange to annual audits by the Secretary. Provides that if the Secretary determines that an Exchange or a state has engaged in serious misconduct with respect to compliance, the Secretary may rescind from payments otherwise due to the state under this or any other Act administered by the Secretary an amount not to exceed 1% of such payments per year until corrective actions are taken by the state that are determined to be adequate by the Secretary. Includes additional protections against fraud and abuse and applies the False Claims Act to payments made by, through, or in connection with an Exchange if those payments include any Federal funds. Modifies the application of the False Claims Act's public disclosure bar as follows: 1) In lieu of denying a court jurisdiction over a whistleblower action based on public disclosure (with limited exceptions), directs the court to dismiss such an action or claim unless A) the Government opposes that dismissal; B) the Attorney General brings the action; or C) the whistleblower is an original source of the allegation or transaction in question. 2) The definition of original source is expanded so that the whistleblower need only show either that he/she A) had voluntarily disclosed to the Government the pertinent information before the public disclosure; or B) has independent and material knowledge that adds to the content of the public disclosure and voluntarily provided that information to the Government before filing a whistleblower action.

*GAO oversight.* Requires GAO, within 5 years of after the date on which Exchanges are required to be operational, to conduct an ongoing study of Exchange activities and the enrollees in QHPs offered through Exchanges. Specifies the scope of the study and requires, where appropriate, recommendations for improvements in the operations or policies of Exchanges; a survey of the cost and affordability of insurance provide under the Exchanges for owners and employees of small business concerns, including data on enrollees in Exchanges and individuals purchasing coverage outside of the Exchanges; and how many physicians, by area and specialty, are not taking or accepting new patients enrolled in federal government health care programs, and the adequacy of provider networks of federal government health care programs.

Effective 3/23/2010.

**PART III—STATE FLEXIBILITY RELATING TO EXCHANGES****Sec. 1321. State flexibility in operation and enforcement of Exchanges and related requirements.**

*Establishment of standards.* As soon as practicable after enactment, and with the exception of standards for which the Secretary issues guidelines under the PHS Act, the Secretary is required to issue regulations setting standards for meeting the requirements under Title I of the bill and any amendments made to Title I, with respect to: (1) the establishment and operation of Exchanges (including SHOP Exchanges); (2) the offering of QHPs through the Exchanges; (3) the establishment of reinsurance and risk adjustment programs; and (4) such other requirements as the Secretary determines

appropriate. In establishing these standards, the Secretary is required to consult with the NAIC and its members and with health insurance issuers, consumer organizations and such other individuals as the Secretary selects to ensure balanced representation among interested parties.

*State action.* Requires each state that elects, at the time and in the manner specified by the Secretary, to apply the requirements specified in the above standard to adopt and have in effect by 1/1/2014 those federal standards or state law or regulation that the Secretary determines implements the standards within the state.

*Failure to establish Exchange or implement requirements.* If a state fails to establish an Exchange within 24 months of enactment, or the Secretary determines, on or before 1/1/2013 that an electing state will not have an Exchange operational by 1/1/2014 or has not taken the necessary actions to implement other related federal requirements, the Secretary is required (directly or through agreement with a not-for-profit entity) to establish and operate an Exchange within the state and to take actions to implement the other federal requirements. Enforces federal authority related to non-electing states through the HIPAA enforcement provisions of the PHS Act (newly designated §2736(b)) without regard to any limitation on the application of those provisions to group health plans.

*No interference with state regulatory action.* Clarifies that nothing in this title preempts any state law that does not prevent the application of the provisions of this title.

*Presumption for certain state-operated Exchanges.* Presumes a state Exchange that operated before 1/1/2010 to be federally qualified under this Act and thus to continue to operate if it has insured a percentage of its population not less than the percentage of the population projected to be covered nationally after the Act's implementation unless the Secretary determines, after a review process, that the Exchange does not comply with federal standards. Requires the Secretary to establish the process necessary to assist the state Exchange in coming into compliance.

Effective 3/23/2010.

#### **Sec. 1322. Federal program to assist establishment and operation of nonprofit, member-run health insurance issuers.**

*Establishment of program.* Requires the Secretary to establish a Consumer Operated and Oriented Plan (CO-OP) program to foster the creation of qualified nonprofit health insurance issuers to offer QHPs in the individual and small group markets in the states in which the issuers are licensed to offer such plans.

*Loans and grants under the CO-OP program.* Requires the Secretary by 7/1/2013 to: award to persons applying to become qualified issuers, loans to provide assistance in meeting their start-up costs and grants to provide assistance in meeting any state solvency requirements in which the applicant seeks to be licensed to issue qualified health plans. In awarding loans and grants, requires the Secretary to take into account the recommendations of the advisory board (see below); give priority to applicants that will offer QHPs on a statewide basis, will utilize integrated care models, and have significant private support; and ensure that there is sufficient funding to establish at least one qualified nonprofit health insurance issuer in each state, except that this does not prohibit the Secretary from funding the establishment of multiple issuers in any state if

the funding is sufficient to do so. Provides that if no health insurance issuer applies to be a qualified nonprofit health insurance issuer within a state, the Secretary may use amounts appropriated under this section for the awarding of grants to encourage the establishment of a qualified nonprofit health insurance issuer within the state or the expansion of a qualified nonprofit health insurance issuer from another state to the state.

Requires, as a condition of a loan or grant, that the recipient enter into an agreement with the Secretary to meet and continue to meet the requirements for the loan or grant. Requires the agreement to state that no portion of the funds made available by any loan or grant under this section may be used for carrying on propaganda, or otherwise attempting, to influence legislation; or for marketing. Provides for sanctions in the event of a recipient's failure to meet requirements.

By 7/1/2013, and prior to awarding loans and grants, the Secretary is required to issue regulations with respect to repayment of loans and grants in a manner that is consistent with state solvency regulations and other similar state laws that may apply. Requires that such loans be repaid within 5 years and grants be repaid within 15 years, taking into account any appropriate state reserve requirements, solvency regulations and requisite surplus note arrangements that must be constructed in a state to provide for repayment.

*Advisory board.* Provides for an advisory board to be made up of 15 members appointed by GAO from among individuals with qualifications described in §1805(c)(2) of the SSA (relating to the qualifications for MedPAC commissioners). Requires appointees to meet ethics and conflict of interest standards protecting against insurance industry involvement and interference. Requires the board to be appointed within 3 months of enactment, provides for a process for filling vacancies, and authorizes no compensation except for travel expenses, including a per diem. Applies the Federal Advisory Committee Act, except that §14 of such Act shall not apply. Terminates the board on the earlier of the date that it completes its duties under this section or 12/31/2015.

*Qualified nonprofit health insurance issuer.* Defines a qualified non-profit health insurance issuer as an organization organized under state law as a nonprofit, member corporation; substantially all of the activities of which consist of the issuance of QHPs in the individual and small group markets in each state in which it is licensed to issue such plans and meets other requirements of this subsection. Provides that an organization are ineligible if it, or a related entity (or any predecessor of either), was a health insurance issuer on 7/16/2009 or it is sponsored by a state or local government, any political subdivision thereof, or any instrumentality of such government or political subdivision. To be qualified, the governance of the organization must be subject to a majority vote of its members; its governing documents incorporate ethics and conflict of interest standards protecting against insurance industry involvement and interference; and, as provided in regulations promulgated by the Secretary, the organization is required to operate with a strong consumer focus, including timeliness, responsiveness, and accountability to members.

Any profits made by the organization must be used to lower premiums, to improve benefits, or for other programs intended to improve the quality of health care delivered to its members. Requires, in addition, that the organization meet all the requirements that other issuers of QHPs are required to meet in any state where the issuer offers a QHP, including solvency and licensure requirements, rules on payments to providers, and compliance with network adequacy rules, rate and form filing rules, any applicable state

premium assessments and any state law specified in §1324 (see below). Limits eligibility to an organization in a state that has in effect (or the Secretary has implemented for the state) the market reforms required by this Act.

*Establishment of private purchasing council.* Permits issuers participating in the CO-OP program to establish a private purchasing council to enter into collective purchasing arrangements for items and services that increase administrative and other cost efficiencies, including claims administration, administrative services, health information technology, and actuarial services. Prohibits the Council from setting payment rates for participating facilities and providers. Clarifies that federal antitrust laws continue to apply.

*Limitation on participation.* Prohibits a representative of any federal, state, or local government from serving on the board of directors of a qualified nonprofit health insurance issuer or with a private purchasing council.

*Limitations on Secretary.* Prohibits the Secretary from participating in any negotiations between one or more qualified nonprofit health insurance issuers (or a private purchasing council) and any health care facilities or providers, including any drug manufacturer, pharmacy, or hospital; and from establishing or maintaining a price structure for reimbursement of any health benefits covered by such issuers. Clarifies that this section is not meant to authorize the Secretary to interfere with the competitive nature of providing health benefits through qualified nonprofit health insurance issuers.

*Appropriations.* Appropriates \$6 billion to carry out this section.

*Tax exemption for qualified nonprofit health insurance issuer.* Amends §501(c) of the IRC (relating to list of exempt organizations) to provide a tax exemption to a qualified nonprofit health insurance issuer which has received a loan or grant under the CO-OP program, but only with respect to periods for which the issuer is in compliance with the requirements of the section and any agreement with respect to the loan or grant. Requires the reporting of certain information to the IRS.

*GAO study and report.* Requires GAO to conduct an ongoing study on competition and market concentration in the health insurance market after the implementation of the reforms made by this legislation. Requires the study to include an analysis of new issuers of health insurance in such market. Requires GAO, by no later than 12/31 of each even-numbered year (beginning with 2014) to report to the appropriate committees of the Congress the results of the study including any recommendations for administrative or legislative changes the Comptroller General determines necessary or appropriate to increase competition in the health insurance market.

Effective 3/23/2010.

**Sec. 1323. Funding for the Territories (as amended by sec. 1204 of HCERA).**

*In general.* Provides that a territory that has elected to establish an Exchange consistent with the requirements of the Act to be treated as a state for purposes of funding for start up of the Exchange. Alternatively, if it fails to elect to establish a qualified Exchange, then the territory will be entitled to an increase in the cap on their federal Medicaid payments.

*Terms and conditions.* To qualify for the funding, requires the election to be received by 10/1/2013 and is contingent upon entering into an agreement between the territory and the Secretary that requires that funds be used only to provide premium and cost-sharing assistance to residents of the territory in obtaining health insurance coverage through the Exchange and the premium and cost-sharing assistance be structured so as to prevent any gap in assistance for individuals between the income level at which Medicaid is available and the income level at which premium and cost-sharing assistance is available under the agreement.

*Allocation.* Provides for the appropriation of \$1 billion to be available for 2014 through 2018. Specifies how much is to be allocated for Puerto Rico (\$925 million) and for other territories.

Effective 3/23/2010.

**Sec. 1324. Level playing field (as modified by sec. 10104).**

Provides that any health insurance coverage offered by a private issuer not be subject to any of the federal or state insurance laws listed below if a QHP offered by a CO-OP or a multi-state QHP is not subject to such laws. Provides that the federal and state laws are those relating to: guaranteed renewal, rating, preexisting conditions, non-discrimination, quality improvement and reporting, fraud and abuse, solvency and financial requirements, market conduct, prompt payment, appeals and grievances, privacy and confidentiality, licensure and benefit plan material or information.

Effective 3/23/2010.

**PART IV—STATE FLEXIBILITY TO ESTABLISH ALTERNATIVE PROGRAMS**

**Sec. 1331. State flexibility to establish basic health programs for low-income individuals not eligible for Medicaid (as modified by sec. 10104)**

*Establishment of program and eligibility.* Requires the Secretary to establish a basic health program meeting the requirements of this section under which a state may enter into contracts to offer one or more standard health plans providing at least the essential health benefits to eligible individuals in lieu of offering such individuals coverage through an Exchange. Defines an eligible individual as a state resident not eligible to enroll in Medicaid for benefits that, at a minimum, consist of the essential health benefits; whose household income is between 133% and 200% of the poverty line for the size of the family involved; who is not eligible for minimum essential coverage (see below) or is eligible for an employer-sponsored plan that is not affordable coverage (see below); and who has not attained age 65 as of the beginning of the plan year. Prohibits an eligible individual from using a state Exchange. Makes legal immigrants whose income is less than 133% of the federal poverty level (FPL), and who are not eligible for Medicaid by virtue of the five year waiting period, eligible for the basic health program.

*Certification as to benefit coverage and costs.* Requires the state to establish to the satisfaction of the Secretary that for an eligible individual enrolled in a standard health plan offered through the program, the state provides that the monthly premium (after reduction for any premium tax credits and cost-sharing reductions allowable with respect to either plan) an eligible individual is required to pay does not exceed the amount of the monthly premium that the individual would have been required to pay (in the rating area

in which the individual resides) if enrolled in the applicable second lowest cost silver plan offered through an Exchange; and that the cost-sharing an eligible individual is required to pay under the standard health plan does not exceed that required under a platinum plan in the case of an eligible individual with household income not in excess of 150% of the poverty line for the size of the family involved; and the cost-sharing required under a gold plan in the case of any other eligible individual; and the benefits provided under the standard health plans offered through the program cover at least the essential health benefits.

*Standard health plan.* Defines a “standard health plan” as one that the state contracts with under which the only individuals eligible to enroll are eligible individuals; that provides at least the essential health benefits; and, in the case of a plan that provides coverage offered by a health insurance issuer, has a medical loss ratio of at least 85%.

*Contracting process.* Requires a state basic health program to establish a competitive process for entering into contracts with standard health plans, including negotiation of premiums and cost-sharing and negotiation of benefits in addition to the essential health benefits. Requires a state, as part of its competitive process, to include specific requirements including innovative features (e.g., care coordination and care management for enrollees); consideration of, and the making of suitable allowances for, differences in health care needs of enrollees and differences in local availability of, and access to, health care providers (but does not allow discrimination on the basis of pre-existing conditions or other health status-related factors); managed care; and performance measures. Requires a state, to the maximum extent feasible, to make multiple standard health plans available to eligible individuals to ensure individuals have a choice of such plans. Permits a state to negotiate regional compacts with other states to include coverage of eligible individuals. Requires a state to seek to coordinate the administration of, and provision of benefits under, its program with Medicaid, CHIP and other state-administered health programs to maximize the efficiency of such programs and to improve the continuity of care.

*Transfer of funds to states.* Requires the Secretary to transfer to the state with an eligible program for each fiscal year for which one or more standard health plans are operating within the state an amount equal to 95% of the premium tax credits and the cost-sharing reductions that would have been provided for the fiscal year to eligible individuals enrolled in standard health plans in the state if such eligible individuals were allowed to enroll in QHPs through an Exchange. Requires a state to establish a trust for the deposit of the amounts received and provides such amounts only be used to reduce the premiums and cost-sharing of, or to provide additional benefits for, eligible individuals enrolled in standard health plans within the state. Requires the Secretary to make funding amounts available on a per enrollee basis, taking into account specified factors, and take into consideration the experience of other states with respect to participation in an Exchange and such credits and reductions provided to residents of the other states, with a special focus on enrollees with income below 200% of poverty. Requires the CMS Actuary, in consultation with the Office of Tax Analysis of the Department of the Treasury, to certify the methodology used to make determinations.

*Abortion.* Applies the bill’s limitations on coverage of abortion-related services to a state basic health program in the same manner as such rules apply to QHPs.

*Secretarial oversight.* Requires the Secretary to conduct annually a review of each state program to ensure compliance.

Effective 3/23/2010.

**Sec. 1332. Waiver for State innovation.**

*Application.* Permits a state to apply to the Secretary for the waiver of all or any specified requirements with respect to health insurance coverage within that state for plan years beginning on or after 1/1/2017. Requires the waiver application to include a comprehensive description of the state legislation and program to implement a plan meeting the waiver requirements and a 10-year budget that is budget neutral for the federal government. Applies the Act's requirements relating to essential benefits, affordable choices of plans and consumer choice, cost-sharing requirements, the refundable credits for premiums, and employer and individual responsibility requirements.

*Pass through of funding.* Provides that with respect to a state waiver, under which (due to the structure of the state plan), individuals and small employers in the state would not qualify for the Act's premium tax credits, cost-sharing reductions, or small business credits or which they would otherwise be eligible, the Secretary must provide for an alternative means by which the aggregate amount of such credits or reductions are paid to the state. Requires such amount to be determined annually by the Secretary, taking into consideration the experience of other states with respect to participation in an Exchange and credits and reductions provided under such provisions to residents of the other states.

*Waiver consideration and transparency.* Requires a waiver application to be considered by the Secretary in accordance with specified regulations.

*Regulations and reporting.* Within 180 days of enactment, requires the Secretary to promulgate regulations relating to waivers that provide procedures for: public notice and comment at the state level; the submission of an application that ensures the disclosure of the provisions of law that the state involved seeks to waive and the specific plans of the state to ensure that the waiver will be in compliance with requirements; a process for providing public notice and comment after the application is received by the Secretary; a process for submission to the Secretary of periodic reports by the state concerning the implementation of the program under the waiver; and a process for the periodic evaluation by the Secretary of the program under the waiver. Requires the Secretary to annually report to Congress concerning actions taken by the Secretary with respect to applications for waivers under this section.

*Coordinated waiver process.* Requires the Secretary to develop a process for coordinating and consolidating the state waiver processes and the existing waiver processes applicable under Medicare, Medicaid, CHIP and any other Federal law relating to the provision of health care items or services. Requires this process to permit a state to submit a single application for a waiver under any or all of such provisions.

*Granting of Waivers.* Requires the Secretary to grant a request for a waiver only upon determining that the state plan will provide coverage at least as comprehensive as the essential benefits coverage offered through Exchanges as certified by the CMS Actuary; will provide coverage and cost sharing protections against excessive out-of-pocket



spending that are at least as affordable as the provisions of this title would provide; will provide coverage to at least a comparable number of its residents as the provisions of this title would provide; and will not increase the federal deficit.

*Scope of waiver and determinations by Secretary.* Requires the Secretary to determine the scope of a waiver but may not waive any federal law or requirement that is not within the authority of the Secretary. Requires the determination within 180 days after the receipt of an application from a state. Requires notice of a favorable decision and the terms and effectiveness of such waiver. Requires that if the Secretary determines a waiver should not be granted, he or she notify the state and the appropriate committees of Congress and provide the reasons.

*Term of waiver.* Prohibits a waiver for longer than 5 years unless the state requests continuation; such request must be deemed granted unless the Secretary, within 90 days after the date of its submission to the Secretary, either denies such request in writing or informs the state in writing with respect to any additional information which is needed in order to make a final determination with respect to the request.

Effective 3/23/2010.

**Sec. 1333. Provisions relating to offering of plans in more than one State (as modified by sec. 10104).**

*Health care choice compacts.* Effective 1/1/2016, two or more states may form Health Care Choice Compacts to facilitate the purchase of individual health insurance coverage across state lines. Requires the Secretary, by 7/1/2013, in consultation with the NAIC, to issue regulations for the creation of compacts under which one or more QHPs can be offered in the individual markets in all participating states but, except as specified, only be subject to the laws and regulations of the state in which the plan is written or issued. Subjects the issuer of any QHP to which the compact applies to the following laws of the state in which the purchaser resides: market conduct, unfair trade practices, network adequacy, and consumer protection standards (including rating standards), including addressing disputes as to the performance of the contract. Requires the issuer to be licensed in each state in which it offers the plan under the compact or to submit to the jurisdiction of each such state with regard to the above standards (including allowing access to records as if the insurer were licensed in the state) and to clearly notify consumers that the policy may not be subject to all the laws and regulations of the state in which the purchaser resides. Prohibits a state from entering into an agreement unless it enacts a law (after the date of this bill's enactment) that specifically authorizes the state to enter into such agreements.

*Approval of contracts.* Permits the Secretary to approve compacts only if the Secretary determines that the compact will: 1) provide the essential benefits coverage offered through Exchanges; 2) provide coverage and cost sharing protections against excessive out-of-pocket spending that are at least as affordable as the provisions of this title would provide; 3) provide coverage to at least a comparable number of its residents as the provisions of this title would provide; 4) not increase the federal deficit; and 5) not weaken enforcement of insurance laws and regulations (described above) in any state that is included in such compact.

Effective as of 1/1/2016 except that regulations are due by 7/1/2013.

**Sec. 1334 Multi-state plans (as modified by sec. 10104).**

*Oversight by the Office of Personnel Management.* Requires the Director of OPM to enter into contracts with issuers (which may include a group of issuers affiliated either by common ownership and control or by common use of a nationally licensed service mark) without regard to the requirements under the law authorizing the FEHBP or other statutes requiring competitive bidding, to offer at least 2 multi-state QHPs through each Exchange in each state. Requires these plans to provide individual, or in the case of small employers, group coverage. Requires contracts to be at least for 1 year, automatically renewable in the absence of notice of termination by either party. Requires the coverage to be in accordance with the types required under the Act. Requires the Director to ensure that at least one contract is with a non-profit entity.

Requires the Director to implement this provision in a manner similar to the manner in which he or she implements the contracting under FEHBP including (through negotiation with each multi-state plan): 1) a medical loss ratio; 2) profit margin; 3) premiums; 4) such other terms and conditions of coverage as are in the interests of enrollees in such plans. Permits the Director to prohibit the offering of a multi-state plan that does not meet the terms and conditions with respect to consumer protections. Requires the Director to ensure that with respect to multi-state QHPs offered in an Exchange, there is at least one that does not provide coverage of elective abortions. Permits the Director to withdraw a contract only after notice and opportunity for hearing.

*Eligibility.* To be eligible, an issuer must agree to offer a multi-state QHP meeting requirements in each Exchange in each state; is licensed in each state and is subject to all requirements of state law not inconsistent with this section, including the standards and requirements that a state imposes that do not prevent the application of the Act's insurance reforms; otherwise complies with minimum standards prescribed for carriers under FEHBP to the extent they do not conflict with this Act; and meets other requirements as determined appropriate by the Director, in consultation with the Secretary.

*Requirements.* Provides that a plan meets the requirements if, in the determination of the Director, it offers a benefits package that is uniform in each state and consists of the essential benefits package; meets requirements relating to the offering of the bronze, silver and gold levels of coverage and catastrophic coverage in each state Exchange; the issuer rates its premiums on the basis of the rating requirements of the bill; and the issuer offers the plan in all geographic regions and in all states that have adopted adjusted community rating before the date of enactment. Permits states to require that benefits in addition to the essential benefits be provided to enrollees of a multi-state QHP offered in that state but only if the state defrays any additional cost for premium credits resulting from the additional benefits.

*Application of certain state rating requirements.* Provides that in the case of a multi-state QHP offered in a state with age rating lower than 3:1, the state may require that Exchanges operating in that state only permit the offering of multi-state plans that comply with those more protective age rating requirements.

*Credits.* Provides that an individual enrolled in a multi-state QHP is eligible for premium credits and cost sharing assistance in the same manner as an individual enrolled in a QHP.

*Plans deemed to be certified.* Deems a multi-state QHP as certified by an Exchange.

*Phase-in.* Notwithstanding the requirements above related to offering in all states and being licensed in all states, requires the Director to contract with an issuer for the offering of a multi-state QHP if: 1) with respect to the first year for which the issuer offers the plan, the issuer offers it in at least 60% of the states; 2) for the second year, at least 70% of the states; 3) for the third year, at least 85%; and for each subsequent year, in all states.

*Applicability.* Applies the FEHBP requirements to multi-state QHPs to the extent that the requirements do not conflict with a provision of this title.

*Continued support for FEHBP.* Clarifies that OPM must maintain effort with respect to the administration of FEHBP. Provides for a separate risk pool apart from the enrollees in FEHBP. Permits the Director to establish separate units or offices within OPM and to appoint additional personnel to ensure that the administration of multi-state QHPs does not interfere with effective administration of FEHBP. Clarifies that carriers participating in FEHBP are not required to also offer a multi-state QHP. Premiums paid for multi-state QHPs are not considered Federal funds for any purpose.

*Advisory board.* Requires the Director to establish an advisory board to provide recommendations on the activities described above. Requires a significant percentage of the members of the board to be comprised of enrollees in multi-state QHP or representatives of such enrollees.

*Authorization of appropriations.* Authorizes to be appropriated such sums as may be necessary to carry out this section.

Effective 3/23/2010.

## **PART V—REINSURANCE AND RISK ADJUSTMENT**

### **Sec. 1341. Transitional reinsurance program for individual markets in each State (as modified by sec. 10104)**

*In general.* By 1/1/2014, each state is required to establish a transitional reinsurance program as part of the federal standards or state law or regulation it adopts to comply with the Act's requirements relating to establishing Exchanges and adopting federal insurance standards. Permits the state to establish (or contract with) one or more applicable reinsurance entities to carry out this program.

*Model regulation.* Requires the Secretary, in consultation with the NAIC and as part of the Secretary's responsibilities related to the bill's federal insurance reforms, to include provisions in regulation that enable states to establish and maintain a reinsurance program under which health insurance issuers, and third party administrators on behalf of group health plans, are: 1) required to make payments to the reinsurance entity for any plan year beginning 1/ 2014 (and ending 12/1/2016) and 2) the applicable reinsurance entity collects payments and uses the payments to make reinsurance payments to issuers that cover high risk individuals in the individual market (excluding grandfathered health plans) for any plan year beginning in such 3-year period. Requires the Secretary to include in the regulation the method by which individuals will be identified as high risk on the basis of: 1) a list of at least 50 but not more than 100

medical conditions identified as high-risk conditions and that may be based on the identification of diagnostic and procedure codes indicative of individuals with pre-existing, high-risk conditions; or 2) any other comparable objective method of identification recommended by the American Academy of Actuaries.

*Payment amount.* Requires that the formula provide for equitable allocation of available funds through reconciliation and allows it to be designed to provide a schedule of payments that specifies the amount that will be paid for each of the identified health conditions or uses any other comparable method for determining payment amounts that is recommended by the American Academy of Actuaries and that encourages the use of care coordination and care management programs for high risk conditions.

*Required contributions.* Requires the Secretary to include in the regulations the method for determining the amount each issuer and group health plan is required to contribute for each plan year beginning in the 36-month period beginning 1/1/2014. Permits the contribution amount to be based on the percentage of revenue of each issuer and the total costs of providing benefits to enrollees in self-insured plans or on a specified amount per enrollee and may be required to be paid in advance or periodically throughout the plan year. Requires the method for determining contributions to be designed so that: 1) the contribution amount for each issuer proportionally reflects each issuer's fully insured commercial book of business for all major medical products and the total value of all fees charged by the issuer and the costs of coverage administered by the issuer as a third party administrator; 2) the amount may include an additional amount to fund the administrative expenses of the reinsurance entity; 3) the aggregate contribution amounts for all states shall, based on the best estimates of the NAIC and without regard to administrative amounts, equal \$10 billion for plan years beginning in 2014, \$6 billion for plan years beginning 2015, and \$4 billion beginning in 2016; and 4) in addition to the aggregate contribution amounts, each issuer's contribution amount for any calendar year reflects its proportionate share of an additional: \$2 billion for 2014, \$2 billion for 2015, and \$1 billion for 2016. Permits states to collect additional amounts from issuers on a voluntary basis.

*Expenditure of funds.* Permits contribution amounts collected for any calendar year to be allocated and used in any of the three calendar years for which amounts are collected based on the reinsurance needs of a particular period or to reflect experience in a prior period; amounts remaining unexpended as of 12/31/2016 may be used to make payments under any reinsurance program of a state in the individual market in effect in the 2-year period beginning on 1/1/2017.

*Applicable reinsurance entity.* Defines such an entity as a not-for-profit organization, the purpose of which is to help stabilize premiums for coverage in the individual market in a state during the first 3 years of operation of an Exchange when the risk of adverse selection related to new rating rules and market changes is greatest; and the duties of which shall be to carry out the reinsurance program by coordinating the funding and operation of the risk-spreading mechanisms designed to implement the reinsurance program. Permits a state to have more than 1 reinsurance entity and 2 or more states to enter into agreements to provide for a reinsurance entity to carry out such program in all such states. Exempts the entity from federal taxes (except for any taxes on unrelated business income).

*Coordination with state high-risk pools.* Requires a state to eliminate or modify any state high-risk pool to the extent necessary to carry out the reinsurance program established

under this section. Permits the state to coordinate its high-risk pool with such program to the extent not inconsistent with the provisions of this section.

Effective 3/23/2010.

**Sec. 1342. Establishment of risk corridors for plans in individual and small group markets.**

*In general.* Provides for risk-corridors (as in Medicare Part D) for plans that offer coverage in the individual and small group markets in 2014 through 2016. Provides for voluntary participation by insurers in the risk-corridors, which would be applied after reinsurance.

*Payment methodology.* If a participating plan's allowable costs for a plan year are between 103% and 108% of a "target amount," the Secretary must pay the plan an amount equal to 50% of the amount that exceeds 103% of the target; if a plan's allowable costs exceed 108% of the target, the Secretary must pay an amount equal to the sum of 2.5% of the target plus 80% of allowable costs in excess of 108% of the target. If a plan's allowable costs for a plan year are between 92% and 97% of the target, the plan must pay the Secretary an amount equal to 50% of the excess of 97% of the target; if a plan's allowable costs are less than 92% of the target, the plan must pay an amount equal to the sum of 2.5% of the target plus 80% of the excess of 92% of the target amount over the allowable costs.

*Definitions.* Defines "allowable costs" as costs equal to the total costs (other than administrative costs) of the plan in providing benefits covered by the plan. Requires that such costs be reduced by any risk adjustment and reinsurance payments. Defines "target amount" as premiums (including any premium subsidies under any governmental program), reduced by the administrative costs of the plan.

Effective 3/23/2010.

**Sec. 1343. Risk adjustment.**

*Low actuarial risk plans.* Requires each state, using the criteria and methods described below, to assess a charge on health plans and issuers (with respect to health insurance coverage) if the actuarial risk of the enrollees for a year is less than the average actuarial risk of all enrollees in all plans or coverage in the state for the year that are not self-insured group health plans (which are subject to the provisions of ERISA).

*High actuarial risk plans.* Requires each state to provide a payment to plans and issuers if the actuarial risk of the enrollees for a year is greater than the average actuarial risk of all enrollees in all plans and coverage in the state for the year that are not self-insured, ERISA group health plans.

*Criteria and methods.* Requires the Secretary, in consultation with states, to establish criteria and methods to be used in carrying out the risk adjustment. Permits the Secretary to utilize criteria and methods similar to those for Part C or D of Medicare. Requires them to be included in the standards and requirements the Secretary prescribes for the state Exchanges and insurance standards.

*Scope of application.* Applies to a health plan or an issuer if such plan or issuer provides coverage in the individual or small group market within a state. Does not apply to a grandfathered health plan or that plan's issuer.

Effective 3/23/2010.

**Implementation Funding (added by sec. 1005 of HCERA)**

Establishes a Health Insurance Reform Implementation Fund within HHS to carry out the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010. Appropriates to the Fund \$1 billion for federal administrative expenses to carry out the Acts and amendments made to such Acts.

Effective 3/23/2010.

**Subtitle E—Affordable Coverage Choices for All Americans**

**PART I—PREMIUM TAX CREDITS AND COST-SHARING REDUCTIONS**

**SUBPART A—PREMIUM TAX CREDITS AND COST-SHARING REDUCTIONS**

**Sec. 1401. Refundable tax credit providing premium assistance for coverage under a qualified health plan (as modified by sec. 10105, sec. 1001 of HCERA, and sec. 1004 of HCERA)**

Creates a new refundable premium assistance tax credit for coverage under a qualified health plan for individuals with household income from 100% through 400% of the federal poverty level (FPL). Individuals must be citizens or lawful US residents, and enroll in a qualified health plan through a state Exchange. (Individuals who receive a free choice voucher payment from an employer for a month under sec. 10108 are not eligible for the credit for that month.) Individuals eligible for a premium assistance tax credit may enroll in any qualified health plan other than a catastrophic plan (see section 1302.) Sec. 1412 provides for advance payment of credits.

Modified adjusted gross income (MAGI) used to determine eligibility defined (here and for purposes of Medicaid eligibility, see sec. 2002) as adjusted gross income increased by amounts excluded from gross income for citizens or residents living abroad and any tax-exempt interest. Household income is the sum of the modified adjusted gross income of the taxpayer and all individuals in the family for whom a deduction is allowed and who were required to file a tax return.

Legal immigrants with incomes at or below 100% of FPL who are not eligible for Medicaid or CHIP due to the 5-year waiting period are eligible for the premium tax credit, and treated as if their income was 100% of FPL for the purpose of the premium tax credit calculation.

Premium assistance tax credit is an amount which caps the individual's premium contribution based on a percentage of household income, using the table below. Within each tier the percentage is determined on a linear sliding scale. These amounts are to be indexed after 2014 to reflect the excess rate of growth in premiums over income for the preceding calendar year. After 2018, an additional adjustment will be made if the aggregate amount of premium tax credits and cost sharing reductions (see sec. 1402) exceeds 0.504% of the GDP in the preceding calendar year. In that case, the additional

increase in the percentages will be the excess rate of growth in premiums over the consumer price index. Credits are determined monthly, and the total credit for a tax year is the sum of these monthly amounts.

Household income tier (as % of poverty)	Initial premium percentage	Final premium percentage
Up to 133%	2%	2%
133% up to 150%	3%	4%
150% up to 200%	4%	6.3%
200% up to 250%	6.3%	8.05%
250% up to 300%	8.05%	9.5%
300% up to 400%	9.5%	9.5%

The value of the credit for a month equals the lesser of the monthly premiums for the plan in which the individual or family is enrolled, or the amount by which the monthly cost of the second lowest cost silver plan premium exceeds the individual's premium contribution amount as calculated using this table. The silver plan premium to be used is that for second lowest-cost silver plan offered through the Exchange for the area where the individual resides, adjusted for age and applicable to the individual or family as appropriate. (Special rules apply in the case of couples filing a joint return and one of them is ineligible for the credit because he or she is not lawfully present.) Any wellness discounts are not counted in computing the premium.

Benefits offered in excess of the essential health benefits, including any benefits mandated by state law, will not be counted in determining the premium for calculation of the premium tax credit, under rules to be prescribed by the Secretary of HHS. In the case of individuals enrolling in a both a qualified health plan and a stand alone plan providing for pediatric dental coverage, amounts allocable to pediatric dental coverage will be included in the premium for calculating the premium tax credit, under regulations prescribed by the Secretary.

Individuals eligible for minimum essential coverage other than in the individual insurance market are generally not eligible for the credit. (For the definition of minimum essential coverage see sec. 1501.) However, individuals eligible for minimum essential coverage through an employer plan (as an employee or by relationship to an employee) are eligible for the credit if the employee's required premium contribution exceeds 9.5% of household income, or the plan's share of total allowed costs of plan benefits (i.e., actuarial value) is less than 60%. These individuals must still enroll in a qualified health plan through a state Exchange to receive a credit. The 9.5% amount is indexed after 2014 in the same manner as the premium percentages described above.

Married taxpayers must file a joint return to be eligible for a premium tax credit. Dependents not directly eligible for the tax credit. No tax deduction is allowed for the portion of premiums paid for with the tax credit.

Individuals not lawfully present in the U.S. are not eligible for premium tax credits and, if part of a taxpayer's household, they are excluded from the calculations. Premiums are reduced by the amount attributable to these individuals, they either are not counted in determining household size for the purpose of relating household income to the FPL and household income is reduced by a fraction computed as the poverty level excluding

these individuals divided by the poverty level including them, or a comparable method is used. The Secretary of HHS to consult with the Treasury Secretary to determine calculations that minimize burden on eligible individuals.

The final tax credit will be reconciled with advance payments made under section 1412. Any excess amounts paid in advance will be added to taxes owed, except when the taxpayer's household income is less than 400% of FPL, in which case the amount repaid is limited to \$400 (\$250 when the taxpayer is an unmarried individual). These limits will be indexed after 2014 to the consumer price index for all urban consumers (CPI-U) and rounded to next lowest \$50.

Exchanges are required to provide information to taxpayers and to the Treasury on: the level of coverage; the total premium without regard to the premium tax credit; the aggregate amount of any advance payments made to the taxpayer; the name address and tax identification number of each covered individual; and on information provided to the Exchange with respect to changes in circumstances affecting eligibility for the credit; and other information necessary to determine whether an excess advance payments were made.

The Treasury Secretary will prescribe regulations as necessary to implement the tax credit, including coordination with the advance credit program provided under section 1412 and with respect to reconciling advance payments where filing status has changed.

Within 5 years of enactment, GAO is to study and report to Congress on the affordability of health insurance coverage, including the impact of the premium tax credit and small employer tax credits on maintaining and expanding coverage; the availability of affordable plans, including whether the 9.5% premium contribution threshold with respect to employer coverage is appropriate and whether it could be lowered without significantly increasing costs or decreasing employer coverage; and the ability of individuals to maintain essential benefits coverage.

Under sec. 1412, states are not prohibited from providing payments for coverage on behalf of an individual in addition to the premium tax credit and cost sharing reductions.

Effective for taxable years ending after 12/31/2013.

**Sec. 1402. Reduced cost-sharing for individuals enrolling in qualified health plans. (as modified by section 1001 of HCERA).**

Cost sharing reductions are provided to individuals eligible for premium assistance tax credit who are enrolled in a silver plan in the individual market offered through an Exchange. Reductions apply only for months for which the premium assistance tax credit is allowed. Treatment of legal immigrants not eligible for Medicaid applies as for the premium tax credit (sec. 1401) and definitions used for premium tax credits apply. Eligibility determinations to be made with respect to the taxable year for which the advance determination is made under sec. 1411, not the taxable year for which the premium tax credit applies.

HHS notifies the insurance issuer of an individual's eligibility, and the issuer reduces the individual's cost-sharing amounts. The issuer notifies HHS of reductions made, and the Secretary is directed to make periodic and timely payments to the issuer equal to the value of the reductions. The Secretary may establish a capitated payment system for



payment of the cost-sharing reductions. Any capitated system must take into account the value of the reductions and make appropriate risk adjustments.

The amount of the cost-sharing reduction varies by income. The otherwise applicable out-of-pocket cost sharing limits (sec. 1302) to be reduced by two-thirds for individuals with incomes greater than 100% of FPL through 200% of FPL, by one-half for those greater than 200% through 300% of FPL, and by one-third for those greater than 300% through 400% of FPL. If necessary, the Secretary is to then adjust the out-of-pocket limits to ensure that when these cost sharing reductions are taken into account, the plan share of total allowed costs of benefits (actuarial value) of the individual's plan does not exceed 94% in the case of individuals with incomes from 100% through 150% of FPL, 87% for those from 150% through 200% of FPL, 73% for those from 200% through 250% of FPL and 70% for those from 250% through 400% of FPL. (Sec. 1302 sets the silver plan actuarial value at 70%.) Further adjustments to be made to ensure that for individuals from 100% to 150% of FPL, the plan's share of total allowed costs of benefits is increased to 94% and that it is increased to 87% for those from 150% to 200% of FPL.

Cost sharing reduction does not apply to benefits offered in excess of the essential health benefits, including any benefits mandated by state law. In the case of individuals enrolled in both a qualified health plan and a stand-alone dental plan, cost sharing reductions do not apply to the portion of premiums that, under regulations prescribed by the Secretary of HHS, are properly allocable to pediatric dental benefits.

Special rules for Indians eliminate all cost sharing for Indians with incomes below 300% of FPL, and no cost sharing shall apply to items or services directly provided by the Indian Health Service, an Indian tribe, tribal organization or urban Indian organization. The Secretary to make payments to plans to reflect the increased actuarial value of the plan resulting from these rules.

Individuals not lawfully present in the U.S. not eligible for cost sharing reductions and, if part of a taxpayer's household, are excluded from the calculations in the same manner as they are excluded for the purpose of the premium tax credit.

Under sec. 1412, states are not prohibited from providing payments on behalf of an individual in addition to the premium tax credit and cost sharing reductions.

## **SUBPART B—ELIGIBILITY DETERMINATIONS**

### **Sec. 1411. Procedures for determining eligibility for Exchange participation, premium tax credits and reduced cost-sharing, and individual responsibility exemptions.**

Secretary of HHS to establish a program for eligibility determination for participation in the individual market in the Exchange and for premium tax credits and cost sharing reductions. Determinations to include whether individuals are citizens or otherwise lawfully present, and in the case of the premium tax credit or cost sharing reductions, whether they meet the income and coverage requirements, the amount of the premium tax credit or cost sharing reduction, whether the individual's employer coverage is unaffordable, and whether to certify upon request an exemption from the personal responsibility requirement (individual mandate) or the associated penalty.

Specifies the information to be provided by applicants to the Exchange (including regarding citizenship or immigration status), applicants for premium tax credits and cost sharing reductions, and applicants for exemptions from the individual responsibility requirement under sec. 1501.

Directs that Exchanges submit to HHS applicant information for verification. HHS to submit certain applicant information for verification to the Social Security Commissioner, and, in the case of individuals who attest to being lawfully present aliens or for whom the Commissioner has not verified the applicant's information, to the Secretary of Homeland Security. Information on income and family size to be submitted to Treasury for verification. HHS reports to the Exchanges results of verification. If citizenship or immigration information cannot be verified, documentation procedures in place under Medicaid as of 1/1/2010 to apply. If an Exchange is notified of inconsistencies in other information, the Exchange to make reasonable effort to clarify, and provide notice and 90-day opportunity to correct the information. Provides for specific actions to be taken by the Exchange with respect to certain inconsistencies. HHS Secretary to establish a federal appeals process (in consultation with Secretaries of Treasury and Homeland Security and the Social Security Commissioner). Secretary has flexibility to modify methods to reduce administrative costs and burdens on applicants if requirements for confidentiality, disclosure, maintenance and use of information are met. Secretary may delegate verification to Exchange in the case of information that is not contained in federal records. Processes to be established regarding appeals of eligibility determinations and for periodic redetermination of eligibility.

Provides for confidentiality of applicant information, limits use of information provided by applicants only for the purposes of efficient operation of the Exchange and prohibits disclosure except as provided. Civil money penalties of up to \$25,000 apply if an applicant's failure to provide correct information is attributable to negligence or disregard of rules or regulations and for improper use or disclosure of information. No property liens or levies are permitted.

A separate appeals process is to be established under which employers notified that they are subject to the tax under sec. 1513 are able to present information to the Exchange for review and have access to the data used to make the determination, to the extent allowable by law. This process to be separate from existing appeals under the tax code. Employers are not generally entitled to taxpayer return information used in determining whether the employer tax penalty applies except that the employer may be notified as to the employee's name and whether the employee's income is above or below the threshold for affordability. The Secretary may prescribe a process under which an employee may provide a waiver authorizing the employer to have access to the employee's tax return.

The Secretary of HHS, in consultation with Treasury, is to study and report by 1/1/2013 with any recommendations on the procedures necessary to ensure protection of the rights of employees to preserve confidentiality of taxpayer return information and enroll in a plan through an Exchange if an employer does not provide affordable coverage, and the rights of employers to adequate due process and access to information necessary to determine any payment assessed on employers.

**Sec. 1412. Advance determination and payment of premium tax credits and cost-sharing reductions.**

The HHS Secretary, in consultation with Treasury, is to establish a program under which upon request of an Exchange, advance determinations are made under section 1411 with respect to eligibility for premium tax credits and cost sharing reductions. HHS notifies the Exchange and the Treasury of the advance determinations and the Treasury makes advance payments to the health plan issuers in order to reduce premiums payable by eligible individuals. HHS will also provide the Treasury with the name and employer identification number of each employer with respect to whom one or more employees were eligible for the premium tax credit and cost sharing reductions because the employer did not offer minimum essential coverage or it was determined to be unaffordable or it did not meet the minimum actuarial value. (See sec. 1401)

Eligibility to be determined during the open enrollment period (or other as specified by the Secretary) and on the basis of the individual's household income for the most recent taxable year for which the Secretary of HHS determines information is available after consultation with the Secretary of Treasury. Processes for making advance determinations on the basis of other information to be developed by the Secretary for non-filers and in cases of substantial changes in income, changes in family size or circumstances, filing status, or other significant changes affecting eligibility, including a allowing an individual claiming a decrease in income of 20% or more or filing for unemployment benefits to have eligibility determined on the basis of income for a later period or an estimate of current year income.

With respect to the premium tax credit, HHS will notify Treasury and the Exchange with respect to an advance determination regarding an individual, and Treasury will make advance payment to the health plan issuer on a monthly basis (or other as determined by the Secretary). Issuers must reduce the premium charged the individual by the amount of the advance, notify the Exchange and the Secretary of the reduction, and display the amount of the reduction in each billing statement. In the case of nonpayment of premiums by an individual, the issuer must notify the Secretary and provide a three-month grace period before discontinuing coverage. When the individual's tax return is later filed for the year, the premium tax credit is reconciled with any advance payments made (see sec. 1401).

In the case of cost sharing reductions, HHS will notify Treasury and the Exchange of an individual's eligibility and Treasury will make advance payments to the health plan issuer as specified by HHS. Under Section 1402, HHS also notifies the issuer of an individual's eligibility, and the issuer reduces the individual's cost-sharing amounts.

States are not prohibited from providing payments on behalf of an individual in addition to the premium tax credit and cost sharing reductions.

**Sec. 1413. Streamlining of procedures for enrollment through an Exchange and State Medicaid, CHIP, and health subsidy programs.**

The Secretary is to establish a system under which individuals applying to a state Exchange who are found to be eligible for health subsidy programs are enrolled in the program. For this purpose, health subsidy programs are defined as the premium credits (sec. 1401), cost sharing reductions (sec. 1402), Medicaid, CHIP, or a basic health plan program offered under state flexibility provided in sec.1331. The Secretary is to develop a standard application form for states that may be used for all programs; may be filed

online, in person, or by telephone; may be filed with an Exchange or other state health subsidy program; is user friendly; and does not require applicants to subsequently provide additional information unless the information provided is inconsistent or insufficient. States may develop and use alternate forms, if approved.

States are required to develop an electronic interface for all the health subsidy programs that allows for eligibility determination based on a single application, to be compatible with the data verification methods established under sec. 1411. Requires state participation in a data matching arrangement to be developed consistent with standards established by the Secretary, including those for privacy and data security.

The Secretary may establish model agreements for data sharing requirements, and safeguards for privacy and data integrity established for tax returns and under sec. 1411. Requirements do not prohibit state Exchanges from contracting with state Medicaid agencies for eligibility determinations for all programs, if applicable standards are met. Nothing changes the requirement that Medicaid eligibility must be determined by a public agency.

**Sec. 1414. Disclosures to carry out eligibility requirements for certain programs.**

Provides under the Internal Revenue Code for disclosure of specific taxpayer return information upon written request of the Secretary of HHS to officers, employees and contractors of HHS for purposes of determining eligibility for premium tax credits (sec 1401), cost sharing reductions (sec. 1402), Medicaid, CHIP, or a basic health program under state flexibility provided in sec.1331. HHS permitted to disclose information on inconsistencies to an Exchange or other state agency or their contractors. Also provides for disclosure under the Social Security Act of names and Social Security numbers to the Secretary of HHS and Exchanges for the purposes of carrying out the Act.

**Sec. 1415. Premium tax credit and cost-sharing reduction payments disregarded for Federal and Federally-assisted programs.**

For the purposes of determining eligibility for any other federal program or state or local program financed with federal funds, amounts received as premium tax credits are not to be treated as income or as assets for the month of receipt or following 2 months. Any cost-sharing reduction amounts or advance payment of the premium tax credit shall be treated as payment made to the qualified health plan and not the individual.

**Sec. 1416. Study of geographic variation in application of FPL (added by sec. 10105).**

Requires the Secretary to study the feasibility and implications of adjusting the FPL to reflect geographic variation in the cost of living. If the Secretary determines that an adjustment is feasible, a methodology should be included in the study. Report to Congress due no later than 1/1/2013. Study to include the territories and disparity among poverty level and cost of living in the territories.

**PART II—SMALL BUSINESS TAX CREDIT**

**Sec. 1421. Credit for employee health insurance expenses of small businesses (as modified by sec. 10105).**

Provides tax credits to firms with no more than 25 full-time equivalent employees (FTEs) and average annual FTE wages of no more than \$50,000. Wage limits indexed to the CPI-U beginning in 2014. Employer must pay at least 50% of the premium. Amounts contributed pursuant to a salary reduction arrangement are not counted as employer

contribution. Credits limited to 2 years, but periods prior to 2014 are not counted toward the two-year limit.

Subject to the sliding scale described below, the amount of the credit to equal a proportion of the employer's aggregate premium contributions. The credit computation is different for 2010 through 2013 than it is for 2014 and thereafter (when the state Exchanges are presumed to be operating.) For the initial years, the maximum proportion is 35% generally and 25% for tax-exempt employers. For 2014 and beyond, the maximum proportions increase to 50% and 35% respectively.

For 2010 through 2013, the employer's premium contribution is computed as the lower of the actual premiums paid, or the amounts that would have been paid based on the average premium paid in the small group market in the state or sub-state area, as calculated by the Secretary of HHS.

For 2014 and beyond, the employer's contribution is computed as the lower of the actual amount paid by the employer for employee coverage in the state Exchange, or what the employer's share of the premium would be if employees were all enrolled in an average cost Exchange plan, as determined by the Secretary.

FTEs calculated by dividing total hours worked by all employees during a tax year by 2,080. Hours worked by an employee in excess of 2,080 are not counted. The Secretary of Treasury, in consultation with the Labor Secretary to determine hours for employees not paid by the hour. Average wages equal to total wages divided by FTEs, rounded to the next lowest \$1,000. Certain seasonal worker hours and wages are not counted; and certain leased employees are included.

No deduction may be taken for employer premiums for which the credit is received. The credit is treated as a general business credit. The credit is also available for tax liability under the alternative minimum tax. For tax exempt employers, the credit counts against payroll tax contributions and may not exceed the employer's total payroll tax obligation.

The maximum credit applies to firms with 10 or fewer FTEs and average FTE wages of up to \$25,000. A sliding scale reduces the credit as average compensation increases, ending at \$50,000. The credit is simultaneously reduced on a sliding scale for firms with more than 10 employees, ending at 25 employees.

Self-employed individuals, 2 percent shareholders of an S corporation and 5 percent owners of a C corporation are not treated as employees for purposes of the credit. Sole proprietorships may not receive the credit for the owner and family members. Aggregation rules apply.

Effective for tax years beginning with 2010.

## **Subtitle F—Shared Responsibility for Health Care**

### **PART I—INDIVIDUAL RESPONSIBILITY**

#### **Sec. 1501. Requirement to maintain minimum essential coverage (as modified by sec. 10106 and sec. 1002 of HCERA).**

For months beginning 1/1/2014, requires individuals to be covered under minimum essential coverage (defined below), and establishes an excise tax penalty on individuals not meeting the coverage requirement. The requirement is not applicable to individuals with a religious conscience exemption, defined as those with a certification under section 1311 as a member of a recognized religious sect that qualifies for exemption from self-employment taxes and as an adherent of established tenets or teaching of such sect; individuals not lawfully present in the U.S.; and individuals who are incarcerated other than incarceration pending disposition of charges.

Penalty to equal the lesser of the sum of monthly penalties applicable for the year (described below) or the national average premium for bronze level coverage offered in the Exchanges for the applicable family size. Penalty halved for individuals under age 18. Penalty to be paid on income tax returns. Penalties with respect to dependents of another taxpayer to be paid by the other taxpayer.

Monthly penalty to be 1/12 of the greater of 1) the flat dollar amount penalties specified per individual in the bill for the year, with a maximum of 3 times that amount for a household, without regard to the reduced penalty for those under age 18, or 2) a percentage of household income specified in the bill for the year. The per-individual flat dollar amount and percentage of income penalties are specified as \$95 or 1% of income for 2014, \$325 or 2% of income for 2015, and \$695 or 2.5% of income for 2016 and beyond. For 2017 and beyond, the flat dollar amounts are indexed to the CPI-U, rounded to the next lowest \$50.

Exemptions from the excise tax penalty provided for those with incomes below the level required for filing an income tax return; members of Indian tribes, for hardship as determined by the HHS Secretary if there is no affordable qualified health plan available through the Exchange, or the individual's employer, covering the individual; those with gaps in coverage of less than 3 months; and individuals who cannot afford coverage. Individuals who cannot afford coverage are those for whom the individual's annual required contribution (defined below) exceeds 8% of household income (defined using modified adjusted gross income as for the premium tax credit). The 8% amount is indexed after 2014 to reflect the increase in premium growth over income growth.

In the case of an individual offered employer coverage, the individual's required contribution is the portion of the annual premium paid by the individual for self-only coverage, and includes any amounts paid through a salary reduction arrangement. In the case of coverage purchased through the Exchange, the required contribution is the lowest cost bronze plan available from the Exchange, reduced by any allowable tax credit. For determining affordability of coverage for individuals eligible for employer coverage by reason of relationship to an employee, the affordability of the coverage to the employee is determinative.

Minimum essential coverage needed to meet the requirement is defined as coverage under a government sponsored plan (Medicare; Medicaid; CHIP; TRICARE; the

veteran's health care program, Peace Corps health plan), an employer sponsored plan, plans offered in the individual market in a state, a grandfathered plan, and other coverage, such as state high risk pools, as determined by the Secretary of HHS in coordination with the Treasury. It does not include coverage under excepted benefits (§2791 of PHS Act, which includes such coverage as accident-only, and separate dental or vision coverage.)

Individuals residing outside the U.S. and residents of U.S. territories are deemed to meet the minimum essential coverage requirement.

Penalties to be paid upon notice and demand by the Treasury Secretary, as with other assessable penalties under the tax code, except taxpayers failing to timely pay a penalty shall not be subject to criminal prosecution or penalty and the Secretary may not impose property liens or levies.

This section also provides findings with respect to the effects of the individual responsibility requirement on interstate commerce.

Effective for taxable years ending after 12/31/2013.

#### **Sec. 1502. Reporting of health insurance coverage.**

Any entity providing minimum essential coverage (insurers, employer health plans, public plans, etc.) must provide the Treasury information as prescribed on the individuals provided coverage, dates of coverage, whether coverage is through an Exchange plan, amounts of any advance of premium or cost sharing reductions, and other information the Secretary may require. In the case of employer coverage, the information must also identify the employer, the employer paid portion of the premium and other information the Secretary may require with respect to the small employer tax credit. Statements also to be furnished annually to individuals by January 31st. Penalties apply for failure to comply.

By June 30 each year, IRS, in consultation with the Secretary of HHS, is to send a notification to individuals who filed a tax return and are not enrolled in minimum essential coverage, providing information on the state Exchange.

Effective for calendar years beginning in 2014.

### **PART II—EMPLOYER RESPONSIBILITIES**

#### **Sec. 1511. Automatic enrollment for employees of large employers.**

Adds a requirement under the Fair Labor Standards Act that employers with more than 200 full-time employees that offer at least one health plan must automatically enroll new full-time employees into a health plan and continue enrollment of current employees. Adequate notice and opportunity for employee opt out must be provided. Overrides state requirements with respect to payroll only to the extent the requirement prevents an employer from instituting automatic enrollment. Secretary of Labor to promulgate regulations. Provision effective on enactment; employer requirement effective on date of promulgation of regulations.

**Sec. 1512. Employer requirement to inform employees of coverage options.**

Amends Fair Labor Standards Act to require employers to provide employees at the time of hiring, (and existing employees by 3/1/2013), with information about the health insurance Exchange, the availability of premium tax credits in the Exchange in the case of employees with employers who offer coverage but pay less than 60% of the premium, and the loss of employer contribution (and accompanying tax exclusion) for coverage purchased by employees through the Exchange except where a free choice voucher is provided under sec. 10108. Secretary of Labor to promulgate regulations. Effective 3/1/2013.

**Sec. 1513. Shared responsibility for employers (as modified by sec. 10106 and sec. 1003 of HCERA).**

Effective 1/1/2014, applicable large employers are subject to an assessment (excise tax) for a month if at least one employee receives a premium tax credit for coverage through the Exchange. Applicable large employers are defined as those with an average of 50 or more full-time employees in the preceding year, unless the employer exceeds 50 employees for 120 days or fewer during the year as a result of hiring seasonal workers. Employers are not subject to the employer penalty for a month with respect to any employee to whom a free choice voucher is paid under sec. 10108. No assessment is made in the case of an employee who enrolls in Medicaid.

In determining whether the employer is an applicable large employer, the contribution of part time employees is to be counted towards the 50 employee threshold by summing the total number of monthly hours of part-time employees and dividing by 120. Full-time employee defined with respect to a month as one employed on average at least 30 hours per week. The Secretary of Treasury, in consultation with the Labor Secretary, is to issue guidance and regulations as needed to determine hours of service of an employee, including rules for treatment of employees not compensated by the hour. Specified aggregation rules apply; new employers are included if it is reasonably expected that they will average 50 or more employees during the year.

Applicable large employers that do not offer minimum essential coverage to full-time employees and their dependents must pay the excise tax if at least one full-time employee receives a premium tax credit or cost sharing reduction for health insurance through a state Exchange. The tax is to equal \$166.67 a month (1/12th of \$2,000) times the total number of the firm's full-time employees reduced by 30 employees.

An assessment (excise tax) is also imposed on an employer that offers minimum essential coverage to full-time employees and their dependents if one or more full-time employees qualifies for the premium tax credit through the Exchange because the employer does not offer minimum essential coverage, or the coverage is determined to be unaffordable to the employee. (See sec. 1401.) In this case, the monthly tax is \$250 (1/12th of \$3,000) per subsidized employee, capped, in aggregate, at \$166.67 a month (1/12 of \$2,000) times the total number of full-time employees reduced by 30 employees.

All amounts are indexed after 2014 to the national increase in average per capita premiums, rounded to the next lowest \$10. The excise tax is not deductible for income tax purposes. Payments are due upon notice and demand by the Secretary of Treasury who has discretion regarding whether payments are collected monthly, annually or otherwise, and who must develop process for cases in which the excise tax is assessed



on an employer with respect to a tax credit eligible employee who later is deemed ineligible.

Requires the Secretary of Labor to conduct a study using the National Compensation Survey to determine whether employees' wages are being reduced as a result of the shared responsibility taxes imposed on employers. Report due to the House Ways and Means and Senate Finance Committees.

**Sec. 1514. Reporting of employer health insurance coverage.**

Applicable large employers (see sec. 1513) and offering employers must provide the Treasury a certification as to whether the employer offers minimum essential coverage (see sec. 1501) to employees, the length of any waiting period required, the lowest-cost plan's premium and employer contribution, the number of full-time employees for each month during the year, identification of the employees enrolled in the employer's plan, and other information. The Secretary is to determine the form and manner of the certification. Offering employers are defined for this section as those for whom the required contribution of any employee exceeds 8% of wages paid the employee by the employer. The 8% amount is indexed after 2014 to the growth of premiums over income from 2013 to the preceding year.

Employers must also furnish to each named employee by 1/31 of each year the information provided to Treasury with respect to the employee. The Secretary may provide that this information be provided on the W2 or by the health insurance issuer.

Penalties are imposed for failure to comply. The Secretary has authority to review the accuracy of information reported by employers with respect to the reporting requirements, including the employer premium contribution.

Effective 1/1/2014.

**Sec. 1515. Offering of Exchange-participating qualified health plans through cafeteria plans.**

Provides that reimbursement or direct payment for the premiums for coverage under any QHP offered through the Exchange is a qualified benefit under a cafeteria plan (as defined under §125 of the IRC) if the employer is a qualified employer, meaning (in general) a small employer that elects to make all of its full time employees eligible for one or more qualified plans offered in the small group market through an Exchange. Otherwise, reimbursement or direct payment for premiums for coverage under a QHP offered through an Exchange is not a qualified benefit under a cafeteria plan.

Effective for taxable years beginning after 12/31/2013.

## **Subtitle G—Miscellaneous Provisions**

### **Sec. 1551. Definitions.**

Unless otherwise specified, applies the definitions in §2791 of the PHS Act to this title.

### **Sec. 1552. Transparency in government.**

Within 30 days of enactment, the Secretary of HHS is to publish on the HHS website a list of all authorities provided to the Secretary under the Act (and amendments made by the Act).

Effective 3/23/2010.

### **Sec. 1553. Prohibition against discrimination on assisted suicide.**

Prohibits federal, state and local governments, health care providers receiving federal assistance under the Act, or any health plan created under the Act from discriminating against individuals or physicians and other health care professionals and institutional health care entities that do not provide an item or service furnished for the purpose of assisting in or causing the death of an individual through assisted suicide, euthanasia or mercy killing. Clarifies that the provision does not apply to or affect limitations with respect to abortion; withholding or withdrawing of medical care, nutrition or hydration; or items or services that increase risk of death if furnished for pain alleviation. Designates the HHS Office of Civil Rights to receive complaints of discrimination based on this provision.

Effective 3/23/2010.

### **Sec. 1554. Access to therapies.**

Prohibits the Secretary of HHS from promulgating any regulation that creates: unreasonable barriers to individuals for obtaining appropriate medical care, impedes timely access to services, interferes with communications between patient and provider regarding the full range of treatment options, restricts the ability of providers to disclose information to patients making health care decisions, violates ethical standards or the principals of informed consent, or limits the availability of health care treatment for the full duration of a patient's medical needs.

Effective 3/23/2010.

### **Sec. 1555. Freedom not to participate in Federal health insurance programs.**

Provides that no individual, company, business, nonprofit entity or health insurance issuer offering group or individual health insurance coverage shall be required to participate in any federal health insurance program created under this Act or in any federal health insurance program expanded by this Act and no fine or penalty can be imposed for failure to participate in such programs.

Effective 3/23/2010.

### **Sec. 1556. Equity for certain eligible survivors.**

Amends the Black Lung Benefits Act with respect to presumptions regarding miner disability and to eliminate an exception regarding filing of claims by survivors of miners already determined eligible at time of death.

Effective with respect to certain claims filed after 1/1/2005 that are pending on or after 3/23/2010.

**Sec. 1557. Nondiscrimination.**

Provides that except as otherwise provided for in this title (or amendment made by this title) an individual shall not, on the grounds prohibited under title VI of the Civil Rights Act of 1964, title IX of the Education Amendments of 1972, the Age Discrimination Act of 1975 or section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 794), be excluded from participation in, be denied the benefits of, or be subjected to discrimination under, any health program or activity, any part of which is receiving federal financial assistance, including credits, subsidies, or contracts of insurance, or under any program or activity that is administered by an Executive Agency or any entity established under this title (or amendments). Provides that the enforcement mechanisms under such laws apply with respect to violations. Clarifies that nothing in this title or an amendment made by it is meant to invalidate or limit the rights, remedies, procedures, or legal standards available to individuals aggrieved under those provisions of law, or to supersede state laws that provide additional protections against discrimination on any basis described above. Permits the Secretary to promulgate implementing regulations.

Effective 3/23/2010.

**Sec. 1558. Protections for employees.**

*Prohibition.* Amends the Fair Labor Standards Act to prohibit employers from discharging or discriminating against an employee because he or she receives a premium credit or cost sharing subsidy; testifies, assists in testimony, or otherwise provides information to the employer or federal and state authorities information about an employer's violation of any requirements of the bill; or objects or refuses to participate in any activity the employee reasonably believes to be a violation. Clarifies that nothing in this section shall be deemed to diminish the rights of any employee under any federal or state law or under any collective bargaining agreement and the rights and remedies in this section may not be waived by any agreement, policy, form or condition of employment.

Effective 3/23/2010.

**Sec. 1559. Oversight.**

Provides the HHS Inspector General with oversight authority with respect to Title I of the bill as it relates to HHS.

Effective 3/23/2010.

**Sec. 1560. Rules of construction.**

Clarifies that nothing in this title (or an amendment made by this title) is meant to modify, impair or supersede antitrust laws (as specifically defined); to modify or limit the application of the exemption for the Hawaii Prepaid Health Care Act as provided for under ERISA; to prohibit an institution of higher education from offering a student health insurance plan, to the extent that such requirement is otherwise permitted under applicable federal, state or local law; or to modify any existing federal requirement concerning the state agency responsible for determining eligibility for programs identified in §1413.

Effective 3/23/2010.

**Sec. 1561. Health information technology (HIT) enrollment standards and protocols (as modified by sec. 10107).**

Requires that within 180 days of enactment, the Secretary of HHS (in consultation with the HIT Policy Committee and HIT Standards Committee) develop interoperable and secure standards and protocols that facilitate enrollment of individuals in federal and state health and human services programs, as determined by the Secretary.

The Secretary is to determine appropriate methods for facilitating enrollment, including providing notification to individuals of eligibility and verification of eligibility. Standards and protocols to allow for electronic matching against existing federal and state data; simplification and submission of electronic documentation; reuse of stored eligibility information and documentation; capability for individuals to apply, recertify and manage eligibility information online; ability to expand the enrollment system to integrate new programs and rules, and to operate at increased volume; communication of notices and other functionalities.

The Secretary to notify states of standards and protocols once developed and approved by the HIT Policy and HIT Standards committees, and may require that states incorporate the standards as a condition of receiving federal HIT investments.

The Secretary to award grants to states or sub-state governments to develop and adapt systems to implement the protocols and standards. Enrollment technologies developed under grants to be shared with other states and appropriate entities.

Effective 3/23/2010.

**Sec. 1562. GAO study regarding the rate of denial of coverage and enrollment by health insurance issuers and group health plans (as added by sec. 10107).**

Requires a GAO study of the incidence of enrollment denials and denials of coverage for medical services to health plan enrollees. Data samples to include types of services for which coverage is denied and reasons for coverage and enrollment denials and to include cases for which coverage denial is later reversed. Data from QHPs and others to be included. Report due to Secretaries of HHS and Labor one year after enactment; report to be published on the internet.

Effective 3/23/2010.

**NOTE: Taking into account the changes in title X, PPACA has 3 sections numbered 1563, which follow here.**

**Sec. 1563. Conforming amendments (as modified by sec. 10107).**

Makes miscellaneous conforming amendments. (This was originally section 1562 in PPACA, and renumbered in the sec. 10107 amendments.)

Effective 3/23/2010.

**Sec. 1563. Small Business Procurement (as added by sec. 10107).**

Prohibits waiver of various federal procurement requirements relating to small business concerns with respect to any contract awarded under the bill.

Effective 3/23/2010.

**Sec. 1563. Sense of the Senate promoting fiscal responsibility.**

Provides that the Senate makes the following findings: Based on CBO estimates, the Act will reduce the deficit between 2010 and 2019; continue to reduce budget deficits after 2019; extend the solvency of the Medicare HI Trust Fund; will increase the surplus in the Social Security Trust Fund and the initial net savings generated by the Community Living Assistance Services and Supports (CLASS) program are necessary to ensure the solvency of that program. In addition, it is the sense of the Senate that the additional surplus in the Social Security Trust Fund generated by the Act should be reserved for Social Security and the net savings generated by the CLASS program be reserved for that program.

**Sec. 10108. Free Choice Vouchers.**

Effective 1/1/2014, an employer that offers minimum essential coverage and pays any portion of the premium must provide “free choice vouchers” equal to the employer premium contribution to qualifying employees for their use in purchasing coverage through an Exchange. Qualifying employees are those with household income no greater than 400% of FPL, who do not enroll in the employer plan, and whose required contribution toward the employer plan falls in a range which for 2014 is more than 8% of household income but not more than 9.8% of household income. After 2014, both the percentages are to be indexed to reflect the rate of premium growth in excess of income growth from 2013 to the preceding year.

The amount of the voucher is the contribution the employer would make to the employee’s coverage if the employee were enrolled in the employer plan (for individual or family coverage whichever is applicable). If more than one plan is offered, the plan to be used is the one for which the employer pays the largest share of the cost. (The cost of a plan to be determined using methods under sec. 2204 of the Public Health Service Act with respect to COBRA continuation coverage.) The employer pays the amount to the Exchange. If the amount of the voucher exceeds the premium for the employee’s chosen plan from the Exchange, the difference is paid to the employee.

Voucher amounts are deductible to the employer, and are not counted as taxable income to the employee to the extent that the voucher does not exceed the amount of the premium for the employee’s chosen plan.

An individual receiving a voucher for a month is not eligible for a premium tax credit under sec. 1401. Employers are not subject to the employer penalty under sec. 1513 for a month with respect to an employee to whom a free choice voucher is paid.

**Sec. 1004(d) of HCERA: Adult dependents.**

Amends various references in the tax code with respect to dependents to also identify children who have not attained age 27 by the end of the tax year. Amendments apply to the tax treatment of employer provided health coverage, self-employed health insurance, voluntary employees’ beneficiary association payments, and retiree health benefits.

## **TITLE II—ROLE OF PUBLIC PROGRAMS**

### **Subtitle A—Improved Access to Medicaid**

#### **Sec. 2001. Medicaid coverage for the lowest income populations (as modified by sec. 10201 and sec. 1201 of HCERA).**

Expansion of coverage to 133% of FPL; benchmark benefits. Effective 1/1/2014, requires states to expand Medicaid eligibility to include individuals with incomes not exceeding 133% of the FPL who are under age 65, not pregnant, not entitled to Medicare, and not otherwise eligible for Medicaid. Benefits for this newly eligible population are limited to the benchmark and benchmark-equivalent packages established under the Deficit Reduction Act (DRA), with changes described below, regardless of whether the state has opted to provide benchmark coverage as provided under the DRA. Existing prohibitions on requiring certain individuals (e.g., those defined by the Secretary as medically frail or with special needs, hospice patients, dual eligibles, and others) to enroll in benchmark plans will also apply to the expansion population. No federal matching is available for benefits beyond the benchmark or benchmark-equivalent definition.

Effective 1/1/2014, standards for Medicaid benchmark benefit packages and benchmark equivalent coverage are required to provide at least the essential health benefits offered through the Exchange (see sec. 1302). Effective upon enactment, amends benchmark equivalent coverage to include prescription drug and mental health benefits as basic services. Mental health parity requirements apply to benchmark benefit package or benchmark equivalent packages offered by an entity that is not a Medicaid managed care organization and that provides both medical/surgical and mental health or substance abuse benefits. Early Periodic Screening Diagnostic and Treatment (EPSDT) coverage is deemed to meet the mental health parity requirement.

As part of the conforming changes to Medicaid in this provision, mandatory Medicaid eligibility for children ages 6 to 19 is increased from 100% of FPL to 133% of FPL.

Federal Medical Assistance Percentage (FMAP) for newly eligible population. Provides 100% federal funding for newly eligible individuals (for calendar quarters) in 2014, 2015, and 2016, 95% in 2017, 94% in 2018, 93% in 2019 and 90% thereafter. Newly eligible individuals are defined as those who are not children and who, as of 12/1/2009, were not eligible under the state plan or a waiver for full Medicaid benefits, benchmark benefits, or benchmark equivalent coverage, or were eligible but not enrolled due to a capped or limited enrollment that was full.

FMAP for expansion states. Additional federal matching funds are also provided to expansion states for individuals who are not newly eligible. Expansion states are defined as those that on the date of enactment provide statewide coverage of parents and nonpregnant childless adults at or above 100% of FPL that includes inpatient hospital services; is not dependent on access to employer coverage, employer contribution, or employment; and is not limited to premium assistance, hospital-only benefits, high-deductible plans, or alternative benefits under a health opportunity accounts demonstration program.

From 1/1/2014 through 12/31/2015, expansion states which the Secretary determines will not receive any additional federal payments for newly eligible individuals, and for which the state has not been approved to divert disproportionate share funds toward the

costs of providing coverage under a waiver in effect in July 2009 will receive an additional 2.2 percentage points in federal matching funds for amounts expended for individuals who are not newly eligible.

In addition, the matching rates for expansion states for nonpregnant childless adults are increased by an amount that consists of a transition percentage of the amount by which the federal matching rate for the state is less than the matching rate provided for newly eligible individuals. The transition percentage is 50% for 2014, 60% for 2015, 70% for 2016, 80% for 2017, 90% for 2018, and 100% for 2019 and thereafter.

States electing to apply presumptive eligibility to individuals may extend it to this population.

*Other FMAP provisions.* States that require political subdivisions within the state to contribute toward the state share of Medicaid expenditures will not be eligible for an increase in federal matching funds (under sec. 2001 for newly eligible individuals or expansion states or under sec. 2006) if they require political subdivisions to pay a greater share of Medicaid expenditures or a greater percentage of the nonfederal share of disproportionate share hospital (DSH) payments than would have been required under the state plan or state law as of December 31, 2009. Voluntary contributions are not considered to be required contributions. The treatment of voluntary and required contributions to apply also to increases in federal matching funds provided under the American Recovery and Reinvestment Act (ARRA) of 2009 (P.L. 111-5).

*Optional expansion prior to 2014.* States are given the option to expand coverage prior to 1/1/2014 through a state plan amendment to the population that will become mandatory on that date. States may phase-in such eligibility by income but may not cover higher income individuals before lower income individuals. An individual may not be enrolled if they are the parent of a child under age 19 who is uninsured and eligible for Medicaid but not enrolled. Effective 4/1/2010.

*Maintenance of income eligibility.* As a condition of receiving federal Medicaid funding, states may not apply income eligibility standards, methodologies, or procedures that are more restrictive than those in effect upon enactment, including waivers, until the Secretary determines that a state Exchange is fully operational, or, in the case of children, until 10/1/2019. An exception is provided through 12/31/2013 with respect to state coverage of individuals who are nonpregnant nondisabled adults with incomes above 133% of FPL if on or after 12/31/2010 the state certifies to the Secretary that the state has or is projected to have a budget deficit. Application of modified adjusted gross income in accordance with sec. 2002 (see below) is not considered a change in standards, methodologies, or procedures. States may also move individuals from coverage under a waiver to coverage under a state plan amendment and may apply standards, methodologies, and procedures that are less restrictive than those in effect on enactment.

*State reports on Medicaid enrollment.* Beginning January 2015, states are to report annually on the number of enrollees disaggregated by population, outreach and enrollment processes and other data required by the Secretary to monitor enrollment and retention of eligible individuals. Secretary to report to Congress annually beginning in April 2015.

State option for coverage above 133% of FPL. Effective 1/1/2014, states have the option to cover individuals under age 65 who are not otherwise eligible and have incomes above 133% of FPL but not exceeding the highest income eligibility level under the state plan (or a waiver). States may phase-in such eligibility by group (including non pregnant childless adults) or income but may not cover higher income individuals before lower income individuals. An individual may not be enrolled if they are the parent of a child under age 19 who is eligible and uninsured but not enrolled.

**Sec. 2002. Income eligibility for nonelderly determined using modified adjusted gross income (as modified by sec. 1004 of HCERA).**

Effective 1/1/2014, states must use modified adjusted gross income (MAGI) for determining the eligibility of nonelderly individuals, and, for individuals in a family greater than one, household income is to be used. (The definitions of MAGI and household income are set forth in sec. 1401.)

In addition, states may not use income disregards, but in determining eligibility using MAGI, states are required to reduce the MAGI by the dollar amount that is 5% of the upper income limit that applies to the individual. No asset tests may be imposed.

The new requirements will not apply to 1) individuals over age 65, 2) the blind or disabled, 3) those made eligible for Medicaid through another program such as SSI or foster care or through Express Lane eligibility determinations, 4) low-income Medicare beneficiaries, and 5) the medically needy. The requirements will not apply for the purposes of determining eligibility for Medicare Part D subsidies or long-term care.

Beneficiaries determined eligible prior to 1/1/2014 will remain eligible until the later of the next redetermination date or 3/31/2014.

States are required to establish income eligibility thresholds using MAGI and household income that are not less than the effective income eligibility thresholds in place on the date of enactment. Thresholds are to be submitted to the Secretary for approval. For purposes of maintenance of income eligibility (sec. 2001), states are to work with the Secretary to ensure that individuals do not lose coverage during the transition to MAGI and household income. The Secretary is given authority to waive provisions of Medicaid and CHIP to ensure that states establish income and eligibility determination systems that protect beneficiaries. In approving thresholds, the Secretary to ensure that children do not lose Medicaid eligibility as the result of the new income thresholds.

The Secretary may not waive the requirements with respect to MAGI, asset tests and disregards except as necessary to coordinate with eligibility requirements of dual eligibles and individuals requiring institutional care.

The change does not affect or limit the application of the requirement that income be considered as of the point in time at which an application for enrollment is processed and the application of any rules regarding sources of countable income.

**Sec. 2003. Requirement to offer premium assistance for employer-sponsored insurance (as modified by sec. 10203).**

Amends §1906A, enacted under the Children's Health Insurance Program (CHIP) Reauthorization Act (CHIPRA), which establishes a state Medicaid option regarding premium assistance for employer-sponsored coverage. Effective 1/1/2014, the premium



assistance option is no longer restricted to children and the CHIPRA requirement related to cost-effective applies. The CHIP provision deeming qualified employer coverage as meeting the cost-effectiveness requirement is repealed. (Although the amendments in sec. 2003 require states to implement Medicaid premium assistance, sec. 10203(b), declares the requirement null and void which appears to maintain premium assistance as optional.)

**Sec. 2004. Medicaid coverage for former foster care children (as modified by sec. 10201).**

Effective 1/1/2014, requires states to provide Medicaid coverage to children under age 26 who were in foster care under state responsibility when they turned age 18 (or a higher age if the state has elected to extend foster care beyond age 18), were enrolled in Medicaid while in foster care, and do not fall into any other Medicaid eligibility category (other than the new category for individuals under 133% of FPL established in sec. 2001), or fall into another of these categories but have income that exceeds the applicable eligibility level. Individuals who qualify either under this former foster care provision or the new eligibility requirements will be treated as eligible under this provision. States may extend presumptive eligibility to this population. States may not require individuals covered under this provision to enroll in benchmark coverage or benchmark-equivalent coverage.

**Sec. 2005. Payments to territories (as modified by sec. 1204 of HCERA)**

Total amounts for Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands and American Samoa are increased by \$6.3 billion for the period from 7/1/2011 through 9/30/2019. Amounts are distributed in proportion to amounts applicable to the territories as of the date of enactment. Beginning 7/1/2011, increases the applicable FMAP for territories from 50% to 55%.

**Sec. 2006. Special adjustment to FMAP determination for certain states recovering from a major disaster.**

Effective 1/1/2011, provides additional federal matching funds for any state having experienced statewide a federally declared major disaster at any time in the preceding 7 years and for which there is a difference of at least 3 percentage points between the state's FMAP for a year and its FMAP for the previous year (including the ARRA hold harmless adjustment, if applicable). A state meeting these conditions would receive an adjustment of 50% of the difference between these two FMAPs. In subsequent years, the adjustment would be 25% of the difference between the FMAP and the previous year's FMAP including the disaster adjustment. Adjustment not to affect payments for DSH, CHIP or Title IV of the Social Security Act, except for Part E (foster care and adoption assistance).

**Sec. 2007. Medicaid Improvement Fund rescission.**

Rescinds any unobligated funds remaining in the Medicaid Improvement Fund.

**Subtitle B—Enhanced Support for the Children's Health Insurance Program**

**Sec. 2101. Additional federal financial participation for CHIP (as modified by sec. 10201 and 10203).**

Additional federal matching provided for FY 2016 through FY 2019, by increasing the enhanced matching rate for each state by 23 percentage points, capped at 100%. Increase in the enhanced match does not apply to certain expenditures, for example,

those for program administration, children in families with incomes in excess of 300% of FPL, or citizenship documentation.

States required to maintain CHIP income eligibility levels in place upon enactment through 9/30/2019. States may expand eligibility and may continue to operate enrollment caps to stay within federal allotments.

Beginning in FY 2016, states may enroll CHIP eligible children in a qualified health plan (QHP) certified by the Secretary as at least comparable to the state's CHIP program. States are to establish procedures so that children eligible for CHIP but denied enrollment due to an enrollment cap are screened for Medicaid eligibility and enrolled if found eligible. For children found ineligible for Medicaid, the state is required to provide for enrollment in a qualified health plan offered in the state Exchange that has been certified by the Secretary as at least comparable to CHIP. (These children will be deemed ineligible for CHIP for the purpose of determining eligibility for the premium tax credit and cost sharing reductions.) The Secretary is directed to review benefits and cost sharing of plans offered in the state Exchanges and certify by 4/1/2015 those plans that offer benefits for children and impose cost sharing that are at least comparable to the state CHIP program.

Bonus payments to states for increased CHIP enrollment are ended on 9/30/2013.

Requires use of modified adjusted gross income (MAGI) for eligibility determinations beginning 1/1/2014. (A similar requirement applies with respect to Medicaid under sec 2002.) Children made ineligible for Medicaid because of the elimination of income disregards are made eligible for CHIP, except when excluded due to institutionalization or as a child eligible for coverage under a state employee health benefits plan.

Appropriates additional funding for CHIP: \$17.406 billion for FY 2013 (same as total of amounts provided in prior law), \$19.147 billion for FY 2014, and 2 semi-annual allotments of \$2.85 billion each for FY 2015 along with a one-time appropriation for that year of \$15.361 billion, totaling \$21.061 billion. Provides for rebasing in FY 2013 and FY 2015 (following process established in prior law). Extends the child enrollment contingency fund and the authority to use certain funds for Medicaid expenditures through 2015.

Amends the existing exclusion from CHIP eligibility for children of state employees to provide that children are not excluded from CHIP eligibility if the state meets specified maintenance of effort requirements with respect to its employee health plan, or if the state determines on a case-by-case basis, that the annual aggregate premiums and cost sharing for the child's family in the state employee plan would exceed 5% of family income.

Requires state CHIP agencies to participate in the system for streamlined enrollment in an Exchange, Medicaid and CHIP. (See sec.1413 and sec. 2201.)

Extends CHIP outreach and enrollment grants through FY 2015 and changes the appropriation from \$100 million for FY 2009-13 to \$140 million for FY 2009-15.

**Sec. 2102. Technical corrections**

Makes various technical changes to provisions of CHIPRA, effective as if included upon enactment of CHIPRA. Also includes a technical change with respect to cost sharing for Indians as if included in the ARRA (PL 111-5).

**Subtitle C—Medicaid and CHIP Enrollment Simplification****Sec. 2201. Enrollment simplification and coordination with state health insurance Exchanges.**

Effective 1/1/2014, as a condition of Medicaid participation, states must establish procedures for enrollment simplification and coordination with state health insurance Exchanges and CHIP. To meet this requirement, states must establish a website for Medicaid applications, enrollment and renewals; enroll individuals identified by an Exchange as eligible for Medicaid or CHIP; ensure that individuals who apply for Medicaid or CHIP but found ineligible are screened for eligibility in the Exchange and for premium assistance, and are enrolled without further application and additionally given information regarding cost sharing subsidies and other assistance available through the Exchange. States must also ensure that state Medicaid and CHIP agencies and the Exchange use a secure electronic interface, and must coordinate to ensure that individuals who are enrolled in both an Exchange plan and Medicaid or CHIP are provided benefits, including EPSDT for children. States must also conduct outreach to vulnerable and underserved populations. The enrollment website to be linked to any Exchange website and allow individuals who are eligible for both Medicaid and premium assistance to compare benefits, premiums and cost sharing. State Medicaid and CHIP agencies must comply with the requirements of sec. 1413 which relate to streamlining of enrollment through an Exchange.

State Medicaid and CHIP agencies may enter into agreements with the Exchange under which the agency determines eligibility for premium assistance in the Exchange, under conditions and requirements established by the Treasury Secretary. Requirements for states to assess individuals for the purpose of providing home and community-based services under a state plan or waiver are not affected.

**Sec. 2202. Permitting hospitals to make presumptive eligibility determinations for all Medicaid eligible populations.**

Allows all hospitals participating in a state Medicaid plan to elect to be entities eligible to make presumptive eligibility determinations with respect to whether any individual is eligible for Medicaid, subject to guidance from the Secretary. The requirements that currently apply to presumptive eligibility for specific populations would apply to this provision, even if the state has not elected to provide presumptive eligibility for these populations. As is the case with current presumptive eligibility options, payments made under this provision would not count in calculating a state's payment error rate. Effective 1/1/2014.

**Subtitle D—Improvements to Medicaid Services****Sec. 2301. Coverage for freestanding birth center services.**

Requires states to cover freestanding birth center services and other covered services provided by a freestanding birth center that is licensed or otherwise approved by the state to provide prenatal care and delivery or postpartum care and other covered ambulatory services and that complies with other state health and safety requirements.

States to provide separate payments to providers such as nurse midwives and birth attendants recognized under state law as determined appropriate by the Secretary. Effective upon enactment, with additional time given to states requiring legislation to comply.

**Sec. 2302. Concurrent care for children.**

Election of hospice benefits for a child under Medicaid or CHIP does not constitute a waiver of rights to other Medicaid-covered treatment services. Effective 3/23/2010.

**Sec. 2303. State eligibility option for family planning services.**

Offers states the option of providing eligibility only for family planning services and supplies to individuals who are not pregnant with family incomes up to the state's income limit for pregnant women. States may include individuals previously covered for these services under a waiver. Scope of services includes medical diagnosis and treatment services provided pursuant to family planning services in a family planning setting. States may provide presumptive eligibility for this coverage for a limited period (roughly no more than 60 days) for individuals who do not file an application. Prohibits states from enrolling individuals of childbearing age desiring family planning services in benchmark or benchmark equivalent plans that do not include family planning services. Effective 3/23/2010.

**Sec. 2304. Clarification of definition of medical assistance.**

Clarifies that Medicaid coverage may include provision of care or services as well as payment for care or services. Effective 3/23/2010.

**Subtitle E—New Options for States to Provide Long-Term Services and Supports**

**Sec. 2401. Community First Choice Option (as modified by sec. 1205 of HCERA).**

Beginning 10/1/2011, provides new state option, with a federal match of FMAP+ 6 percentage points, to provide home and community based attendant services for Medicaid eligible individuals who would require the level of care provided in a hospital, nursing facility, intermediate care facility for people with mental retardation (ICF/MR) or institution for mental disease, and who have incomes below 150% of FPL, or if greater, the level that would qualify for Medicaid institutional coverage. Individuals must elect to receive home and community-based attendant services and states must meet additional requirements. States must make services available to assist in accomplishing activities of daily living, instrumental activities of daily living, and health-related tasks under a person-centered plan of care, in a home or community setting, and under an agency-provider model or other delivery model selected and managed by the individual or individual's representative, and provided by a qualified individual, as defined by the Secretary.

Services and supports to include back up systems or mechanisms to ensure continuity of services and supports and voluntary training on how to select, manage and dismiss attendants. Specified excluded services are room and board costs, special education and related services, assistive technology devices (other than back-up systems such as beepers and electronic devices), medical supplies and equipment and home modifications. States may also include expenditures for costs of transition from institutional to home and community based setting, and for services to reduce the need for human assistance.

A state plan amendment must meet specified requirements regarding collaboration with a development and implementation council, provision of services statewide and in the most integrated setting appropriate for the individual, maintenance of state expenditures for the elderly and disabled, establishment of a quality assurance program, and information collection and reporting.

Program must also comply with specified federal and state labor laws.  
Secretary to conduct evaluation of the effectiveness of this option; states must provide data. Interim evaluation report to Congress due 12/31/2013; final due 12/31/2015.

**Sec. 2402. Removal of barriers to providing home and community-based services.**

Requires the Secretary to issue regulations to ensure that states develop service systems designed to allocate resources for services in a manner responsive to needs and choices of beneficiaries receiving non-institutional long-term care services and supports; to provide support and coordination for these beneficiaries; and to improve coordination among and regulation of all providers of home and community based services in order to consistently administer policies across programs and oversee services to ensure coordination of eligibility, development of systems for complaints, quality monitoring, and an adequate number of qualified direct care workers.

Modifies state options for providing home and community based services (HCBS) under §1915 to include a new option to include individuals with incomes below 300% of the SSI eligibility level who qualify under a home and community based waiver. For this population, states may elect to offer, for a 5-year period, targeted HCBS which vary in amount, duration and scope to specific targeted populations; and to offer full Medicaid benefits to individuals eligible for HCBS. Eliminates state options to limit the number of eligible individuals, to time-limit eligibility, and to waive statewideness, but allows waiver of comparability of benefits. Effective beginning on first day of first fiscal year quarter after enactment, or 4/1/2010.

**Sec. 2403. Money Follows the Person Rebalancing Demonstration.**

Extends the Money Follows the Person Rebalancing Demonstration established under the Deficit Reduction Act through 9/30/2016, and changes the institutional residency requirement for demonstration eligibility to a period of not less than 90 days with no maximum, excluding short-term rehabilitative services. Date of final report changed to 9/30/2016 (from 9/30/2011). Effective 30 days after enactment, or 4/22/2010.

**Sec. 2404. Protection for recipients of home and community-based services against spousal impoverishment.**

For the 5-year period beginning 1/1/2014, applies existing spousal impoverishment protection to individuals receiving home and community based services, including medically needy individuals.

**Sec. 2405. Funding to expand State Aging and Disability Resource Centers.**

Appropriates \$10 million annually for 5 years beginning in FY 2010 for continued funding of Aging and Disability Resource Centers.

**Sec. 2406. Sense of the Senate regarding long-term care.**

Expresses sense of the Senate that the Congress should address the need for long-term care services in a comprehensive way that guarantees elderly and disabled individuals the services they need, including community based services.

**Subtitle F—Medicaid Prescription Drug Coverage**

**Sec. 2501. Prescription drug rebates (as modified by sec. 1206 of HCERA).**

Increases the minimum rebate percentage for most single source drugs from 15.1% to 23.1%, and for clotting factors and drugs approved exclusively for pediatric conditions from 15.1% to 17.1%. Increases the rebate percentage for generic drugs from 11% to 13%. All increases effective 1/1/2010. Payments to states are reduced by the total amount of the rebate increases. (That is, all savings from the percentage increases flow to the federal government.)

Effective on enactment (3/23/2010), the rebate for a new drug that is a line extension of an existing brand name drug or innovator multiple source drug that is an oral solid dosage form is equal to the amount computed for the new drug, or if higher, the product of 1) the average manufacturer price (AMP) for the line extension that is an oral solid dosage form, 2) the highest additional rebate (calculated as a percentage of AMP) for any strength of the original drug, and 3) the total number of units of each dosage form and strength of the line extension paid for by the state Medicaid plan in the rebate period, as reported by the state. (Line extension defined as a new formulation such as an extended release formulation.)

Establishes that a maximum rebate for a single source drug or innovator multiple source drug is 100% of AMP, effective 1/1/2010.

Extends prescription drug rebates to covered outpatient drugs dispensed to Medicaid beneficiaries by Medicaid managed care organizations MCOs, except for those subject to discounts under section 340B. States to collect the rebates from manufacturers, and capitation rates to plans to be based on actual cost experience related to rebates and subject to federal regulations requiring actuarially sound rates. MCOs are required to report to the state information on covered drugs dispensed to Medicaid beneficiaries and other data required by the Secretary.

**Sec. 2502. Elimination of exclusion of coverage of certain drugs.**

Removes smoking cessation agents, barbiturates, and benzodiazepines from Medicaid's excludable drug list for prescription drug coverage effective 1/1/2014. Smoking cessation agents include those approved by the FDA under the over-the-counter monograph process when used to promote tobacco cessation.

**Sec. 2503. Providing adequate pharmacy reimbursement.**

Changes the generic drug upper payment limit to 175% of the weighted average, based on utilization, of the most recent average manufacturer prices (AMP) for pharmaceutically and therapeutically equivalent multiple source drugs available nationally for purchase by retail community pharmacies. Directs the Secretary to implement a smoothing process for determining AMP similar to the process used in determining Average Sales Price for drugs and biologicals under Medicare.

Defines AMP to mean average prices paid by wholesalers of drugs distributed to retail community pharmacies and by retail community pharmacies that purchase drugs directly from the manufacturer. AMP excludes not only customary prompt pay discounts extended to wholesalers (as in prior law) but also 1) bona fide service fees paid by manufacturers to wholesalers or retail community pharmacies, including distribution service fees, inventory management fees, product stocking allowances, and fees associated with administrative services agreements and patient care programs such as medication compliance and patient education, 2) reimbursement by manufacturers for recalled, damaged, expired or otherwise unsalable returned goods, and 3) payments received from, or rebates or discounts provided to, pharmacy benefit managers, managed care organizations, insurers, hospitals, clinics, mail order pharmacies, long term care providers or other entities not doing business as wholesalers and retail community pharmacies.

Clarifies that retail community pharmacies do not include mail order, long-term care pharmacies, hospitals, clinics, pharmacy benefit managers, charitable or other nonprofit or government pharmacies.

Expands the disclosure requirement to include disclosure within 30 days after the end of each month, the total number of units used to calculate the monthly AMPs for each covered outpatient drug.

Modifies the definition of multiple source drug to require that it be sold or marketed in the United States rather than the specific state. Clarifies survey of retail prices is specific to retail community pharmacies.

Imposes a duty of confidentiality on CMS with respect to weighted monthly average of AMP and average retail survey price data reported.

Effective 10/1/2010, without regard to whether final regulations have been promulgated.

### **Subtitle G—Medicaid Disproportionate Share Hospital (DSH) Payments**

#### **Sec. 2551. Disproportionate share hospital payments (as modified by sec. 10201 and sec. 1203 of HCERA).**

Specifies aggregate reductions in DSH allotments to states for FY 2014 through FY 2020; Secretary to apply a DSH health reform methodology to reduce allotments to individual states, applied equally by calendar quarter. The amount of the reduction is to be treated as an overpayment to be disallowed against a state's regular spending draw, and not subject to reconsideration processes.

Aggregate reductions total \$500 million for FY 2014, \$600 million each for FY 2015 and FY 2016, \$1.8 billion for FY 2017, \$5 billion for FY 2018, \$5.6 billion for FY 2019, and \$4 billion for FY 2020.

A DSH health reform methodology is to be developed by the Secretary so that the largest percentage reductions are imposed on states that have the lowest percentages of uninsured individuals in the most recent year or that do not target DSH payments to hospitals with high volumes of Medicaid and uncompensated care. A smaller percentage reduction is to be imposed on states identified under prior law as "low-DSH states." The methodology is also to take into account the extent to which the DSH allotment for a

state was taken into account in the budget neutrality calculation with respect to a coverage expansion approved under a section 1115 waiver as of July 31, 2009. A state with a DSH allotment of \$0 for the 2<sup>nd</sup>, 3<sup>rd</sup> and 4th quarters of FY 2012 will receive an allotment of \$47.2 million. For FY 2013, such states will receive \$53.1 million. Makes special provisions with respect to DSH payments for Hawaii.

## **Subtitle H—Improved Coordination for Dual Eligible Beneficiaries**

### **Sec. 2601. 5-year period for demonstration projects.**

Provides that waivers under sections 1915 or 1115 of the Social Security Act that provide Medicaid to dual eligibles (including waivers that involve other individuals as well as dual eligibles) may be conducted for 5 years, and a state may request a 5-year extension unless the Secretary determines that conditions of the waiver were not met or that it would no longer be cost effective or efficient to extend the waiver.

### **Sec. 2602. Providing federal coverage and payment coordination for dual eligible beneficiaries.**

Not later than 3/1/2010, mandates establishment within CMS of a federal Coordinated Health Care Office to more effectively integrate Medicare and Medicaid benefits and improve coordination between the federal Government and states. Director to be appointed by, and report to, the CMS Administrator. Specifies goals of the Office and identifies responsibilities as 1) providing states, Medicare Advantage (MA) special needs plans (SNPs), physicians and other relevant parties with education and tools for developing programs that align Medicare and Medicaid benefits for dual eligibles, 2) supporting state efforts to coordinate and align acute and long-term care services for dual eligibles with other Medicare benefits, 3) supporting coordination of contracting and oversight by the states and CMS to support goals of the Office, 4) consulting and coordinating with MedPAC and MACPAC, and 5) studying the provision of drug coverage for new full-benefit dual eligibles; and monitoring and reporting total expenditures, health outcomes and access to benefits for all dual eligibles.

Requires submission of annual reports under the annual budget transmittal to Congress containing recommendations for legislation that would improve care coordination and benefits for dual eligible individuals.

## **Subtitle I—Improving the Quality of Medicaid for Patients and Providers**

### **Sec. 2701. Adult health quality measures.**

Directs the Secretary to recommend and publish a core set of health care quality measures for Medicaid-eligible adults (similar to the quality provisions for children enacted under CHIPRA). Recommendations to be published for comment by 1/1/2011 and published by 1/1/2012. By 1/1/2013, the Secretary, in consultation with the states, to issue a standardized format for reporting the core set of adult quality measures. Beginning 1/1/2014, and every 3 years thereafter, Secretary to report to Congress on adult measures along with children's measures.

Within 12 months after publication of the initial core set of adult quality measures, a Medicaid Quality Measurement Program is established, parallel to that for children's measures, and the same amount to be spent for each program in grants and contracts for the development and testing of new measures. Within 24 months after the program is established and annually thereafter, the Secretary is to publish recommended changes to core quality measures.



States to report annually on quality measures; Secretary to report by 9/30/2014 and annually thereafter on state findings. Appropriates \$60 million annually for fiscal years 2010-2014.

**Sec. 2702. Payment Adjustment for Health Care-Acquired Conditions.**

Requires the Secretary to identify current state practices that prohibit payment for healthcare acquired conditions (HACs), determine appropriate practices, and apply them to the Medicaid program through regulations to be effective 7/1/2011. The regulations are to prohibit federal payment for HACs and ensure that the prohibition will not result in loss of access to care for Medicaid beneficiaries. Secretary to apply the Medicare HAC regulations as appropriate to the Medicaid program, and may exclude certain HACs that are applied to Medicare if inapplicable to Medicaid.

**Sec. 2703. State option to provide health homes for enrollees with chronic conditions.**

Beginning 1/1/2011, creates a new state plan option under which Medicaid enrollees with chronic conditions could designate a health home. Permits waiver of statewideness and comparability and any other provision as determined by the Secretary. 90% FMAP to apply to payments to health homes for the first 8 quarters the state option is in effect. State plan amendment to include method of payment, which may be tiered, and will not be limited to payment per member per month and may provide for alternative methods of payment as proposed by the state and approved by the Secretary. State plan amendments to propose a method for monitoring preventable hospital readmissions and a plan for use of health information technology in providing services under this provision. States also to require that Medicaid participating hospitals refer emergency room patients with chronic conditions to designated providers.

Health home providers must agree to report on quality measures as specified by the Secretary.

States must consult and coordinate with the Substance Abuse and Mental Health Services Administration as appropriate in addressing issues regarding prevention and treatment of mental health and substance abuse for individuals with chronic conditions.

Beginning 1/1/2011, planning grants are available to states, with state matching required; total to be spent on grants is limited to \$25 million.

Eligible individuals are those with 2 chronic conditions; 1 chronic condition and are at risk for a second; or 1 serious and persistent mental health condition. Conditions to include mental health, substance abuse, asthma, diabetes, heart disease, and overweight (BMI>25), and others determined by the Secretary.

The Secretary is to establish standards for qualifying health homes, which may include individual designated providers, providers operating in coordination with a team of professionals, and health teams. Team of professionals could be freestanding, virtual, or based at a hospital, community health center, clinic, physician's office or group practice, academic health center or other entity.

Services to include comprehensive care management, care coordination and health promotion, transitional care from inpatient to other settings, patient and family support, referral to community and social support services and use of health IT where feasible. Requires independent evaluation with report to Congress by 1/1/2017. Interim report due 1/1/2014.

**Sec. 2704. Demonstration project to evaluate integrated care around a hospitalization.**

Establishes a bundled payment demonstration project under Medicaid in up to 8 states. Bundled payment to apply to an episode of care which includes a hospital stay, and concurrent physician services provided during hospitalization. Demonstration to run from 1/1/2012 through 12/31/2016. States may target certain beneficiaries or geographic areas of state, but Secretary to ensure the project as a whole is representative and focuses on conditions offering opportunity to improve quality and reduce expenditures. Participating hospitals must have robust discharge planning programs to ensure beneficiaries are appropriately placed in post-acute care. Payments under the project to be adjusted for severity of illness and other beneficiary characteristics. No additional beneficiary cost sharing to be required. Secretary is given authority to waive any provision of Title XI, Medicare and Medicaid. Evaluation and report is due within 1 year of conclusion of demonstration.

**Sec. 2705. Medicaid Global Payment System Demonstration Project.**

Requires the Secretary, in coordination with the new Center for Medicare and Medicaid Innovation (established in sec. 3021), to conduct the Medicaid Global Payment System Demonstration Project for fiscal years 2010-2012, under which up to 5 states would pay participating large safety net hospital systems or networks under a global capitated payment model. Budget neutrality is not required. The Innovation Center is to test and evaluate the project with respect to health outcomes and spending, and the Secretary may modify or terminate a project during the testing. The Secretary to evaluate and report within one year after the demonstration ends. Authorizes such sums as necessary.

**Sec. 2706. Pediatric Accountable Care Organization Demonstration Project.**

Requires the Secretary to establish a 5-year Pediatric Care Accountable Care Organization (ACO) Demonstration Project, consistent with the Medicare Shared Savings program established in sec. 3022. Project to begin 1/1/2012 and end on 12/31/2016. States will apply to the Secretary to participate. The Secretary, in conjunction with participating states and pediatric providers, is to establish performance guidelines for quality. Participating states, in conjunction with the Secretary, are to establish annual minimum program savings that must be achieved by an ACO in order to receive an incentive payment. The Secretary may establish an annual cap on incentive payments for an ACO. ACOs must agree to participate for at least 3 years. Authorizes such sums as necessary.

**Sec. 2707. Medicaid emergency psychiatric demonstration project.**

Requires the Secretary to establish a 3-year demonstration under which states would apply to pay institutions of mental disease for stabilizing adult Medicaid beneficiaries with an emergency medical condition, defined as when an individual expresses suicidal or homicidal thoughts or gestures and is determined dangerous to self or others. States must specify a mechanism for how participating institutions will determine whether a patient is stabilized, which must commence within 3 days of admission. States

may employ utilization review or other management practices. Waives limitations on payment for institutions for mental disease and allows waiver of statewideness and comparability to the extent necessary. Appropriates \$75 million in fiscal year 2011, to be available through 12/31/2015. Evaluation and report due by 12/31/2013 including a recommendation regarding continuation and expansion nationally.

#### **Subtitle J—Improvements to the Medicaid and CHIP Payment and Access Commission (MACPAC)**

##### **Sec. 2801. MACPAC assessment of policies affecting all Medicaid beneficiaries.**

Appropriates \$11 million in funds for MACPAC in FY 2010, with \$2 million to come from CHIP. Funds available until expended.

Expands MACPAC mission to include review of policies affecting access to services, not just children's access, and provides that recommendations and reports are for the Secretary and the states as well as the Congress. Changes annual reporting dates to March 15 and June 15.

References to MACPAC review of payment policies are broadened to include payments to managed care entities, nonphysician health professionals, and specified service providers, and to include review of how payment factors and methods enable beneficiaries to obtain services, affect provider supply and affect providers serving a disproportionate share of low-income and other vulnerable populations. Also to review access to preventive, acute and long-term care services.

Requires additional topics for MACPAC study: eligibility policies, enrollment and retention processes, coverage policies, quality of care, and Medicare/Medicaid interactions. Also requires review of national and state-specific Medicaid and CHIP data and requires reports based on such reviews. The existing "early warning system" is to identify not only provider shortage areas but other factors that adversely (or may adversely affect) access to care or the health status of Medicaid and CHIP beneficiaries; findings are to be included in their annual June report. MACPAC to review and comment on Medicaid and CHIP regulations in reports to the Secretary and Congress. Reports to include federal and state budget consequences of MACPAC recommendations.

Requires consultation, coordination and information sharing with MedPAC, particularly with respect to dual eligibles and adult Medicaid beneficiaries. Also requires regular consultation with states, and the federal coordinated health care office created elsewhere in the bill. (Conforming changes to MedPAC included.)

Amends qualifications of commissioners; changes include addition of dentists, and experts in health facilities management. Authorizes MACPAC to secure information from states as necessary, as a condition of states receiving federal Medicaid and CHIP funds.

#### **Subtitle K—Protections for American Indians and Alaska Natives**

##### **Sec. 2901. Special rules relating to Indians.**

Medicaid to be primary payer to Indian tribes, tribal organizations and urban Indian organizations. Indian tribes, tribal organizations and urban Indian organizations are added to the definition of an Express Lane Agency for the purposes of Medicaid and CHIP eligibility determinations.

**Sec. 2902. Elimination of sunset for reimbursement for all Medicare Part B services furnished by certain Indian hospitals and clinics.**

Eliminates the sunset provision on Medicare Part B reimbursement for services furnished by certain Indian hospitals and clinics.

**Sec. 10201(i) Amendments to Section 1115 Waivers.**

Requires the Secretary to promulgate regulations no later than 9/19/2010, relating to section 1115 demonstration projects that provide for: 1) public notice and comment at the state level sufficient to ensure meaningful public input, including public hearings; 2) requirements relating to goals, state and federal costs, and state plans for compliance with Medicaid and CHIP requirements; 3) a federal public notice and comment process on state applications; 4) periodic reports on implementation from the states to the Secretary; and 5) periodic evaluation by the Secretary. Secretary to annually report to Congress on actions with respect to state applications for section 1115 demonstration projects.

**Sec. 10202. Incentives for States to Offer Home and Community-Based Services as a Long-Term Care Alternative.**

Establishes a “balancing incentives payment program” for fiscal years 2012 through 2015 with respect to home and community based alternatives to nursing home care. Provides additional FMAP to participating states; caps total payments for this purpose for the entire period at \$3 billion.

A state may apply for participation if less than half of its total long-term care Medicaid expenditures are for non-institutionally based services. Application must include a proposed budget to expand and diversify specified non-institutionally based long-term services and supports, including structural changes, optional presumptive eligibility, case management and the use of core standardized assessment instruments. If a state chooses to expand home and community based services through the option under section 1915(i), the application is also to include an election to increase eligibility for these services from 150% of FPL to a higher level, up to 300% of the SSI eligibility level.

Applying states must indicate how they will achieve a target spending percentage by 10/1/2015, representing how much of the state’s total long-term care Medicaid expenditures are for home and community based services. For states starting at less than 25%, the target percentage is to achieve 25%. For other states, the target is 50%.

Increased FMAP for participating states for non-institutionally-based long-term care services and supports is 5 percentage points for states starting at less than 25% of Medicaid long-term care expenditures for non-institutionally based services and supports and 2 percentage points for other states.

Participating states must maintain eligibility standards, procedures and methodologies for non-institutionally based long-term-care services in effect on 12/31/2010. States must also make specified structural changes within 6 months of application for development of “no wrong door—single entry system” for accessing long-term care services, conflict-free case management service, and core standardized assessment instruments. States must also collect specified data on services, quality and outcomes measures.

**NOTE:** Other provisions in PPACA directly involving Medicaid but described elsewhere in this summary involve preventive benefits (4106-4108) and fraud and abuse (6501-6508, among other provisions of Title VI).

**Sec. 1202 of HCERA. Payments to Primary Care Physicians.**

Requires states to pay physicians for primary care services furnished in 2013 and 2014 at a rate that is no less than 100% of the Medicare payment rate. (If greater, the Medicare payment rate in effect in 2009 is to be used.) Limited to physicians with a primary specialty designation of family medicine, general internal medicine or pediatric medicine. Primary care services include those in the Evaluation and Management category under the Healthcare Common Procedure Coding System (HCPCS) used by Medicare, and services related to immunization administration for vaccines and toxoids (CPT codes 90465, 90466, 90467, 90471, 90472, 90473, or 90474). Medicaid managed care plans must make payments to physicians consistent with these minimum payment rates, regardless of the manner in which payments are made by the plans, including capitation payments.

For services furnished from 1/1/2013 through 12/31/2014, provides for 100% federal funding for the difference between the payment rates required under this provision and the level of payment in effect on July 1, 2009. Regular federal matching applies for any payment amounts above the minimum requirement.

**Subtitle L—Maternal and Child Health Services**

**Sec. 2951. Maternal, infant, and early childhood home visiting programs.**

Requires states, as a condition of receiving maternal and child health block grant funds, to conduct a needs assessment to identify communities that are at risk for poor maternal and child health and have few quality home visitation programs, and to submit a report describing how the state intends to address the identified needs.

Mandates the Secretary to implement a new state grant program for early childhood home visitation. Indian Tribes, Tribal Organizations and Urban Indian Organizations are also eligible for such grants. Nonprofit organizations may also be eligible where a state has not applied or been approved for such a grant. Grant recipients must establish 3- and 5-year benchmarks for demonstrating program effectiveness, use 1 or more specified service delivery models, and give priority to specified high-risk populations. Appropriates \$1.5 billion between FY 2010 and FY2014 for the home visitation program.

**Sec. 2952. Support, education, and research for postpartum depression.**

Encourages the Secretary to expand and intensify research and related activities on postpartum depression or postpartum psychosis (postpartum conditions). Expresses the Sense of the Congress that the National Institute of Mental Health may conduct a nationally representative longitudinal study during FY2011 through 2019 of the relative mental health consequences for women of resolving a pregnancy (intended or unintended) in various ways, with the first report on study findings to be submitted to Congress not later than 5 years after enactment. Authorizes \$3 million for FY 2010 and such sums for FYs 2011 and 2012 for a grant program for projects for the establishment, operation, and coordination of effective and cost-efficient systems for the delivery of essential services to individuals with, or at risk for, postpartum conditions and to their families. Services include education, inpatient care management, case management,

and support services, such as respite care and counseling. Eligible entities are public or nonprivate entities, including public or nonprofit private hospitals.

**Sec. 2953. Personal responsibility education (as modified by Sec. 10201).**

Appropriates \$75 million for each of FYs 2010 through 2014 for allotments to states for personal responsibility education programs aimed at reducing pregnancy and birth rates for youth populations (individuals ages 10-20). In each of FYs 2012-2014, authorizes 3-year grants to local organizations, including faith-based organizations or consortia, for such programs in states that elect not to submit an application for such allotments for FY 2010 or 2011. Programs must be evidence-based, medically accurate and complete, emphasize both abstinence and contraception for the prevention of pregnancy and sexually transmitted infections, and address at least 3 adulthood preparation subjects (such as healthy relationships, including marriage and family interactions, financial literacy, and parent-child communication). Reserves \$10 million each FY for grants to entities to implement innovative strategies, and 5 percent of the remaining appropriations for Indian tribes or tribal organizations.

**Sec. 2954. Restoration of funding for abstinence education.**

Restores funding for the abstinence education grant program by appropriating \$50 million for each of FYs 2010 through 2014.

**Sec. 2955. Inclusion of information about the importance of having a health care power of attorney in transition planning for children aging out of foster care and independent living programs.**

Effective 10/1/2010, requires the following: (1) that the mandatory transition plan for a youth about to age out of foster care include information about the importance of designating another individual to make health treatment decisions on behalf of the youth and provide the youth with the option to execute a health care power of attorney or similar document; (2) that states applying for Chafee Foster Care Independence Program funds certify that foster care or former foster care adolescents receiving independent living services will receive such information and have such option; and (3) that the health care oversight plan developed collaboratively between the state child welfare agency and the state Medicaid agency address health insurance options and information about a health care power of attorney or similar document, and provide the option to execute such a power of attorney or similar document.

**Sec. 10211. Definitions for pregnancy assistance fund.**

Defines terms relevant to a new Pregnancy Assistance Fund and its permissible uses. For example, defines intervention services, with respect to domestic violence, sexual violence, sexual assault, or stalking, as 24-hour telephone hotline services for police protection and referral to shelters. Defines accompaniment as assisting, representing, and accompanying a woman seeking judicial relief for child support, child custody, restraining orders, and restitution for harm to persons and property, and in filing criminal charges, including the payment of court costs and reasonable attorney and witness fees. And defines supportive social services as transitional and permanent housing, vocational counseling, and individual and group counseling aimed at preventing domestic violence, sexual violence, sexual assault, or stalking.

**Sec. 10212. Establishment of pregnancy assistance fund.**

Directs the Secretary to establish a Pregnancy Assistance Fund for the purpose of awarding competitive grants to states to assist pregnant and parenting teens and women.

**Sec. 10213. Permissible uses of Fund.**

Specifies the permissible uses of grants made from the Pregnancy Assistance Fund to include the following: (1) to make funding available to institutions of higher education to establish, maintain, or operate pregnant and parenting student services (with a 25 percent matching requirement); (2) to make funding available to high schools and community service centers to establish, maintain, or operate such services (with no matching requirement); (3) to assist Statewide offices in providing intervention services, accompaniment, and supportive social services for eligible pregnant women who are victims of domestic violence, sexual violence, sexual assault, or stalking, and technical assistance and training relating to violence against such women to government agencies and courts, professionals working in legal, social service, and health care settings, and others; and (4) to increase public awareness and education concerning services available to pregnant and parenting teens and women. Pregnant and parenting student services include conducting a needs assessment, assesses an institution's or school's performance in meeting various needs (e.g., child care, flexible or alternative academic scheduling, and baby food, clothing or furniture), identifying other resources to meet such needs and assisting pregnant and parenting students, fathers or spouses in locating and obtaining services that meet such needs, and providing referrals for prenatal care and delivery, infant or foster care, or adoption to a student who requests such information. Institutions of higher education and high schools receiving funds must submit an annual report to their respective state, for which the state must specify performance criteria not later than 180 days before the report's due date. Each state must, in turn, submit an annual report to the Secretary regarding the activities supported by grants from the Pregnancy Assistance Fund, the number of students served, and the results of the services provided.

**Sec. 10214. Appropriations.**

Appropriates \$25 million for each of FYs 2010-2019 for the Pregnancy Assistance Fund.

**Sec. 10221. Indian health care improvement.**

Enacts the Indian Health Care Improvement Reauthorization and Extension Act of 2009, S. 1790, as reported by the Senate Committee on Indian Affairs on 12/16/2009, after making several amendments (including deletions) to the reported bill and explicitly applying to the Indian Health Service any limitations on providing abortions in any federal law, not just those found in the HHS appropriations bills.

### **TITLE III—IMPROVING THE QUALITY AND EFFICIENCY OF HEALTH CARE**

#### **Subtitle A—Transforming the Health Care Delivery System**

#### **PART I—LINKING PAYMENT TO QUALITY OUTCOMES UNDER THE MEDICARE PROGRAM**

##### **Sec. 3001. Hospital Value-Based purchasing program (as modified by sec. 10335).**

Directs the Secretary to establish a value-based purchasing (VBP) program under the Medicare hospital inpatient prospective payment system. Quality performance standards are applicable in FY 2012 to affect payments beginning in FY 2013. Initial measures will be selected from those that hospitals currently must report to receive a full annual market basket update and will cover at least these areas: acute myocardial infarction (AMI), heart failure, pneumonia, surgical care, health-care associated infections, and patient perception of care (as measured by Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)). Selected measures may not include measures of readmissions, which are subject to a separate policy. Beginning with payments for FY 2013, outcome measures must be appropriately risk-adjusted. Beginning with payments for FY 2013, each measure specified by the Secretary must be endorsed by the entity with a contract under section 1890(a), most likely the National Quality Forum, unless the Secretary makes an exception and uses a measure not so endorsed after due consideration of measures endorsed or adopted by a consensus organization identified by the Secretary. Measures selected by the Secretary must be reported by hospitals and included in the Hospital Compare Internet website for at least one year prior to the beginning of a performance period in the VBP program. Beginning in FY 2014, the Secretary must add efficiency measures including measures of Medicare spending per beneficiary, adjusted for factors such as age, sex, race and severity of illness, and other factors.

VBP payments are funded by reductions in payments made with respect to all MS-DRGs: 1% in FY 2013, 1.25% in FY 2014, 1.5% in FY 2015, 1.75% in FY 2016, and 2.0% in FY 2017 and succeeding years. Reductions do not apply to payments for IME, DSH, outliers, and low-volume add-on payments. Secretary must ensure that all reductions in a given year are returned to hospitals in VBP payments in the same year. Hospitals that meet or exceed minimum performance standards set by the Secretary will receive VBP incentive payments based on attainment or improvement, whichever score is higher. Performance is assessed and publicly reported for each measure and condition and for total hospital performance, but VBP payments are based only on the total performance score. Secretary has discretion on how to weight categories of measures/conditions when determining a hospital's total score. Performance standards are set by the Secretary taking into account past hospital experience with the measures, historical performance standards, improvement rates; and opportunity for continued improvement and must be announced at least 60 days before the start of the performance period. Information on aggregate payment reductions and incentive payments under the VBP program and the number of hospitals affected will be publicly reported.

These hospitals are excluded from the VBP program (but are still subject to reporting requirements in order to receive a full market basket update): hospitals subject to the penalty for failure to report quality measures successfully; hospitals cited by the



Secretary for health and safety deficiencies posing immediate jeopardy; and hospitals with an insufficient number of measures or cases applicable to the hospital for the performance period.

Prohibits judicial review of VBP program policies and methodologies established by the Secretary, including measure selection and performance standards, but a hospital can appeal its performance assessment or performance score to the Secretary. Methodologies for assigning scores and calculating VBP payments must be transparent and established through public rulemaking. The Secretary must work with hospitals, patients, researchers, policymakers and other stakeholders to improve the information available on the Hospital Compare website and to make it more user-friendly.

The Government Accountability Office (GAO) will evaluate the VBP program and submit an interim report to Congress by 10/1/2015 and a final report by 7/1/2017. The Secretary must submit a report by 1/1/2016, including analysis of whether the VBP program resulted in lower Medicare spending or other financial savings to hospitals and recommendations on the appropriateness of the Medicare program sharing any of the savings with hospitals.

Not later than March 23, 2012, the Secretary must establish two 3-year demonstration programs, one to test VBP models for critical access hospitals (CAHs) and the other for hospitals excluded from the VBP program due to an insufficient number of measures and cases. Separate reports and recommendations on each demonstration are due to Congress 18 months after their completion. The projects must be budget neutral.

**Sec. 3002. Improvements to the physician quality reporting incentive (PQRI) system (as modified by sec. 10327).**

Extends PQRI incentive payments through 2014 and establishes a mandatory physician quality reporting program beginning in 2015. Eligible professionals who successfully report quality data for the quality reporting period designated by the Secretary for the applicable year will receive a 1.0% bonus in 2011 and a 0.5% bonus in 2012, 2013 and 2014. Eligible professionals who do not successfully report quality data during the designated quality reporting period will have their Medicare payments reduced by 1.5% in 2015 and by 2.0% in 2016 and each subsequent year. The payment incentives and reductions are based on the Medicare fee schedule amounts (determined after applicable adjustments) for all covered services furnished by the eligible professional. The penalty applies to the applicable year and is not cumulative. Eligible professionals include physicians, practitioners (described in 1842(b)(18)(C)), physical and occupational therapists, qualified speech-language pathologists and qualified audiologists.

Establishes an additional registry option beginning in 2011 for eligible professionals to provide data on quality measures. The provision allows reporting through a Maintenance of Certification program operated by a specialty body of the American Board of Medical Specialties that meets the Secretary's criteria for reporting through a registry.

Increases the otherwise applicable PQRI incentive payment by 0.5 percentage point for years 2011 to 2014 for eligible professionals: i) for whom required quality data is submitted for a year on their behalf by a qualified American Board of Medical Specialties Maintenance of Certification (MOC) or equivalent program (as determined by the Secretary) that meets the criteria for a registry; and ii) who – more frequently than is

required for board certification – participate in an MOC and complete a qualified MOC practice assessment. Other requirements also apply. For years after 2014, authorizes Secretary to incorporate participation in an MOC program and successful completion of a qualified MOC program practice assessment into the composite of measures of quality of care for purpose of the physician fee schedule value-based payment modifier [described in sec. 3007 below].

Requires the Secretary to provide timely feedback to eligible professionals concerning whether they are reporting data properly and the likelihood (based on an interim assessment) that they will receive an incentive payment. By 1/1/2011, requires an informal appeals process for eligible professionals to request a review of a determination that they did not satisfactorily submit data on the quality measures.

By 1/1/2012, requires the Secretary to develop a plan to integrate clinical reporting on quality measures with reporting requirements relating to the meaningful use of electronic health records.

**Sec. 3003. Improvements to the physician feedback program.**

Amends the physician feedback program to require utilization reports based on an episode grouper that combines separate but clinically-related services into an episode of care for which the physician (or group of physicians) is accountable. Secretary must develop the episode-grouper by 1/1/2012; make the methodology available to the public; and seek endorsement by the entity with a contract with the Secretary under section 1890(a) [e.g. the National Quality Forum]. The Secretary will establish methodologies to attribute items and services, in whole or in part, to physicians; identify appropriate physicians for purposes of comparison; and aggregate items and services attributed to a physician into a composite measure per individual.

Requires the Secretary, beginning in 2012, to provide feedback reports to physicians or groups of physicians using the episode grouper to compare their resource use for items and services furnished or ordered with that of other physicians or groups of physicians caring for patients with similar conditions. Feedback reports must include appropriate adjustments to account for differences in the demographic characteristics and health status of individuals and also to eliminate the effect of geographic adjustments in payment rates. Requires education and outreach activities to physicians on the operation of, and methodologies used, under the feedback program.

Requires public disclosure of the methodologies used to analyze data, including adjustments for patient and geographic differences. Requires aggregate reports on physicians be made available to the public.

Requires coordination of the feedback program with the value-based payment modifier (see sec. 3007) and other similar provisions.

**Sec. 3004. Quality reporting for long-term care hospitals, inpatient rehabilitation hospitals, hospice programs and psychiatric hospitals or units (as modified by sec. 10322).**

Directs the Secretary to establish quality reporting programs for long term care hospitals, inpatient rehabilitation hospitals, hospice programs and psychiatric hospitals or units. Requires selection and publication of quality measures for each entity type by 10/1/2012 followed by implementation of mandatory reporting in fiscal or rate year 2014. Measures

specified by the Secretary must be endorsed by the entity with a contract under section 1890(a), most likely the National Quality Forum, unless the Secretary makes an exception and uses a measure not so endorsed after due consideration of measures endorsed or adopted by a consensus organization identified by the Secretary. Failure to report quality measures will result in a 2.0% reduction in the annual market basket update. Such reduction may result in a negative Medicare payment update for the affected year but it applies only to the applicable year and is not carried forward to future years. For all of these entity types, the Secretary will make reported data available to the public.

**Sec. 3005. Quality reporting for PPS-exempt cancer hospitals.**

Directs the Secretary to establish a quality reporting program for Medicare PPS-exempt cancer centers. Requires selection and publication of quality measures by 10/1/2012 followed by implementation of mandatory reporting in fiscal 2014. Measures specified by the Secretary must be endorsed by the entity with a contract under section 1890(a), most likely the National Quality Forum, unless the Secretary makes an exception and uses a measure not so endorsed after due consideration of measures endorsed or adopted by a consensus organization identified by the Secretary. Amends the provider agreement for PPS-exempt cancer centers to require them to report designated quality measures. The Secretary will make reported data available to the public.

**Sec. 3006. Plans for a Value-Based purchasing program for skilled nursing facilities, home health agencies and ambulatory surgical centers (as modified by sec. 10301).**

Requires the Secretary to submit to Congress, Medicare value-based purchasing implementation plans for home health agencies and skilled nursing facilities by 10/1/2011 and for ambulatory surgical centers by 1/1/2011. Each plan is to include consideration of several specified issues involving measure development and selection (including coordination with the requirements of sections 1890 and 1890(a) to the extent feasible), reporting and validation of data, setting performance thresholds, the structure and financing of payment adjustments, and public reporting. Requires the Secretary to consult with relevant stakeholders and to consider experiences with demonstrations that are relevant to value-based purchasing in each setting.

**Sec. 3007. Value-based payment modifier under the physician fee schedule.**

Directs the Secretary to develop and implement a budget-neutral adjustment to the physician fee schedule to vary payments to physicians or groups of physicians based upon the quality of care they provide relative to cost. The modifier is separate from and does not replace the geographic adjustment factors.

The Secretary will establish a composite of appropriate, risk-based measures of quality that reflect the health outcomes and health status of Medicare beneficiaries. The Secretary must seek endorsement of the quality measures by the entity with a contract with the Secretary under section 1890(a) [e.g., the National Quality Forum].

The Secretary also will establish a composite of appropriate measures of costs such as the episode-based measures developed for the physician feedback program (see sec. 3003). The composite cost measure will be adjusted to remove the effect of geographic adjustments in payment rates and to take into account risk factors (such as socioeconomic and demographic characteristics, ethnicity, and health status of individuals and other factors determined by the Secretary). Costs are defined as

expenditures per individual. The Secretary may consider the amount of growth in expenditures per individual for a physician compared to the amount of such growth for other physicians. The payment modifier is to be applied in a way that promotes systems-based care.

By 1/1/2012, the Secretary must publish the specific measures of quality and cost, the specific dates for implementation of the payment modifier, and the initial performance period. The Secretary will begin implementing the modifier through the rulemaking process during 2013 for the Medicare physician fee schedule. During the initial performance period, which will begin in 2014 and be used to determine payment adjustments in 2015, the Secretary will provide information to physicians about the quality and cost of care they provide. The Secretary will apply the payment modifier beginning 1/1/2015 for specific physicians and groups of physicians selected by the Secretary. Beginning no later than 1/1/2017, the modifier will be applied to all physicians and groups of physicians.

From 1/1/2015 through 12/31/2016, the modifier applies only to physicians as defined in sec.1861(r). Beginning on 1/1/2017, the Secretary may include all eligible professionals as that term is defined for the physician quality reporting program.

Requires the Secretary to take into account the special conditions of providers in rural and other underserved communities. Directs the Secretary to coordinate the payment modifier with the physician feedback program and other similar provisions. Prohibits judicial review of policies established to implement the payment modifier.

**Sec. 3008. Payment adjustment for conditions acquired in hospitals.**

For FY 2015 and subsequent years, hospitals in the top quartile with respect to national rates of hospital acquired conditions (HACs) will have their Medicare payments for all discharges reduced by 1%. The Secretary will designate the applicable period for determining which hospitals are in the top quartile for a fiscal year and will apply an appropriate risk adjustment in making the determination. A HAC is defined as a condition that an individual acquires during a hospital stay and that the Secretary designates to be subject to inpatient PPS payment restrictions under subsection 1886(d)(4)(D)(iv) as well as other hospital-acquired conditions specified by the Secretary. Requires the Secretary to provide confidential reports to hospitals in the top quartile prior to FY 2015 and in future years. Also requires public reporting and posting on the Hospital Compare Internet website regarding HACs in these hospitals after allowing them to review the information to be made public and to submit corrections. The provision applies to Medicare inpatient PPS hospitals and to hospitals paid under a section 1814(b)(3) waiver [i.e., Maryland], unless the affected state demonstrates annually that it has a state program which achieves results at least equal to the results in the national program. Requires the Secretary to study and report to Congress by 1/1/2012 regarding possible expansion of the HAC program to other facilities such as long term care hospitals, inpatient rehabilitation facilities, other hospitals excluded from the inpatient PPS, SNFs, hospital outpatient departments, ambulatory surgical centers and health clinics.

**Sec. 10326. Pilot testing pay-for-performance programs for certain Medicare providers.**

Requires the Secretary to initiate separate pilot programs by 1/1/2016 to test value-based purchasing for psychiatric hospitals and units, long-term care hospitals, rehabilitation hospitals, PPS-exempt cancer hospitals, and hospice programs. Provides

authority to waive requirements of titles XI and XVIII of the Social Security Act and requires budget neutrality. Authorizes Secretary to expand the duration and scope of the pilot programs after 1/1/2018 based on the Secretary's determination that expansion would reduce Medicare spending (also certified by the chief actuary), maintain or increase quality, and not deny or limit coverage or benefits for beneficiaries.

**Sec. 10331. Public reporting of performance information.**

Requires the Secretary to develop a Physician Compare Website with information on physicians and other professionals participating in the Medicare Physician Quality Reporting Initiative by 1/1/2011, and implement public reporting of that information using quality and patient experience measures by 1/1/2013.

The measures used include assessment of coordination of care and care transition, efficiency, safety, effectiveness and timeliness of care. The Secretary is required to consider input from multi-stakeholder groups on measure selection.

The Secretary is to ensure patient privacy and include, if practicable, processes to assure statistically valid and reliable data, the opportunity to review data before being made public, accuracy in results, inclusion of data from all patients, attribution in the case of multiple physicians or professionals, and timely feedback.

Permits the Secretary to consider this plan for a transition to value-based purchasing, and to expand the scope of the plan to include other Medicare providers and suppliers.

Permits the Secretary to establish a demonstration program to provide financial incentives to Medicare beneficiaries who are furnished services by high quality physicians. Medicare beneficiaries may not be required to pay increased premiums or cost sharing or be subject to a reduction in Medicare benefits as a result of such demonstration program, and the program may not disadvantage those beneficiaries without reasonable access to high performing physicians or create financial inequities under the Medicare program.

**PART II—NATIONAL STRATEGY TO IMPROVE HEALTH CARE QUALITY**

**Sec. 3011. National strategy (as modified by sec. 10302).**

Requires the Secretary (under the PHSA) to establish and update annually, a national strategy to improve the delivery of health care services, patient health outcomes, and population health through a transparent and collaborative process.

The Secretary is to establish national priorities for the strategy through a comprehensive strategic plan that ensures the priorities identified will have the greatest potential to improve health identify areas with potential for rapid improvement in quality; address gaps in quality, efficiency, and comparative effectiveness information (which must take into account the limitations on uses of comparative clinical effectiveness research, relating to the manner in which that research may be used for purposes of Medicare coverage, reimbursement, or incentive programs); improve Federal payment policy, enhance use of health care data, address high-cost chronic diseases, and other requirements. The plan must coordinate efforts of agencies within HHS and develop strategies to align quality and patient safety incentives among public and private payers. By 1/1/2011, Secretary must submit the initial strategy to Congress. The Secretary to establish a website for the public to see the national priorities, agency-specific plans, and other relevant information.

**Sec. 3012. Interagency Working Group on Health Care Quality.**

The President will convene a working group of Federal agencies to collaborate, consult, and coordinate on fulfilling the national quality improvement strategy and priorities, to avoid duplication of efforts, and to assess alignment of public and private quality efforts. The working group must submit annual reports to Congress on progress of those agencies and recommendations of the group to meet goals.

**Sec. 3013 Quality measure development (as modified by sec. 10303).**

Requires the Secretary (under the PHSA) every 3 years to identify gaps in existing quality measures, or where existing quality measures need improvement, updating or expansion, consistent with the national strategy and priorities, and taking into account annual reports prepared by the qualified consensus-based entity and recommendations of the Agency for Healthcare Research and Quality (AHRQ) & CMS. The Secretary is to develop quality measures to fill identified gaps by contracting with an entity with expertise in measure development and evaluation and that has a process in place to coordinate with the qualified consensus-based entity. Measures developed by the entity must build on Medicare measures; be collected using HIT; be free of charge to the users; and be publicly available. The Secretary is to develop every 3 years provider-level outcome measures for hospitals and physicians, and other providers the Secretary finds appropriate. Measures must be developed for acute and chronic diseases (including, if feasible, for the 5 most prevalent and resource-intensive medical conditions) and primary and preventive care (including, if feasible, by distinct patient populations). At least 10 measures for acute and chronic diseases must be developed within 2 years and 10 measures for primary and preventive care by 03/23/2013.

CMS must contract for development of measures for purposes of the Medicare program, in consultation with the AHRQ, and CMS must publicly report on hospital-acquired condition measures used for payment adjustments to hospitals for rates of hospital-acquired infections.

Authorizes appropriations of \$75 million to HHS for each of fiscal years 2010 – 2014 for these purposes, at least ½ of which is to be used by CMS for measure development for programs under the Social Security Act.

**Sec. 3014. Quality measurement (as modified by sec. 10304).**

Requires a consensus-based entity to convene multi-stakeholder groups for input on selection of quality and efficiency measures under Medicare program and on national priorities for health improvement.

Requires CMS to consult the qualified consensus-based entity and the multi-stakeholder groups on measure selection for use in reporting and payment under Medicare program, including a pre-rulemaking process for input from the entity and groups. Under the process, CMS must publish, by December 1st of each year beginning with 2011, a list of measures (whether endorsed by the consensus-based entity or not) being considered for use in Medicare reporting and payment, and CMS must provide the consensus-based entity 60 days to submit its recommendations on the measures (after having convened the multi-stakeholder group to develop those recommendations using an open, transparent process). CMS then selects measures (and must provide rationale when selecting unendorsed measures).

CMS must assess quality impact of use of endorsed measures every 3 years; must disseminate measures and incorporate measures in Federal health programs, workforce programs, and training curricula; and must review measures every 3 years to determine whether to continue using them.

Transfers \$20 million to the CMS program management account for each of fiscal years 2010 - 2014 from the Medicare Trust funds for measure selection, use, and review.

**Sec. 3015. Data collection; public reporting (as modified by sec. 10305).**

Requires the Secretary (under the PHSA) to implement a strategic framework for public reporting of performance information. Requires the collection and aggregation of data on quality and resource use from information systems that support health care delivery to carry out public reporting of quality information, and to align such efforts with requirements and assistance for expanding HIT, technology interoperability systems, and related standards, with the scope of collection and aggregation increasing over time. Permits the Secretary to contract with multi-stakeholder groups or other entities that enable summary data to be integrated and compared across multiple sources. Requires the Secretary to establish standardized websites to make public performance information (on clinical conditions that is provider-specific and disaggregated) tailored to meet the needs of many different stakeholders, and to consult the consensus-based entity on the type of information and the best format, with input from multi-stakeholder groups. Requires coordination of reporting with other public reporting requirements (i.e. Medicare reporting requirements). Authorizes appropriations of such sums as may be necessary for fiscal years 2010 through 2014 to carry out the activities.

**PART III—ENCOURAGING DEVELOPMENT OF NEW PATIENT CARE MODELS**

**Sec. 3021. Establishment of Center for Medicare and Medicaid Innovation within CMS (as modified by Sec. 10306).**

Creates within CMS, not later than 1/1/2011, a Center for Medicare and Medicaid Innovation (CMI) to test innovative payment and service delivery models to reduce program expenditures while preserving or enhancing the quality of care. The CMI may also focus on CHIP, in addition to Medicare and Medicaid. The Secretary must select models for testing where there is evidence that the model addresses a defined population for which there are deficits in care leading to poor clinical outcomes or potentially avoidable expenditures. Provides a menu of 20 possible models for testing. Authorizes the Secretary to limit model testing to certain geographic areas. The Secretary must not require as a condition for testing a model that its design ensure that it is budget neutral initially. The Secretary may, through rulemaking, expand (including implementation on a nationwide basis) the duration and scope of a model if doing so would: (1) reduce spending without reducing quality; or (2) improve patient care without increasing spending. Drops the 5-year time limit for the existing Health Care Quality Demonstration Program. Provides a direct appropriation of \$5 million for FY 2010 and \$10 billion for fiscal years 2011-2019 and for each subsequent 10-year period starting with 2020.

**Sec. 3022. Medicare shared savings program (as modified by Sec. 10307).**

Permits providers meeting certain criteria to be recognized as accountable care organizations (ACOs), beginning 1/1/2012, and to qualify for a new shared savings program (provided they meet certain quality thresholds). Note that this is not structured as a pilot program although each ACO must enter into a 3-year agreement with the Secretary. Defines an ACO to include specified groups of providers and suppliers who have an established mechanism for shared governance, including partnerships or joint venture arrangements between hospitals and ACO professionals and hospitals employing ACO professionals. An ACO must be willing to become accountable for the quality, cost and overall care of the Medicare fee-for-service beneficiaries assigned to it.

ACO professional is defined as a physician, as defined in section 1861(r)(1), and a physician assistant, nurse practitioner, or clinical nurse specialist, as described in section 1842(b)(18)(C)(i). The Secretary will determine an appropriate method to assign Medicare fee-for-service beneficiaries to an ACO based on their utilization of primary care services, and each ACO must have a minimum of 5,000 beneficiaries.

ACOs must achieve a certain minimum level of savings (to be determined by the Secretary) before further savings are shared (with the Secretary authorized to determine the percent of shared savings and establish limits on the total amount of shared savings to be paid to an ACO). Per-beneficiary spending benchmarks for Part A and B services to be adjusted for beneficiary characteristics and such other factors as the Secretary determines appropriate. Authorizes the Secretary to use a partial capitation model or any other payment model that will improve the quality and efficiency of items and services furnished under Medicare, in addition to paying ACOs on a fee-for-service basis. The Secretary may give preference to ACOs who are participating in similar arrangements with other payers.

**Sec. 3023. National pilot program on payment bundling (as modified by sec. 10308).**

Requires the Secretary to develop, test and evaluate alternative Medicare payment methodologies through a national, voluntary pilot program for integrated care during an episode of care provided around a hospitalization in order to improve the coordination, quality, and efficiency of health care services. Program must be established not later than 1/1/2013 and will last 5 years. Secretary may expand the duration and scope of the program after 1/1/2016 if the Secretary determines that expansion: i) would reduce spending (which must be certified by the CMS chief actuary) while improving or not reducing the quality of care; and ii) would not deny or limit coverage or provision of benefits for individuals. Requires independent evaluation and an interim report to Congress based on the independent evaluation no later than two years after the start of the pilot program and a final report within three years.

Defines applicable services to be acute care inpatient services; physician services delivered inside and outside of the hospital setting; outpatient hospital services, including emergency department visits; post-acute care services including home health, skilled nursing, inpatient rehabilitation, long term care hospital; and other services identified by the Secretary. Defines an applicable beneficiary as one not enrolled in Medicare Part C or Program of All Inclusive Care for the Elderly (PACE) and having at least one of the 10 applicable patient conditions selected by the Secretary considering various factors specified in the legislation. Establishes the episode of care to begin three days prior to the hospital admission and end 30 days following hospital discharge, unless the Secretary determines another timeframe is more appropriate. Requires the Secretary to receive applications from entities to provide applicable services to applicable individuals; entities may be comprised of providers of services and suppliers, including a hospital, a physician group, a skilled nursing facility, and a home health agency. Requires that all applicable services be furnished by the entity or directed by it. Secretary pays the entity for all applicable services included in the bundle and furnished during an episode of care. Requires the Secretary to establish payments so that an entity is not paid more in a year for all applicable services for treating applicable beneficiaries than it would be paid absent the pilot program, as estimated by the Secretary. Requires payment for post-acute services which are necessary after the last day of the episode of care.



In conducting the pilot program, the Secretary will: 1) develop requirements for entities to participate, including ensuring that beneficiaries have an adequate choice of providers of services and suppliers; 2) test alternative payment methodologies, which may include bundled payments or bids from entities for episodes of care; 3) include payment for services such as care coordination, medication reconciliation, discharge planning, transitional care services and other patient-centered activities determined appropriate. Grants the Secretary authority to waive SSA Title XVIII or Title XI provisions as necessary.

Requires the Secretary to test a continuing care hospital model as part of the pilot program. For this model, an episode of care is defined as a patient's stay in the continuing care hospital plus 30 days following discharge. The applicable conditions for the model are not limited to the 10 patient conditions identified by the Secretary as noted above. A continuing care hospital must provide under common management the medical and rehabilitation services provided in inpatient rehabilitation hospitals, long term care hospitals, and hospital-based skilled nursing facilities.

Requires the Secretary to work with the Agency for Healthcare Research and Quality (AHRQ) and the qualified consensus-based entity under 1890(a) [e.g., the National Quality Forum] to develop episode of care and other quality measures related to care provided across all providers participating in the pilot. Pilot program participants must report quality measures. Measures are to be site-neutral and comprehensive in scope, including measures of functional status improvement, rates of avoidable hospital readmissions, rates of discharge to the community, rates of admission to an emergency room after a hospitalization, incidence of health care acquired infections, efficiency measures, measures of patient-centeredness of care, measures of patient perception of care, and other measures, including measures of patient outcomes, determined appropriate by the Secretary. As practicable, participants will use electronic health records to submit quality measures. Prior to beginning the pilot program, the Secretary must determine which patient assessment instrument (such as the Continuity Assessment Record and Evaluation, or CARE tool), will be used to evaluate a patient's clinical condition in determining the most clinically-appropriate site for post-acute care.

Requires the Secretary to consult with representatives of small and rural hospitals, including critical access hospitals (CAHs), to determine appropriate and effective methods for them to participate in the pilot program or other innovative methods to implement bundled payments.

#### **Sec. 3024. Independence at home demonstration program.**

Authorizes a Medicare demonstration program to test the provision of physician and nurse practitioner-directed home-based primary care to certain beneficiaries and coordinate health care across all treatment settings, beginning not later than 1/1/2012. Eligible beneficiaries are defined as those having 2 or more chronic illnesses, a nonelective hospital admission within the past 12 months, previous acute or subacute rehabilitation services, and 2 or more functional dependencies. Participating practices must furnish services to at least 200 Medicare beneficiaries, must use electronic health information systems, remote monitoring, and mobile diagnostic technology, and may share savings in excess of 5%. For purposes of determining savings, the Secretary must establish an estimated annual spending target (with a risk corridor). Nothing in this section is to be construed as encouraging physicians or nurse practitioners to limit beneficiary access to Medicare-covered services and beneficiaries are not to be required

to relinquish access to any Medicare-covered benefit as a condition of receiving services from an independence at home practice. The demonstration may include no more than 10,000 beneficiaries. Mandates an independent evaluation of the demonstration and a report to Congress.

**Sec. 3025. Hospital readmissions reduction program (as modified by sec. 10309).**

Effective beginning 10/1/2012, reduces payments to Medicare PPS hospitals with excess readmissions. Payment reduction is based on each hospital's ratio of payments for actual risk-adjusted readmissions to payments for expected risk-adjusted readmissions. Does not apply to critical access hospitals. Secretary may exempt hospitals in states paid under section 1814(b)(3) [i.e., Maryland] if the state submits an annual report describing how a similar state program achieves at least comparable results with respect to patient health outcomes and cost savings.

Reduction applies only to base DRG payments, excluding adjustments for indirect medical education (IME), disproportionate share (DSH), outliers, low-volume hospitals, and additional payments made due to status as a sole community hospital or Medicare-dependent small rural hospital. In fiscal years 2013 and 2014, the reduction cannot exceed 1% and 2% respectively. For FY 2015 and subsequent years, the reduction is limited to 3%.

Risk-adjusted actual and expected readmissions must be determined consistent with measures of readmissions that have been endorsed by the entity with a contract under section 1890(a) [e.g. the National Quality Forum (NQF)]. Such measures are specified to have appropriate exclusions for readmissions that are unrelated to the prior discharge such as a planned readmission or transfer to another applicable hospital.

In FY 2013, the policy will apply to readmissions in three high volume/high expenditure conditions with NQF-endorsed measures: heart attack, heart failure and pneumonia. In FY 2015, the policy is expanded to the four additional conditions identified in the June 2007 MedPAC report and to other high volume or high expenditure conditions and procedures, as determined by the Secretary. For the expansion to additional conditions in FY 2015, NQF endorsement must be sought but is not required.

The time period from discharge to readmission is specified by the Secretary except that for an NQF-endorsed readmission measure for a particular condition, the time period is as specified in the measure. (For the NQF-endorsed measures relating to heart attack, heart failure and pneumonia, the period currently is 30 days.)

Administrative or judicial review of most matters pertaining to the readmissions policy is prohibited.

Requires public disclosure of hospital-specific readmission rates on the Hospital Compare Internet website; requires that hospitals have an opportunity to review and correct information before its release. Requires hospitals to report sufficient information, as specified by the Secretary, for the Secretary to determine all-patient readmission rates. Data may be submitted by a state or other entity on behalf of the hospitals rather than by the individual hospitals. Requires the Secretary to post the all-patient readmission rates on the Hospital Compare Internet website.

By no later than 3/23/2012, requires establishment of a quality improvement program under the Public Health Service Act to assist eligible hospitals in improving their readmission rates through the use of patient safety organizations (as defined in section 921(4) of the PHS Act). Eligible hospitals, to be determined by the Secretary using an appropriate risk adjustment, are hospitals that have a high rate of risk-adjusted readmissions for the applicable conditions and that have not taken appropriate steps to reduce such readmissions and improve patient safety as evidenced through historically high rates of readmissions. Requires eligible hospitals and patient safety organizations working with those hospitals to report to the Secretary on the processes employed to improve readmission rates and their impact on readmission rates.

**Sec. 3026. Community-Based Care Transitions Program.**

Establishes a 5-year program, beginning 1/1/2011, called the Community-Based Care Transitions Program, to fund eligible hospitals and community-based partnership organizations to provide patient-centered, evidence-based care transition services to Medicare beneficiaries at the highest risk of preventable re-hospitalization. Program participants are eligible hospitals partnering with a community-based organization or community-based organizations that provide such care transition services. Eligible hospitals are PPS hospitals identified by the Secretary as having high readmission rates. Applications to participate must include a detailed proposal with at least one evidence-based care transition intervention. Secretary will give priority to entities that participate in a care transition program of the Administration on Aging and entities that provide services to medically underserved populations, small communities, and rural areas. Secretary is given waiver authority and may implement the program by program instruction.

Program is funded by a Medicare Hospital Insurance Trust Fund transfer of \$500 million for the period FY 2011 to FY 2015, with funds remaining available until expended. The Secretary may continue or expand the scope and duration of the program based on a determination, certified by the CMS chief actuary, that expansion would reduce Medicare spending without reducing quality.

**Sec. 3027. Extension of gainsharing demonstration.**

Extends from 12/31/2009 to 9/30/2011 the gainsharing demonstration enacted as part of the Deficit Reduction Act of 2005.

**Subtitle B—Improving Medicare for Patients and Providers**

**PART I—ENSURING BENEFICIARY ACCESS TO PHYSICIAN CARE AND OTHER SERVICES**

**Sec. 3101. Increase in the physician payment update (as modified by sec. 10310).**

Sec. 10310 repeals sec. 3101, which would have updated the physician fee schedule conversion factor by 0.5% in 2010 and would have stipulated that the conversion factors for 2011 and subsequent years be computed as if the increase in 2010 had never applied. PPACA includes no provision pertaining to the physician update or the sustainable growth rate (SGR).

**Sec. 3102. Extension of the work geographic index floor and revisions to the practice expense geographic adjustment under the Medicare physician fee schedule (as modified by sec. 1108 of HCERA).**

Extends the work geographic adjustment floor through CY 2010. [3102(a)] For 2010 and 2011, changes the geographic adjustment for practice expenses to reflect 50% (rather than 100%) of the difference in costs of employee wages and rents between each fee schedule area and the national average. Holds harmless areas that would lose under the revised formula. Requires the Secretary to study improvements in the methodology for calculating practice expense adjustments and to implement changes beginning in 2012. [3102(b) as modified by sec. 1108 of HCERA]

**Sec. 3103. Extension of exceptions process for Medicare therapy caps.**

The therapy caps exceptions process is extended for one year through 12/31/2010.

**Sec. 3104. Extension of payment for technical component of certain physician pathology services.**

In 1999, CMS (then known as the Health Care Financing Administration), proposed terminating an exception to a payment rule that had permitted laboratories to receive direct payment from Medicare when providing technical pathology services that had been outsourced by certain hospitals. Congress enacted provisions in BIPA to delay the termination. The special provision has been periodically extended, most recently through December 31, 2009 by the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA). Section 3104 extends the provision through 2010.

**Sec. 3105 Extension of ambulance add-ons (as modified by Sec. 10311).**

Ambulance services are paid on the basis of a national fee schedule, which is being phased in. The fee schedule establishes seven categories of ground ambulance services and two categories of air ambulance services. The national fee schedule is fully phased in for air ambulance services. For ground ambulance services, payments through 2009 are equal to the greater of the national fee schedule or a blend of the national and regional fee schedule amounts. The portion of the blend based on national rates is 80% for 2007-2009. In 2010 and subsequently, the payments in all areas will be based on the national fee schedule amount.. The ambulance fee schedule payment equals a base rate for the level of service plus payment for mileage. Geographic adjustments are made to a portion of the base rate. For the period July 2004 to December 2009, mileage payments are increased for ground ambulance services originating in rural low population density areas. For the period July 1, 2004 before January 1, 2009, there was a 25% bonus on the mileage rate for trips of 51 miles and more. Payments for ground transports originating in rural areas or rural census tracts are increased by 3% for the period of October 1, 2008 before January 1, 2010. MIPPA specifies that any area designated as rural for the purposes of making payments for ambulance services on December 31, 2006, will be treated as rural for the purpose of making air ambulance payments during the period July 1, 2008 ending on December 1, 2011.

The provision would extend the bonus payments and the increased ground ambulance payments until January 1, 2011. The provision to pay certain urban air ambulance services as rural would be extended until January 1, 2011, as well.

**Sec. 3106. Extension of certain payment rules for long-term care hospital services and of moratorium on the establishment of certain hospitals and facilities (as modified by Sec. 10312).**

Extends the regulatory relief provided by the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA, P.L. 110-173), Section 114(c) by two years. Also extends the moratorium on the development of new long-term care facilities for two additional years (MMSEA, Section 114(d)).

**Sec. 3107. Extension of physician fee schedule mental health add-on.**

Extends through 12/31/2010 an existing 5% bonus payment for certain psychiatric therapeutic procedures (originally intended to offset the impact of the budget neutrality adjustment to work values required as a result of the most recent 5-year review of relative values).

**Sec. 3108. Permitting physician assistants to order post-hospital extended care services.**

Effective 1/1/2011, allows a physician assistant who does not have a direct or indirect employment relationship with a SNF, but who is working in collaboration with a physician, to certify the need for post-hospital extended care services for Medicare payment purposes.

**Sec. 3109. Exemption of certain pharmacies from accreditation requirements.**

Allows pharmacies furnishing Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) items and services until 1/1/2011 to submit evidence of accreditation required by section 1834(a)(20) of the SSA.

Exempts pharmacies from the accreditation requirements applicable to DMEPOS suppliers provided certain conditions are met, including a requirement that the pharmacy submit an attestation that its total Medicare DMEPOS billings are and continue to be less than a rolling three year average of 5% of its total pharmacy sales.

**Sec. 3110. Part B special enrollment period for disabled TRICARE beneficiaries.**

Provides a special Medicare Part B 12-month enrollment period for TRICARE beneficiaries, effective for elections made with respect to initial enrollment periods that end after 03/23/2010, during which any Part B premium penalty otherwise applicable is to be waived.

**Sec. 3111. Payment for bone density tests.**

Restores payment for dual-energy x-ray absorptiometry (DXA) bone mass scan services furnished during 2010 and 2011 to 70 percent of the Medicare rate paid in 2006 (using the geographic adjustment factor that would apply in 2010 and 2011, respectively).

Provides for an Institute of Medicine study of the impact of Medicare payment reductions for dual-energy x-ray absorptiometry during 2007, 2008, and 2009 on beneficiary access to bone mass density tests.

**Sec. 3112. Revision to the Medicare Improvement Fund.**

Eliminates all funding in the Medicare Improvement Fund.

**Sec. 3113. Treatment of certain complex diagnostic laboratory tests.**

Creates a 2-year Medicare demonstration program starting 7/1/2011 to test the impact of direct payments for certain complex laboratory tests on Medicare quality and costs. Subject tests are the analysis of gene protein expression, topographic genotyping, or a cancer chemotherapy sensitivity assay. Direct payment may be made to a hospital-based or independent laboratory for tests performed after the hospitalization on specimens collected during an inpatient hospital stay. Total demonstration program payments may not exceed \$100 million. Report to Congress due two years after completion of the demonstration. Provides direct transfer of \$5 million from Medicare Part B Trust Fund for administering and evaluating the demonstration.

**Sec. 3114. Improved access for certified nurse-midwife services.**

Effective 1/1/2011, deletes a provision limiting Medicare reimbursement of nurse-midwives to 65% of what a physician would be paid for the same service.

**Sec. 10336. GAO study and report on Medicare beneficiary access to high-quality dialysis services.**

Directs the Comptroller General to conduct a study on the impact of including oral drugs (for which there is no injectable equivalent) in the Medicare bundled payment for end stage renal disease services on beneficiary access to high quality renal disease services. The study shall analyze the ability of providers to furnish the oral drugs (including compliance with state laws) and the existence of quality measures to safeguard beneficiaries' care. Report to Congress due 03/23/2011.

**PART II—RURAL PROTECTIONS**

**Sec. 3121. Extension of outpatient hold harmless provision.**

Extends hold harmless protection under the Medicare hospital outpatient prospective system through CY 2010 for rural hospitals with 100 or fewer beds and for sole community hospitals (SCHs). The hold harmless payment in CY 2010 continues to equal 85% of the difference between the PPS amount and the pre-BBA amount. Also removes the 100-bed limitation under this provision for SCHs effective only in CY 2010.

**Sec. 3122. Extension of Medicare reasonable costs payments for certain clinical diagnostic laboratory tests furnished to hospital patients in certain rural areas.**

Reinstates reasonable cost payment for rural hospitals with less than 50 beds in certain states (low density rural areas) for some clinical diagnostic tests from 7/1/2008 through 7/1/2011.

**Sec. 3123. Extension of the Rural Community Hospital Demonstration Program (as modified by Sec. 10313).**

Extends the demonstration program for an additional 5 years; expands the maximum number of participating hospitals to 30 (now 10); and expands the number of eligible demonstration states to 20. For hospitals currently in the demonstration, rebases the payment amount for inpatient hospital services provided during the 5-year extension using reasonable costs in the first cost reporting period beginning during the extension.

**Sec. 3124. Extension of the Medicare-dependent hospital (MDH) program.**

Extends the MDH program through FY 2013.

**Sec. 3125. Temporary improvements to the Medicare inpatient hospital payment adjustment for low-volume hospitals (as modified by Sec. 10314 of PPACA).**

Expands the provision providing temporary adjustments to inpatient hospital payments for qualifying low-volume hospitals through FY 2012 and reduces the road mileage qualifying criteria from 25 to 15 road miles for FY 2011 and FY 2012. Increases the discharge qualifying criteria in FY 2011 and FY 2012 from 800 total discharges to 1,600 discharges by Medicare Part A beneficiaries. Revises the payment formula for FY 2011 and FY 2012.

**Sec. 3126. Improvements to the demonstration project on community health integration models in certain rural counties.**

Eliminates the limitation on the number of eligible counties (now 6). Deletes requirement for rural health clinic services. Allows physician services to be included.

**Sec. 3127. MedPAC study on adequacy of Medicare payments for health care providers serving in rural areas.**

Requires MedPAC to submit a report to Congress by 1/1/2011 on the adequacy of Medicare payments for health care providers serving rural areas.

**Sec. 3128. Technical correction related to critical access hospital (CAH) services.**

Makes payment for Medicare CAH services equal to “101 percent of” reasonable costs instead of 100 percent of reasonable cost. The amendment takes effect as if included in the enactment of section 405(a) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA).

**Sec. 3129. Extension of and revisions to Medicare rural hospital flexibility (FLEX) program.**

The FLEX grant program (now authorized through 2010) is extended through 2012 and use of other grant funds to help rural hospitals participate in the legislations health reform provisions is allowed.

**PART III—IMPROVING PAYMENT ACCURACY**

**Sec. 3131. Payment adjustments for home health care (as modified by sec. 10315).**

For 2014 and subsequent years, rebases the home health prospective payment amounts by applying an adjustment percentage to the amounts that would otherwise be paid. The adjustment is made before the annual update is applied. The Secretary will determine the percentage considering factors such as the number and mix of home health services, level of intensity of services, and the average cost of providing care. Rebasing may consider these differences in providers: (1) between hospital-based and freestanding; (2) between for-profit and non-profit; and (3) between urban and rural. Directs the Secretary to phase in the adjustment in equal increments over 4 years, 2014 to 2017. Limits the adjustments to 3.5% per year during the four year transition relative to payment levels on 3/23/2010. Requires MedPAC to report to Congress on the impact of the adjustments and possible recommendations by 1/1/2015.

Makes the reduction in the standard prospective payment amount (or amounts) for outlier payments equal to 5%. Changes the limit in SSA sec. 1895(b)(5) on the total amount of additional payments that can be made for outliers from 5% to 2.5% of total prospective payments projected to be made in a year. Starting in 2011, stipulates that a

home health agency's outlier payments cannot exceed 10% of the agency's estimated total payments (including outlier payments) in a given year.

Provides a 3% add-on payment for home health providers serving rural areas for episodes and visits ending on or after 4/1/2010 and before 1/1/2016.

Directs the Secretary to study the costs of providing home health care to beneficiaries with varying levels of severity and to beneficiaries who are low-income or in medically underserved areas. Specifies types of recommendations to be considered, including payment adjustments for services requiring additional or fewer resources, changes to reflect resources needed to serve low-income beneficiaries or those in underserved areas, or revisions to outlier payments. Allows the Secretary to consider whether patient severity of illness and access to care can be measured by various proxy factors such as population density and patient access, cost variations for serving beneficiaries dually eligible for Medicare and Medicaid, presence of severe or chronic diseases, poverty status, and other factors. Requires consultation with stakeholders and beneficiaries and a report to Congress, with recommendations, by 3/1/2014.

Authorizes a 4-year demonstration project to test potential payment adjustments beginning not later than 1/1/2015. Prohibits reducing the standard prospective payment amounts to offset the cost of the demonstration adjustments. Requires a report to Congress evaluating the demonstration project. Provides a direct appropriation from the Medicare trust funds of \$500 million for FYs 2015-2018 for the costs of the study and demonstration.

#### **Sec. 3132. Hospice reform.**

Beginning no later than 1/1/2011, the Secretary, after consulting with hospice programs and MedPAC, must collect additional data from hospice cost reports, claims and other mechanisms. Examples of the additional data and information to be collected include: (1) type of practitioner providing the hospice visit; (2) length and content of the visit; (3) charge and payment information; (4) number of days attributable to Medicare beneficiaries and dually eligible beneficiaries; (5) days of hospice care by type of service and costs and payment attributable to each type of service; and (6) charitable contributions and other revenue. Requires the Secretary, after consultation with hospice programs and MedPAC and not earlier than 10/1/2013, to issue regulations to revise the methodology for determining hospice payment rates for routine home care and other hospice services. Revisions may include adjustments to per diem payments to reflect changes in resource intensity during the course of the entire episode and at the end of the episode. Changes must be implemented budget neutrally and the revised rates will be updated in future years by the applicable market basket.

Beginning 1/1/2011, imposes additional requirements on hospice providers: (1) that a hospice physician or advanced practice nurse visit the patient to determine continued eligibility prior to the 180<sup>th</sup> day recertification and each subsequent recertification, and attest that such visits took place; and (2) that CMS or its contractors medically review all stays in excess of 180 days occurring in hospices for which such stays exceed a threshold determined by the Secretary.



**Sec. 3133. Improvement to Medicare disproportionate share hospital (DSH) payments (as modified by sec. 10316 and sec. 1104 of HCERA).**

Beginning in FY 2014, reduces Medicare DSH payments to 25% of the amount that otherwise would have been made, resulting in payments that represent the empirically justified amount as determined by MedPAC.

Provides an additional payment to reflect hospitals' continued uncompensated care costs using savings from the reduction in DSH payments. A hospital's additional payment amount equals the product of three factors (as estimated by the Secretary): 1) the aggregate reduction in payments to all hospitals due to the DSH reduction; 2) 1.0 minus the percent change in the percent of individuals under 65 who are uninsured in the most recent period for which data are available compared to 2013, as modified by an additional adjustment; and 3) each individual hospital's share of the total amount of uncompensated care provided by all hospitals. Hospitals' uncompensated care costs are estimated by the Secretary based on appropriate data. The additional adjustment applied to factor two is -0.1 percentage point in FY 2014; -0.2 percentage points in FYs 2015-2017; -1.5 percentage points in FYs 2018-2019; and 0.0 percentage points for subsequent years. The specification of factor two varies. For FYs 2014-2017, it is based on the percent change in the percent of individuals under 65 who are uninsured, and the 2013 baseline is determined by the most recent CBO estimates available before the Senate vote on HCERA. Beginning with FY 2018, it is based on the percent change in the percent of individuals (not restricted to the under-65) who are uninsured, and the 2013 baseline is determined by Census data, or other sources as determined by the Secretary, and certified by the CMS chief actuary. Administrative or judicial review of the factors is prohibited.

**Sec. 3134. Mis-valued codes under the physician fee schedule.**

Requires the Secretary periodically to use specified criteria to identify potentially mis-valued codes and to review and make appropriate adjustments in their assigned relative value units, including potentially consolidating individual services into bundled codes for payment. Requires the Secretary to establish a process to validate relative value units, including a sampling of codes meeting the specified criteria for being potentially mis-valued. Such review may include work elements (such as time, mental effort and professional judgment, technical skill and physical effort, and stress due to risk) and may include the pre, post and intra-service components of work. Adjustments made pursuant to these reviews must be budget neutral and may be implemented by program instruction.

The Secretary may conduct surveys and other data collection, employ analytic contractors, and use existing processes and other means to receive recommendations. Waives the Federal Advisory Committee Act (FACA) and the Federal Acquisition Regulation (FAR) (except for provisions related to confidentiality) for this section. Repeals section 4505(d) of the Balanced Budget Act of 1997 pertaining to requirements for developing practice expense relative value units and repeals SSA section 1868(a) pertaining to potentially overvalued codes.

Criteria for identifying potentially mis-valued codes include: codes (and families of codes) experiencing the fastest growth; codes that have experienced substantial changes in practice expenses; codes for new technologies or services within an appropriate period (such as three years) after their relative values are initially established; multiple codes that are frequently billed in conjunction with furnishing a

single service; codes with low relative values, particularly those that are often billed multiple times for a single treatment; and codes which have not been subject to review since the implementation of the Medicare RBRVS fee schedule.

**Sec. 3135. Modification of equipment utilization factor for advanced imaging services.**

For Medicare fee schedules established for 2011 and subsequent years, increases from 50% to 75% the utilization rate assumption for determining the practice expense relative value units in the methodology specified for expensive diagnostic imaging equipment under the final rule published by the Secretary in the Federal Register on November 25, 2009 (42 CFR 410 et al). Excludes reduced expenditures due to the change from the determination of budget neutrality.

For services furnished on or after 7/1/2010, increases the reduction in payments attributable to the multiple procedure payment reduction applicable to the technical component for imaging under the final rule published by the Secretary in the Federal Register on November 21, 2005 (part 405 of title 42, Code of Federal Regulations) from 25% to 50%. Excludes reduced expenditures due to the change from the determination of budget neutrality, but not for services furnished before 7/1/2010.

By 1/1/2013, requires the CMS chief actuary to make publicly available an analysis of whether the cumulative reduction in expenditures due to the above changes exceeds \$3 billion for the period 2010 to 2019.

**Sec. 3136. Revision of payment for power-driven wheelchairs.**

Restricts the Medicare option to purchase power-driven wheelchairs when they are initially supplied to complex, rehabilitative power-driven wheelchairs. The purchase option is eliminated for other power-driven wheelchairs, which will be reimbursed on a rental basis with ownership title transferring to the individual after 13 months of continuous use. Changes the monthly rental payment amounts for power-driven wheelchairs to 15% of the purchase price for the first 3 months and 6% for the remaining 10 months; the current amounts are 10% and 7.5%, respectively. Change is effective for power-driven wheelchairs furnished on or after 1/1/2011, but does not apply to competitive bid contracts entered into before 1/1/2011.

**Sec. 3137. Hospital wage index improvement (as modified by sec. 10317).**

Extends the hospital reclassifications authorized by Section 508 of the MMA until 9/30/2010 and requires use of the wage index promulgated 8/27/2009 (74 Federal Register 43754), with any subsequent corrections and with two exceptions: 1) effective 4/1/2010, the Secretary will include the average hourly wage data of hospitals whose reclassification is extended only if this results in a higher applicable reclassified wage index; and 2) for a hospital whose reclassification is extended and whose wage index for the period 10/1/2009 to 3/31/2010 is lower than the wage index beginning on 4/1/2010 due to exception 1), the Secretary will make an additional payment equal to the difference for that period.

Requires the Secretary to report to Congress by 12/31/2011 with a plan, developed with stakeholder consultation, to comprehensively reform the Medicare inpatient hospital wage index system taking into account the goals set forth in the June 2007 MedPAC report. Beginning in FY 2011 and continuing until the fiscal year that is one year after the report is submitted to Congress, requires decisions on wage index reclassification

requests to use the average hourly wage comparison criteria in effect on 9/30/2008; the requirement is to be implemented budget neutrally.

**Sec. 3138. Treatment of certain cancer hospitals.**

Requires the Secretary: 1) to conduct a study to determine if costs incurred under the Medicare hospital outpatient prospective payment system by cancer hospitals excluded from the hospital inpatient prospective payment system exceed the costs incurred by other hospitals; and 2) to provide for an appropriate budget neutral adjustment beginning 1/1/2011 if their costs are found to be higher. Requires that the study take into consideration the cost of drugs and biologicals.

**Sec. 3139. Payment for biosimilar biological products.**

Effective 6/1/2010, provides that the average sales price (ASP) for a biosimilar biological product will be calculated according to the methodology used to calculate the ASP for multiple source drugs and that the 6% add-on portion of the Medicare Part B payment will be equal to 6% of the ASP of the reference biological, not 6% of the ASP of the biosimilar.

**Sec. 3140. Medicare hospice concurrent care demonstration program.**

Requires a 3-year demonstration program involving not more than 15 hospice programs representing urban and rural areas to test furnishing Medicare beneficiaries, during the same period, both hospice care and any other covered Medicare items and services from funds that would otherwise be paid to the participating hospice programs through the hospice benefit. Requires budget neutrality over the 3-year period considering all Medicare services. Requires an independent evaluation and report to Congress with recommendations.

**Sec. 3141. Application of budget neutrality on a national basis in the calculation of the Medicare hospital wage index floor.**

Effective 10/1/2010, requires that budget neutrality for the wage index floor be applied through a national, uniform adjustment, as it was applied in FY 2008, rather than the state-level adjustment that was adopted beginning in FY 2009. The referenced floor, enacted in the Balanced Budget Act of 1997, provides that the wage index for a geographic area in a state cannot be less than the wage index applicable to rural areas in the state.

**Sec. 3142. HHS study on urban Medicare-dependent hospitals (MDH).**

Directs the Secretary to study the need for an additional payment in the inpatient prospective payment system for urban MDHs, including whether the adjustment applicable to Medicare-dependent small rural hospitals should be applied to urban MDHs. Defines an urban MDH to be a hospital with more than 60 percent of its inpatient days or discharges during 2 of the 3 most recently audited and settled cost reporting periods are attributable to Medicare patients. The hospital also must not receive any other Medicare payment adjustments, such as indirect medical education (IME), disproportionate share (DSH), or the special payments made to rural referral centers, sole community hospitals, Medicare-dependent small rural hospitals or critical access hospitals.

**Sec. 3143. Protecting home health benefits.**

States that: *"Nothing in the provisions of, or amendments made by, this Act shall result in the reduction of guaranteed home health benefits under title XVIII of the Social Security Act."*

**Sec. 10325. Revision to skilled nursing facility prospective payment system.**

Prohibits the Secretary from implementing Version 4 of the Resource Utilization Groups (referred to as "RUG-IV"), published in the Federal Register on 8/11/2009, prior to 10/1/2011. Beginning 10/1/2010, requires the Secretary to implement the RUG-IV change specific to therapy furnished on a concurrent basis and also implement changes to the look-back period to ensure that only services furnished after admission to a SNF are used as factors in determining case mix classification. Includes a rule of construction that the changes are not be interpreted as delaying implementation of Version 3.0 of the Minimum Data Set (MDS 3.0) beyond 10/1/2010.

**Subtitle C—Provisions Relating to Part C****Sec. 3201. Medicare Advantage payment (replaced by sec. 1102(b) of HCERA).**

For 2011, provides for a one-year freeze in benchmarks for MA local plans using 2010 benchmarks.

New benchmarks for local plans:

After 2011, transitions from pre-HCERA benchmark methodology to new blended benchmark methodology using area percentages of local fee-for-service spending, adjusted to apply the phase-out of IME costs. The percentages are arrayed in quartiles, from lowest to highest in area fee-for-service spending, as follows: 115%, 107.5%, 100%, and 95% of the local fee-for-service levels. For those plans that qualify for quality bonuses, provides for an increase in these percentages--see below. Sets an overall cap on the amount of the new blended benchmark for an area and year on the benchmark that would have been calculated for that area and year using the pre-HCERA benchmark methodology.

2012: 50/50 blend of pre-HCERA benchmark and new blended benchmark.

2013 and after: 100% new blended benchmark.

Provides for alternative phase-ins of new blended benchmark methodology. If benchmarks for 2010 (as determined under the pre-HCERA methodology and a projected application of the new methodology for 2010) differ by more than \$30, then a 4-year phase-in applies, and if by more than \$50, then a 6-year phase-in applies.

Beginning in 2012, provides for new quality incentive payments for plans with quality ratings of 4 or more stars on a 5-star system. Increases quartile percentages by 1.5, 3.0, and 5.0 percentage points in 2012, 2013, and 2014 (and subsequent years), respectively (or twice that amount for qualifying plans in urban floor counties with at least 25% MA penetration and with costs below national average FFS). Permits a plan that did not qualify due to low enrollment to be eligible for bonus payment. For new plans (i.e. those that have not been offered in the previous 3 years), increases quartile percentages by 1.5, 2.5, and 3.5 percentage points in 2012, 2013, and 2014 (and subsequent years), respectively.

Exempts PACE programs from new blended benchmark methodology and excludes them from quality bonuses. Repeals the Comparative Cost Adjustment program that was scheduled to begin in 2010.

**Sec. 3202. Benefit protection and simplification (as modified by sec. 1102(d) of HCERA).**

Limits the cost-sharing that an MA plan may impose to no more than would apply under the FFS Medicare program for chemotherapy, renal dialysis, skilled nursing care, and such other services that the Secretary determines appropriate (including those that the Secretary determines require a high level of predictability and transparency for beneficiaries). Permits MA plans to charge non-discriminatory levels of cost sharing for Medicare-covered services where there is no cost sharing under the original FFS program. Effective for plan years beginning on or after 1/1/2011.

Beginning with 2012, phases-in the beneficiary rebate calculation (i.e., the % of the excess of the Medicare capitated payment amount over the plan premium which the plan is required to rebate to enrollees; the government retains the remainder) over a 3-year period and bases the amount of rebate on the percentage system used for quality incentive payments. At the end of the phase-in, a plan with at least 4.5 stars will have a beneficiary rebate percentage of 70 percent, a plan with between 3.5 and 4.5 stars will have a rebate percentage of 65 percent, and a plan with less than 3.5 stars will have a beneficiary rebate percentage of 50 percent. Treats low-enrollment plans as having a 4.5 star rating and new plans as having a 3.5 star rating.

HCERA struck requirements on plans for the form and priority of use of rebate payments.

**Sec. 3203. Application of coding intensity adjustment during MA payment transition (as modified by 1102(e) of HCERA).**

Makes permanent the Secretary's authority to adjust and update risk adjustment to MA plan payments for coding intensity. Requires minimum adjustments beginning in 2014, and, starting in 2019, sets the minimum adjustment at 5.7 percent until the Secretary implements risk adjustment based on MA diagnostic, cost, and use data. This also applies with respect to PACE programs.

**Sec. 3204. Simplification of annual beneficiary election periods.**

Changes (and lengthens) the annual coordinated election period from November 15 through December 31 to October 15 through December 7. Effective beginning in 2012.

Eliminates the one-time change of enrollment option under which new MA enrollees are currently permitted to change their selection during the first three months of the year.

Provides instead for a limited disenrollment period from January 1 through February 15 for an individual enrolled in an MA plan to instead elect coverage under original Medicare and to enroll in a Medicare prescription drug plan. Effective beginning in 2011.

**Sec. 3205. Extension for specialized MA plans (SNPs) for special needs individuals.**

Provides for improvements to risk adjustment for special needs individuals with chronic conditions. Beginning in 2011, requires the Secretary to use a risk score for new enrollees in chronic care SNPs that reflects the known underlying risk profile and chronic health status of similar individuals. Applies this risk score in lieu of the default risk score for new enrollees of non-SNP MA plans.

Extends SNP authority through 12/31/2013. Requires the Secretary to transition enrollees who do not meet the definitions for a SNP to other MA plans or to original Medicare if they do not meet the definitions by 2013. Permits the Secretary to make exceptions for dual-eligible beneficiaries who lost their Medicaid status in order to give them time to reapply for Medicaid benefits.

Provides the Secretary authority to provide a frailty adjustment for fully-integrated dual-eligible SNPs that have similar average levels of frail beneficiaries as PACE plans, as defined by the Secretary. Limits this authority so that the Secretary is only able to adjust payments to dual-eligible SNPs that fully integrate benefits covered under Titles XVIII and XIX of the SSA. To qualify, dual-eligible SNPs are required to integrate Medicare and Medicaid benefits and payments through an MA contract with the Secretary and a contract with the state Medicaid agency that includes the provision of long-term care.

Extends, until 12/31/2012, a provision in MIPPA that granted SNPs that serve dual-eligible beneficiaries temporary authority to continue to operate even though they have not established contracts with state Medicaid programs. Beginning in 2012, SNPs must be approved by the National Committee for Quality Assurance (NCQA) in order to serve targeted populations.

For 2011 and periodically thereafter, requires the Secretary to evaluate and revise the methodology used to risk adjust MA plan payments in order to as accurately as possible account for higher medical and care coordination costs associated with frailty; individuals with multiple, co-morbid chronic conditions; enrollees with a mental illness diagnosis; and also to account for costs that may be associated with higher concentrations of beneficiaries with these conditions.

**Sec. 3206. Extension of reasonable cost contracts.**

Extends Medicare reasonable cost contracts to 1/1/2013, regardless of any other MA plans serving the area.

**Sec. 3207. Technical correction to MA private fee-for-service plans.**

Beginning for plan year 2011, permits the Secretary to grant employer-based private FFS plans (PFFS) a waiver from the network requirements in a manner similar to the Secretary's authority to waive or modify other MA requirements for employer-based coordinated care plans. Only employer-direct PFFS plans that had enrollment as of October 1, 2009 would be eligible for the waiver.

**Sec. 3208. Making senior housing facility demonstration permanent.**

Permits MA plans that meet specific criteria to limit their service areas to a senior housing facility within a geographic area. Provides that MA plans are eligible if they serve beneficiaries who reside in a continuing care retirement community, have a sufficient number of on-site primary care providers as determined by the Secretary, supply transportation benefits to other providers, and were in existence under a demonstration for at least one year by 12/31/2010. Applies to plan years beginning after 2009.

**Sec. 3209. Authority to deny plan bids.**

Provides that nothing relating to the review of MA plan bids should be construed as requiring the Secretary to accept any or every bid by an MA organization. Authorizes the

Secretary to deny bids that propose significant increases in cost-sharing or decreases in benefits offered under the plan. Applies to bids for contract years beginning on or after 1/1/2011. Applies also to Medicare Part D plan (PDP) bids (see below).

Authorizes the Secretary to reject bids submitted by a PDP sponsor in the same manner as bids may be rejected under Medicare Advantage. Applies for contract years beginning on or after 1/1/2011.

**Sec. 3210. Development of new standards for certain Medigap plans.**

Section 3506 of the bill amends the Public Health Service Act to establish standards and authorize grants for patient decision aids. Directs the Secretary to request the National Association of Insurance Commissioners (NAIC) to review, revise and update Medigap standardized benefit packages “C” and “F” to include nominal cost sharing to encourage the use of appropriate Medicare Part B physician services. Revisions to be based on published evidence or evidence from integrated delivery systems regarding how cost sharing affects use of appropriate physician care. To the extent practicable, the new standards are to be implemented for benefit packages as of 1/1/2015.

**Sec. 1103 of HCERA. Savings from limits on MA plan administrative costs.**

Requires MA plans to maintain minimum medical loss ratios (MLR) of 85%. Imposes penalties for failure to meet MLR requirements: financial with respect to each failure year, limits on new enrollment for plans with 3 consecutive failure years, and termination for plans with 5 consecutive failure years. Medical loss ratio is not defined. Applies to contract years beginning after 2013.

**Subtitle D—Medicare Part D Improvements for Prescription Drug Plans and MA–PD Plans**

**Sec. 3301. Medicare coverage gap discount program (as modified by sec. 1101 of HCERA).**

Medicare coverage gap discount program. Requires the Secretary to establish a Medicare coverage gap discount program by 1/1/2011. Requires the Secretary to enter into agreements meeting specific requirements with drug manufacturers and provide for the performance of specified duties. Requires the Secretary to establish a model agreement for use by the program no later than 9/19/2010, in consultation with manufacturers, and allow for comment on such model agreement. Manufacturers must enter into these agreements by 30 days after the establishment of the model agreement for 2011.

Required discount. Requires manufacturer to give Part D enrollees access to discounted prices (defined as 50% of negotiated prices) on brand-name drugs and biologics that are covered under Part D and are on PDP formularies or are treated as being on PDP formularies through exceptions and appeals processes. Makes the discount available during the entire coverage gap, i.e., at the point where total annual prescription costs of a beneficiary exceed the initial coverage limit (\$2,700 in 2009) until they reach the catastrophic coverage limit (\$6,153 in 2009). Provides that once the prescription costs of a beneficiary exceed the catastrophic limit, the discount ends (and the catastrophic portion of the drug benefit to apply as under current law). Effective as of 1/1/2011.

Eligible beneficiaries. Applies the discount program to Medicare beneficiaries who enroll in Part D, do not qualify for the low-income subsidy, and are not enrolled in an employee-sponsored retiree drug plan.

Discount amount. Provides that eligible beneficiaries automatically receive a 50% discount off the negotiated price for sole-source and multiple source brand-name drugs that are covered under Part D and covered by their plan's formulary or are treated as being on plan formularies through the exceptions and appeals processes. Defines the negotiated price to be the price that plans pay to pharmacies minus the amount of price concessions (i.e., rebates and discounts) that plans pass on to beneficiaries. Excludes dispensing fees from the negotiated price and from the discount (thus, beneficiaries who receive the discount continue to pay pharmacy dispensing fees as under current law).

Counting discount toward TrOOP. Provides that 100% of the negotiated price of discounted drugs (excluding dispensing fees) count toward the annual out-of-pocket threshold (TrOOP).

Beginning in 2011, phases-in a reduction in coinsurance in the coverage gap for eligible beneficiaries such that in 2020 the coinsurance rates for both brand name and generic drugs is 25%.

Reduces the rate by which the upper limit of the coverage gap (i.e., annual out-of-pocket threshold) increases each year.

Administration of the discount / manufacturer compliance. Requires manufacturers to discount drug prices at the pharmacy or through a mail order service. Permits the Secretary to provide for the discount after the point-of-sale for a temporary period until the necessary data systems are in place to implement the discount at the point-of-sale. Requires manufacturers to collect and have available appropriate data as determined by the Secretary to ensure compliance. Provides that discount agreements are effective for an initial period of not less than 18 months and automatically renewed for a period of not less than one year unless terminated.

Specifies compliance and enforcement and due process procedures. Permits manufacturers to terminate an agreement for any reason but the termination would not be effective until the end of the benefit year or the second benefit year if terminated after January 30 of a year.

Permits the Secretary to contract with a third party to administer the drug discount. Authorizes Secretary to assess fines (or program exclusion for repeated violations) in the case of manufacturers.

Provides a safe harbor from anti-kickback penalties for discounts provided under the program. Includes the discounts in the definition of best price for the Medicaid program.

Condition for coverage of Part D drugs. Requires a manufacturer to participate in the coverage gap program by entering into and having in effect an agreement meeting specified conditions for its drugs to be covered under Part D. Applies to covered part D drugs dispensed on or after 1/1/2011. Provides for an exception if the Secretary has determined that the availability of the drug is essential to the health of beneficiaries or that in 2011, there are extenuating circumstances.



**Sec. 3302. Improvement in determination of Medicare part D low-income benchmark premium.**

Excludes from determination of the low-income benchmark any reductions in premium attributable to beneficiary rebate or bonus payments. Effective for monthly premiums beginning in 2011.

**Sec. 3303. Voluntary de minimis policy for low income subsidy (LIS) eligible individuals under prescription drug plans and MA–PD plans.**

Directs the Secretary to develop procedures under which PDPs and MA-PDPs may waive the monthly premium for LIS eligible individuals if the amount of the premium is de minimus. If the premium is waived under these procedures, no reassignment of subsidy eligible individuals will occur based on the fact that the premium is greater than the LIS benchmark. The Secretary may auto-enroll LIS-eligible beneficiaries into these plans. Effective 1/1/2011.

**Sec. 3304. Special rule for widows and widowers regarding eligibility for low-income assistance.**

Determinations or redeterminations of eligibility for an LIS-eligible individual whose spouse has died are extended for one year. Effective 1/1/2011.

**Sec. 3305. Improved information for subsidy eligible individuals reassigned to prescription drug plans and MA–PD plans.**

Requires the Secretary within 30 days of reassignment, to provide LIS eligible individuals who are reassigned to a new Medicare drug plan with information on differences in the formularies of the new and former plans, and on beneficiary rights regarding reconsiderations, grievances and appeals.

**Sec. 3306. Funding outreach and assistance for low-income programs..**

Provides \$45 million in additional funding for state Health Insurance Programs, Area Agencies on Aging, Aging and Disability Resource Centers, and the contract for the National Center for Outreach and Enrollment. Funds provided for 2010-2012 and to remain available until expended. Secretary may request that these organizations use these funds to conduct outreach on disease prevention and wellness promotion.

**Sec. 3307. Improving formulary requirements for prescription drug plans and MA–PD plans with respect to certain categories or classes of drugs.**

Requires the Secretary to identify, as appropriate, categories and classes of drugs which the Secretary determines are of clinical concern, using criteria established by the Secretary. Requires such criteria and any exceptions to be established through the promulgation of a regulation including a public notice and comment period. Requires a PDP sponsor offering a PDP to include all covered Part D drugs in the categories and classes identified by the Secretary to be of clinical concern under a process specified in this section. Permits the Secretary to provide for exceptions that permit a PDP sponsor to exclude from its formulary a particular covered Part D drug in a category or class that is otherwise required to be in the formulary or to otherwise limit access to such a drug including through prior authorization or utilization management.

Codifies the existing 6 protected drug classes: anticonvulsants, antidepressants, antineoplastics, antipsychotics, antiretrovirals and immunosuppressants for treatment of transplant rejection.

Applies to plan year 2011 and subsequent plan years.

**Sec. 3308. Reducing part D premium subsidy for high-income beneficiaries.**

Reduces, beginning in 2011, the Medicare Part D premium subsidy for beneficiaries whose modified adjusted gross income (MAGI) exceeds the thresholds used under Part B (\$85,000 individual/\$170,000 couple in 2009.) Instead of setting the premium subsidy at 74.5% of total Part D premiums, decreases the premium subsidy to reflect the percentages used to decrease the Part B premium subsidy. (For individual MAGIs in 2007, the income-related beneficiary share of total Part B costs were: 35% for incomes between \$80,000 and \$100,000, 50% for incomes between \$100,000 and \$150,000, 65% for incomes between \$150,000 and \$200,000, and 80% for income greater than \$200,000.) Income thresholds for couples filing jointly are twice these dollar amounts. (These income thresholds are per 2007 tax returns and have been inflated by the CPI for 2008 and 2009.) Provides, in section 3402, for inflating income thresholds by the CPI, except for between 2010 and 2019, when income thresholds are not updated.

Expands current authority for the IRS to disclose income information to SSA for purposes of adjusting the Part B subsidy to include the Part D subsidy and related appeals. Provides for the collection of any premium increase through withholding of Social Security benefit payments.

**Sec. 3309. Elimination of cost sharing for certain dual eligible individuals.**

Eliminates Part D cost sharing for full-benefit dual eligibles who would require institutional care but for provision of home and community based care under Medicaid. Effective on a date specified by the Secretary no earlier than 1/1/2012.

**Sec. 3310. Reducing wasteful dispensing of outpatient prescription drugs in long-term care facilities under prescription drug plans and MA-PD plans.**

Beginning for plan years on or after 1/1/2012, requires a PDP sponsor to utilize specific, uniform dispensing techniques, as determined by the Secretary, in consultation with relevant stakeholders (including representatives of nursing facilities, pharmacists, the pharmacy industry (including retail and long-term care pharmacy), PDPs, MA-PDs and any other stakeholders) determined appropriate by the Secretary, such as weekly, daily or automated dose dispensing when dispensing covered Part D drugs to enrollees in a long-term care facility to reduce waste associated with 30-day fills.

**Sec. 3311. Improved Medicare prescription drug plan and MA-PD plan complaint system.**

Requires the Secretary to develop and maintain a complaint system, widely known and easy to use, to collect and maintain information on MA-PDs and PDP complaints that are received by the Secretary (including by a regional HHS office, the Medicare Beneficiary Ombudsman, a subcontractor, carrier, FI, and a Medicare administrative contractor) through the date on which the complaint is resolved. Requires the system to be able to report and initiate appropriate interventions and monitoring based on substantial complaints and to guide quality improvement. Requires the Secretary to develop a model electronic complaint form that is displayed prominently on Medicare.gov and the website of the Medicare Beneficiary Ombudsman. Requires annual reporting to

Congress on the system with an analysis of the number and types of complaints, geographic variations in such complaints, timeliness of agency or plan responses and resolution.

**Sec. 3312. Uniform exceptions and appeals process for prescription drug plans and MA–PD plans.**

Requires each PDP sponsor of a PDP to use a single, uniform exceptions and appeals process (including a uniform model form, to the extent determined feasible by the Secretary) with respect to the determination of PDP coverage for an enrollee under the plan and to provide instant access to this process by enrollees through a toll-free telephone number and an Internet website. Applies to exceptions and appeals made on or after 1/1/2012. Appears to apply to PACE programs.

**Sec. 3313. Office of the Inspector General (OIG) studies and reports.**

Requires the HHS OIG to conduct a study of the extent to which formularies used by PDPs and MA-PDs include drugs commonly used by full-benefit dual eligible beneficiaries. Beginning with 2011, requires the OIG to report to Congress with recommendations as appropriate. Also requires the OIG to study prices for covered Part D drugs under the Medicare prescription drug program and for covered outpatient drugs under Medicaid. Requires the study to compare, for the 200 most frequently dispensed covered Part D drugs and Medicaid covered outpatient drugs (based on volume and expenditures) the prices paid by PDP sponsors and MAOs offering PD plans and the prices paid by a state plan under Medicaid; and an assessment of the financial impact of any such price discrepancies on the Federal government and on Part D enrollees or individuals eligible for Medicaid. Defines “price” and authorizes the OIG to collect any information related to the prices of Part D drugs and covered outpatient drugs under Medicaid necessary to carry out the comparison. Requires the OIG to report no later than 10/1/2011 the results of the study and recommendations for legislation and administrative action determined by the OIG to be appropriate. Prohibits the report from including proprietary information or information that is likely to impact the ability of a PDP sponsor or state to negotiate prices for covered drugs.

**Sec. 3314. Including costs incurred by AIDS drug assistance programs and Indian Health Service in providing prescription drugs toward the annual out-of-pocket threshold under part D.**

Requires that, effective for costs incurred on or after 1/1/2011, costs that are incurred by AIDS Drug Assistance Programs (ADAP) and the Indian Health Service (IHS) in providing prescription drugs to a beneficiary enrolled in a Part D plan count toward the calculation of the enrollee’s true out-of-pocket (TrOOP) threshold (which triggers the catastrophic benefit).

**Sec. 3315. Immediate reduction in coverage gap in 2010 (as superseded by sec. 1101(a) of HCERA).**

Provides for the Secretary to make a single \$250 rebate payment to a Medicare beneficiary who reaches the Part D coverage gap (donut hole) in 2010. The payments will be made from the Medicare Prescription Drug Account.

**Sec. 10328. Improvement in part D medication therapy management (MTM) programs.**

For plan years beginning after 2012, PDP sponsors must offer medication therapy management (MTM) services to Part D enrollees who have multiple chronic conditions,

who take multiple covered Part D drugs, and who incur annual costs for those drugs above a CMS set threshold. Those services include 1) annual face-to-face (or by telehealth) comprehensive medication review, and written post-review summary, by pharmacists or other qualified providers, which may include a medication action plan, and 2) follow-up interventions face-to-face or by telehealth.

PDP sponsors must have in place a process for quarterly review of medication use of enrollees who are at risk but not enrolled in MTM programs, including those who experienced care transitions, if the sponsor has access to that information.

PDP sponsors must have in place an auto-enrollment process for MTM services for enrollees described above that also permits enrollees to opt out.

Rule of construction clarifies that CMS may broaden or modify services required under MTM programs, and may study such programs in the new CMS Innovation Center.

### **Subtitle E—Ensuring Medicare Sustainability**

#### **Sec. 3401. Revision of certain market basket updates and incorporation of productivity improvements into market basket updates that do not already incorporate such improvements (as modified by sec. 10319 and sec. 1105 of HCERA).**

Inpatient and outpatient hospitals, inpatient rehabilitation facilities, and psychiatric hospitals and units. Reduces the annual Medicare payment update by 0.25 percentage points in 2010 and 2011 for inpatient and outpatient hospitals, inpatient rehabilitation facilities and psychiatric hospitals and units. Reduces the update for these providers by 0.1 percentage points in 2012-2013, by 0.3 percentage points in 2014, by 0.2 percentage points in 2015-2016, and by 0.75 percentage points in 2017-2019. The adjustments are applied based on the fiscal year, calendar year or rate year as applicable for the particular provider type. The reductions are applied after applicable adjustments for productivity (described below) and for failure to report quality measures or to be a meaningful user of electronic health records (for inpatient acute hospitals after 2015). The reductions may cause a negative update and may result in payment rates for a year being less than the payment rates for the preceding year.

Long term care hospitals. For long term care hospitals, the reduction applicable to each rate year is 0.25 percentage points in 2010, 0.5 percentage points in 2011, 0.1 percentage points in 2012-2013, 0.3 percentage points in 2014, 0.2 percentage points in 2015-2016, and 0.75 percentage points in 2017-2019. The reductions may cause a negative update and may result in payment rates for a rate year being less than the payment rates for the preceding rate year.

Home health agencies. Hospice providers, Skilled nursing facilities (SNFs). Reduces the market basket update for home health agencies by 1.0 percentage point in 2011 through 2013 and reduces the update for hospice providers by 0.3 percentage points in fiscal years 2013-2019 in addition to the productivity adjustments described below. Reductions may cause a negative update and may result in payment rates for a year being less than the payment rates for the preceding year. In 2014-2019, the 0.3 percentage point reduction applicable to hospice providers is waived if in any year from 2014-2019, the previous year's total percentage of insured population (as reflected in the share of the total, non-elderly population) is more than five percentage points below CBO projections

of such percentage at the time of bill enactment. No change in current law updates for SNFs other than the productivity adjustment described below.

Laboratory services. Eliminates the 0.5 percentage point reduction applicable to laboratory services in fiscal years 2011-2013 and implements a reduction of 1.75 percentage points in fiscal years 2011-2015 in addition to the productivity adjustment described below, which applies to laboratory services beginning in FY 2011. The 1.75 percentage point reduction may cause a negative update and may result in payment rates for a fiscal year being less than the payment rates for the preceding fiscal year, but the productivity offset is not applied if the otherwise applicable update is 0.0 or negative and its application cannot cause the update to be negative. (The restriction on application of the productivity adjustment applies only to laboratory services).

Productivity adjustment. Implements a productivity adjustment to the market basket update for inpatient and outpatient hospitals, inpatient rehabilitation facilities, psychiatric hospitals and units, long term care hospital services and SNFs beginning in calendar, fiscal or rate year 2012, as applicable. Eliminates the one percentage point reduction applicable to renal dialysis facilities in 2012 and subsequent years and applies a productivity adjustment beginning in 2012. Applies a productivity adjustment to the update for hospice providers beginning in FY 2013 and to the update for home health agencies beginning in 2015.

Beginning in 2011, applies a productivity adjustment to consumer price index (CPI) updates for these Part B items and services: ambulance, laboratory, ambulatory surgical center, durable medical equipment, prosthetic devices, orthotics and prosthetics, and any fee schedules applicable to medical supplies, home dialysis supplies and equipment, therapeutic shoes, parenteral and enteral nutrients, equipment, and supplies, electromyogram devices, salivation devices, blood products, and transfusion medicine.

The productivity adjustment is the 10-year moving average of changes in annual economy-wide private non-farm business multi-factor productivity (as projected by the Secretary for the 10-year period ending with the applicable year, fiscal year, cost reporting period, or other annual period).

Except for laboratory services, the productivity adjustments may cause a negative update and may result in payment rates for a year being less than the payment rates for the preceding year.

**Sec. 3402. Temporary adjustment to the calculation of part B premiums.**

For the period 1/1/2011 to 12/31/2019, freezes the current income thresholds and income ranges used to determine the income-related Medicare Part B premium rather than increasing them each year with changes in the consumer price index.

**Sec. 3403. Independent Medicare Advisory Board (as modified by sec. 10320).**

Establishes an Independent Payment Advisory Board to make recommendations and develop proposals to extend Medicare solvency, reduce the rate of per capita Medicare spending, and improve the quality of care in Medicare. Also requires the Board to make annual recommendations on actions to improve quality and constrain the rate of cost growth in the private sector.

Beginning in 2014 and continuing in subsequent years, the Board submits a draft report to MedPAC and to the Secretary by September 1 of each year (except as noted below) with a proposal to reduce Medicare spending by targeted amounts compared to current law and presents a final proposal to Congress and the President by the following January 15. For proposal years 2014-2018, the requirement to submit a proposal does not apply if the growth rate in per capita Medicare spending for Parts A, B, and D is less than the target growth rate or in which the percentage increase in the CPI-M (medical care) is less than the percentage increase in the CPI. Beginning with proposal year 2019, requires the Board to submit a proposal to Congress in years in which the growth rate in per capita Medicare spending is less than the growth rate in national health expenditures.

The Board's proposal cannot include changes that would ration health care; increase revenues, beneficiary premiums or cost-sharing; restrict benefits; or modify eligibility criteria and prior to 12/31/2018, it cannot recommend Medicare payment rate reductions for items and services, furnished before 12/31/2019, by providers and suppliers subject to update reductions (other than the productivity offset) under section 3401 of the legislation. This exclusion affects inpatient and outpatient hospitals, inpatient rehabilitation and inpatient psychiatric facilities, long term care hospitals, home health agencies, hospice programs, and clinical laboratory services. The Board may, however, submit advisory reports to Congress that include recommendations affecting payments for the providers and suppliers who otherwise are excluded from the Board's scope prior to 2020. These advisory recommendations, however, are not subject to the rules for congressional consideration described below.

The Board's proposal may include recommendations to reduce payments under Medicare Parts C and D, such as reductions in direct subsidy payments to Medicare Advantage and Medicare prescription drug plans under paragraphs (1) and (2) of SSA section 1860D-15(a) that are related to administrative expenses (including profits) for basic coverage; denying high bids or removing high bids for prescription drug coverage from the calculation of the national average monthly bid amount; and reductions in payments to Medicare Advantage plans under clauses (i) and (ii) of SSA section 1853(a)(1)(B) that are related to administrative expenses (including profits) and performance bonuses for Medicare Advantage plans under SSA section 1853(n). Any recommendation shall not affect the base beneficiary premium percentage specified under SSA section 1860D-13(a) or the full premium subsidies for low-income Medicare beneficiaries under SSA section 1860D-14(a).

Targeted reduction amounts are established by analyses of the CMS chief actuary comparing the 5-year average rate of growth in per capita Medicare spending for Parts A, B, and D with the 5-year average rate of change of the CPI and CPI-M averaged. Beginning in 2018, the target growth rate is the nominal gross domestic product per capita plus 1.0 percentage point. The Board must submit proposals to eliminate excess Medicare per capita spending growth above the target growth rate or to reduce it by 0.5 percentage points in 2015 if the excess is greater than 0.5%. The actuary's first analysis is due 4/30/2013, with projections for 2015. The Board's initial draft proposals are due to MedPAC and the Secretary on 9/1/2013 and must be submitted to the President by 1/15/2014 for transmission to Congress within 2 days. The Secretary must submit a proposal to Congress and the President (with a copy to MedPAC) by 1/25/2014 to achieve the same level of reduction if the Board fails to submit a proposal.

Provides for expedited congressional consideration with several specified dates and rules to limit debate and amendments. If a Congressional committee with jurisdiction fails to report a legislative package achieving the targeted level of savings by 4/1/2014, the Board's package is automatically discharged from that committee. Except as noted below, the Board's original proposal goes into effect automatically if a package that meets the required level of Medicare savings described above is not enacted by August 15 of the applicable year beginning in 2014. For years beginning with 2019, the proposal does not take effect automatically absent congressional action if the Medicare growth rate is less than the rate of growth in national health expenditures and if this exception did not apply in the immediate prior year. The proposal may be implemented through interim final rulemaking. Prohibits administrative and judicial review.

Requires the Board to make additional proposals on January 15<sup>th</sup> of 2015, 2016 and 2017, following the same process but with higher savings targets each year. The proposal due to Congress in 2015 must reduce excess cost growth by up to 1.0 percentage point in 2016. The proposal due in 2016 must reduce excess cost growth by up to 1.25 percentage points in 2017. The proposal due in 2017 must reduce excess cost growth by up to 1.5 percentage points in 2018.

Provides a direct appropriation to the Board from the Medicare Trust Funds (60% from Part A, 40% from Part B) of \$15 million in FY 2012; for subsequent years, the direct appropriation equals the prior year's amount increased by the CPI.

Provides for consideration of a joint resolution of Congress to approve "the discontinuation of the process for consideration and automatic implementation of the annual proposal of the Independent Payment Advisory Board. Requires the resolution to be introduced by 2/1/2017 and approved by 60% of each chamber's membership by 8/15/2017.

The Board is to have 15 members, appointed by the President, confirmed by the Senate and serving six-year, staggered terms. The Secretary of HHS, Administrator of CMS and the Administrator of the Health Resources and Services Administration (HRSA) are ex officio, non-voting members. MedPAC continues in its current form as an advisory body to Congress. Also establishes a Consumer Advisory Council comprised of 10 consumer representatives (one from each region) to advise the Board.

Beginning 7/1/2014, requires the Board to produce an annual public report with standardized information on system-wide health care costs, patient access to care, utilization, and quality-of-care, including comparison by region, types of services, types of providers, for both Medicare and private payers. Reports also will include information on epidemiological shifts and demographic changes and on the proliferation, effectiveness, and utilization of health care technologies, including variation in provider practice patterns and costs.

Beginning 1/15/2015, requires the Board to submit recommendations biannually to Congress and the President to slow the growth in national health expenditures (excluding expenditures in Medicare and other Federal health care programs) while preserving or enhancing quality of care. Recommendations may encompass Federal programs, state and local governments, and private entities.

Requires GAO to evaluate changes made as a result of the Board's recommendations and to report to Congress by 7/1/2015. Directs GAO, in consultation with the committees having primary jurisdiction, to periodically conduct additional studies and submit reports to Congress as appropriate.

**Sec. 1109 of HCERA. Payment for qualifying hospitals.**

For fiscal years 2011 and 2012, provides an additional Medicare payment to inpatient PPS hospitals located in counties that rank in the lowest quartile of counties with respect to Medicare spending per enrollee under Parts A and B adjusted for age, sex and race. Sets aside \$400 million from the Medicare Hospital Insurance Trust Fund to make the additional payments over the two years. The amount of the additional payment for a hospital is determined by multiplying the total amount of funds available for allocation by its proportion of aggregate PPS payments to the aggregate amount of PPS payments for all qualifying hospitals.

**Subtitle F—Health Care Quality Improvements**

**Sec. 3501. Health care delivery system research; Quality improvement technical assistance.**

Requires AHRQ to work through a Center for Quality Improvement and Patient Safety to conduct research on innovative methods and strategies for quality improvement practices (best practices). The Center must also identify, develop, evaluate, disseminate, and provide training in best practices.

Functions of the Center include, among others, research in redesigns of systems of care, identification of health providers that deliver consistent high-quality efficient services, and translation of strategies and methods into best practices that are designed for use in variety of settings including, if applicable, across continuum of care. The Center is to support research to test, scale, and disseminate best practices.

In prioritizing research and dissemination activities, the Center must take into account the costs of federal health programs, consumer assessments of care, provider assessments of improvement activities, the impact of practices on patients, areas in which gaps are identified, and the evolution of HIT.

The Center must coordinate activities with the newly established CMS Centers for Medicare & Medicaid Innovation.

Authorizes \$20 million for FY 2010 through 2014 to carry out the activities of the Center described above.

The Center is to award grants to entities that demonstrate experience in providing technical support and assistance to health care providers regarding quality improvement and for the provision of technical assistance on implementation of a best practice model for health care providers. Grantees must meet a 20% matching requirement provided directly by the entity or through donations from public or private entities in cash or in-kind.

Director to evaluate grantees' performance and grantees must coordinate with HIT regional extension centers of the Office of National Coordinator for Health Information Technology (ONCHIT).



There is no authorization of appropriations for technical assistance grants.

**Sec. 3502. Establishing community health teams to support the patient-centered medical home (as modified by section 10321).**

Mandates a new grant or contract program to establish health teams that support primary care practices, including obstetrics and gynecology practices, to help them coordinate and manage care, including coordination of the appropriate use of complementary and alternative services to those who request such services and 24-hour care management and support during transitions in care settings. To be eligible to receive a grant or contract, an entity must be a state or state-designated entity, or an Indian Tribe or Tribal Organization. The grants or contracts are also to be used to provide capitated payments to primary care providers as determined by the Secretary. A primary care provider who contracts with a care team must: (1) provide a care plan to the care team for each patient participant; (2) provide access to participant health records; and (3) meet regularly with the care team to ensure integration of care. Primary care is defined as “the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community.”

**Sec. 3503. Medication management services in treatment of chronic disease.**

Creates a program to support medication management services by local health providers. Medication management services will help manage chronic disease, reduce medical errors, and improve patient adherence to therapies while reducing acute care costs and reducing hospital readmissions.

**Sec. 3504. Design and implementation of regionalized systems for emergency care.**

Provides funding to the Assistant Secretary for Preparedness and Response to support pilot projects that design, implement, and evaluate innovative models of regionalized, comprehensive, and accountable emergency care and trauma systems. Requires the HHS Secretary to support emergency medicine research, including pediatric emergency medicine research.

**Sec. 3505. Trauma care centers and service availability.**

Reauthorizes and improves the trauma care program, providing grants administered by the HHS Secretary to States and trauma centers to strengthen the nation’s trauma system. Grants are targeted to assist trauma care centers in underserved areas susceptible to funding and workforce shortages.

**Sec. 3506. Program to facilitate shared decisionmaking.**

Establishes a program at HHS for the development, testing, and disseminating of educational tools to help patients, caregivers, and authorized representatives understand their treatment options.

**Sec. 3507. Presentation of prescription drug benefit and risk information.**

Requires the Food and Drug Administration (FDA) to evaluate and determine if the use of drug fact boxes which would clearly communicate drug risks and benefits and support clinician and patient decision making in advertising and other forms of communication for prescription medications is warranted.

**Sec. 3508. Demonstration program to integrate quality improvement and patient safety training into clinical education of health professionals.**

Establishes a program at AHRQ to give grants to academic institutions to develop and implement academic curricula that integrate quality improvement and patient safety into health professionals' clinical education.

**Sec. 3509. Improving women's health.**

Provides for women's health offices at various Federal agencies to improve prevention, treatment, and research for women in health programs.

**Sec. 3510. Patient navigator program.**

Reauthorizes demonstration programs to provide patient navigator services within communities to assist patients overcome barriers to health services. The program facilitates care by assisting individuals coordinate health services and provider referrals, assists community organizations in helping individuals receive better access to care, provides information on clinical trials, and conducts outreach to health disparity populations.

**Sec. 3511. Authorization of appropriations.**

Authorizes to be appropriated such sums as may be necessary to carry out this subtitle (and any amendments made by this subtitle).

**Sec. 10333. Community-based collaborative care networks.**

Establishes a grant program to support consortia of health care providers (under a joint governance structure) to provide comprehensive coordinated and integrated care to low-income populations. Requires inclusion of all FQHCs in the community and a Medicaid DSH hospital. Authorizes such sums as are necessary to carry out the grant program for each of fiscal years 2011 through 2015.

**Sec. 10334. Minority health.**

Transfers the Office of Minority Health at HHS to the Office of the Secretary. Establishes Offices of Minority Health at the Centers for Disease Control and Prevention (CDC), HRSA, the Substance Abuse and Mental Health Services Administration (SAMHSA), AHRQ, the Food and Drug Administration (FDA), and CMS, and elevates the Office of Minority Health at the National Institutes of Health from a Center to an Institute. These offices will monitor health, health care trends, and quality of care among minority patients and evaluate the success of minority health programs and initiatives.

**Subtitle G—Protecting and Improving Guaranteed Medicare Benefits**

**Sec. 3601. Protecting and improving guaranteed Medicare benefits.**

Provides that nothing in the Act shall reduce Medicare benefits and that Medicare savings under this act shall benefit the Medicare program and Medicare beneficiaries.

**Sec. 3602. No cuts in guaranteed benefits.**

Provides that nothing in the Act shall result in the reduction or elimination of any benefits guaranteed by law to participants in the Medicare Advantage plans.

**Sec. 10323. Medicare coverage for individuals exposed to environmental health hazards.**

Deems certain environmental exposure affected individuals to be Medicare-eligible. Applies to individuals in the vicinity of Libby, Montana diagnosed with an asbestos-related condition, and could apply to individuals in other areas (diagnosed with a medical condition caused by exposure to a public health hazard) for which a future public health emergency declaration is made under section 104(a) of the Comprehensive Environmental Response, Compensation, and Liability Act of 1980. Authorizes a pilot program to provide innovative approaches to furnishing comprehensive, coordinated, and cost-effective care to such individuals, including coverage of items and services not otherwise covered under Medicare. No payments may be made under Medicare to the extent that the affected individuals are eligible to receive benefits through any other public or private benefits plan or legal agreement. Also authorizes a program of competitive grants for early detection of certain medical conditions related to environmental health hazards in geographic areas subject to emergency declarations.

**TITLE IV—PREVENTION OF CHRONIC DISEASE AND IMPROVING PUBLIC HEALTH****Subtitle A—Modernizing Disease Prevention and Public Health Systems****Sec. 4001. National Prevention, Health Promotion and Public Health Council.**

Mandates a National Prevention, Health Promotion and Public Health Council chaired by the Surgeon General and comprised of Department and agency heads from across the Federal Government. Not later than 3/23/2011, the Chairperson, in consultation with the Council, must develop and make public a national prevention, health promotion, and public health strategy and review and revise such strategy periodically. Not later than 7/1/2010 and annually thereafter through 1/1/2015, the Council must submit to the President and relevant Congressional committees a report describing Council activities and national progress in meeting prevention and health promotion goals, containing specific science-based initiatives to achieve the measurable goals of Healthy People 2010 regarding nutrition, exercise, and smoking cessation, and targeting the 5 leading disease killers in the United States, containing specific plans to consolidate or eliminate relevant Federal programs, and providing other specified information. Not less than every 5 years, the Secretary and the Comptroller General of the United States must jointly conduct reviews and evaluations of every Federal disease prevention and health promotion initiative, program, and agency. Also mandates an Advisory Group on Prevention, Health Promotion, and Integrative and Public Health, comprised of not more than 25 non-Federal members appointed by the President (and including a diverse group of licensed health professionals) to develop policy and program recommendations and advise the Council on lifestyle-based chronic disease prevention and management, integrative health care practices, and health promotion.

**Sec. 4002. Prevention and Public Health Fund.**

Appropriates a total of \$5 billion for FYs 2010 through 2014 and \$2 billion for FY 2015 and each FY thereafter for a Prevention and Public Health Fund to support prevention and public health programs to improve health and help restrain the rate of growth in private and public sector health care costs. Amounts in the Fund are to be transferred to accounts for programs authorized by the Public Health Service Act, such as the Community Transformation grant program, the Education and Outreach Campaign for Preventive Benefits, and immunization programs.

**Sec. 4003. Clinical and community preventive services.**

Provides more detailed statutory guidance for the creation and role of the existing Preventive Services Task Force, which reviews the scientific evidence related to the effectiveness, appropriateness, and cost-effectiveness of clinical preventive services for the purpose of developing and updating recommendations for the health care community to be published in the Guide to Clinical Preventive Services. Mandates a separate Community Preventive Services Task Force to review the evidence relating to community preventive interventions for the purpose of developing recommendations to be published in the Guide to Community Preventive Services for individuals and organizations delivering population-based services. Both task forces must submit yearly reports to Congress and related agencies identifying gaps in research and recommending priority areas that deserve further examination.

**Sec. 4004. Education and outreach campaign regarding preventive benefits.**

Directs the Secretary to provide for the planning and implementation of a national public-private partnership for a prevention and health promotion outreach and education campaign to raise public awareness of health improvement across the life span. Not later than 3/23/2011, the Secretary must establish and implement a national science-based media campaign on health promotion and disease prevention. Mandates an Internet website to provide science-based information to health care providers and consumers on guidelines for nutrition, regular exercise, obesity reduction, smoking cessation, and specific chronic disease prevention. Mandates development and operation of a Federal Internet website personalized prevention plan tool that allows individuals to determine their disease risk relating to the 5 leading diseases in the United States and obtain personalized suggestions for preventing such diseases, and an Internet portal for accessing risk-assessment tools developed and maintained by private and academic entities. Funding for the above activities is to take priority over funding for grants for similar purposes, and not more than \$500 million is to be spent on such activities. Directs the Secretary to provide guidance and relevant information to States and health care providers regarding preventive and obesity-related services that are available to Medicaid enrollees, directs each state to design a public awareness campaign to educate Medicaid enrollees regarding the availability and coverage of such services, and requires the first report to Congress on the status and effectiveness of these efforts no later than 1/1/2011.

**Subtitle B—Increasing Access to Clinical Preventive Services****Sec. 4101. School-based health centers (as modified by sec. 10402).**

Appropriates \$50 million for each of FYs 2010-2013 for grants for the establishment of school-based health centers. Funds may be used only for facilities (including the acquisition or improvement of land, or the acquisition, construction, expansion, replacement, or other improvement of any building or other facility), equipment, or similar expenditures, as specified by the Secretary (not for expenditures for personnel or to provide health services). Authorizes such sums for FYs 2010-2014 for grants for the operation of school-based health centers, requires such centers to provide comprehensive primary health services (including referrals to, and follow-up for, specialty care and oral and vision health services), defines various related terms, and specifies that funds may not be used to provide abortions. These funds may be used for acquiring and leasing equipment, providing training, the management and operation of health center programs, and the payment of salaries for physicians, nurses and other

personnel. Grants may also be awarded to pay for the costs associated with expanding and modernizing existing buildings for use as a school-based health center, including the purchase of trailers or manufactured buildings. Imposes a 20 percent matching requirement, which may be waived if it would impose a serious hardship.

**Sec. 4102. Oral healthcare prevention activities.**

Subject to the availability of appropriations, requires the Secretary to begin implementing a 5-year national, public education campaign that is focused on oral healthcare prevention and education, including prevention of oral cancer, not later than 3/23/2012. Authorizes grants to community-based providers of dental services to demonstrate the effectiveness of research-based dental caries disease management activities. Makes mandatory a currently discretionary school-based sealant program and requires the Secretary to award grants to each of the 50 states and territories and to Indian organizations. Directs the Secretary to enter into cooperative agreements with state, territorial, and Indian tribes or tribal organizations to establish oral health leadership and program guidance, oral health data collection and interpretation, a multi-dimensional delivery system for oral health, and to implement science-based programs to improve oral health. Requires the Secretary to update and improve the Pregnancy Risk Assessment and Monitoring System (PRAMS) as it relates to oral healthcare. Requires states to submit reports every 5 years (beginning not later than 3/23/2015) concerning activities conducted under the PRAMS. Also requires the Secretary to develop oral healthcare components that include tooth-level surveillance for inclusion in the National Health and Nutrition Examination Survey, and ensure that the Medical Expenditures Panel Survey includes the verification of dental utilization, expenditures, and coverage findings through conduct of a look-back analysis. Authorizes such sums for FYs 2010-2014 to increase the participation of states in the National Oral Health Surveillance System from 16 states to all 50 states, territories, and District of Columbia, and requires the Secretary to ensure that the system includes the measurement of early childhood caries.

**Sec. 4103. Medicare coverage of annual wellness visit providing a personalized prevention plan (as modified by sec. 10402).**

Effective 1/1/2011, authorizes Medicare coverage of personalized prevention plan services, including a health risk assessment and the furnishing of personalized health advice and a referral, as appropriate, to health education or preventive counseling services. The services may be furnished by: (1) a physician, (2) a nurse practitioner, clinical nurse specialist or physician assistant, or (3) a medical professional (including a health educator, registered dietitian, or nutrition professional) or a team of medical professionals, as determined appropriate by the Secretary, under the supervision of a physician. Not later than 3/23/2011, the Secretary must establish publicly available guidelines for health risk assessments, which may be furnished through an interactive telephonic or web-based program. Not later than 9/23/2011, the Secretary must develop a health risk assessment model. A Medicare beneficiary is eligible to receive personalized prevention plan services each year provided the beneficiary has not received such services or a "Welcome to Medicare" physical within the preceding 12-months. Medicare payment to the provider will be at 100 percent of the physician fee schedule amount (that is, no deductible, no coinsurance) even when the services are provided in a hospital outpatient setting.

**Sec. 4104. Removal of barriers to preventive services in Medicare (as modified by sec. 10406).**

Eliminates cost sharing requirements for Medicare covered preventive services that are recommended (rated A or B) by the U.S. Preventive Services Task Force. Effective 1/1/2011, waives deductible for colorectal cancer screening tests regardless of coding, subsequent diagnosis, or ancillary tissue removal during the screening procedure.

**Sec. 4105. Evidence-based coverage of preventive services in Medicare.**

Effective 1/1/2010, authorizes the Secretary to modify or eliminate Medicare coverage of preventive services (including the services included in the initial preventive physical examination), based on the recommendations of the U.S. Preventive Services Task Force.

**Sec. 4106. Improving access to preventive services for eligible adults in Medicaid.**

States providing Medicaid coverage of other diagnostic, screening, preventive and rehabilitative services must include clinical preventive services assigned a grade of A or B by the US Preventive Services Task Force and adult immunizations recommended by the Advisory Committee on Immunization Practices (and their administration). States providing preventive services and vaccines without imposing any beneficiary cost sharing are to receive the applicable FMAP plus 1 percentage point for these services and for comprehensive tobacco cessation services for pregnant women (see sec. 4107). For the Medicaid population newly eligible in 2014, the specified FMAP applies. Effective 1/1/2013.

**Sec. 4107. Coverage of comprehensive tobacco cessation services for pregnant women in Medicaid.**

Requires states to cover counseling and pharmacotherapy for cessation of tobacco use by pregnant women. No cost sharing may be applied for these services. Services to include diagnostic, therapy, counseling and pharmacotherapy furnished by or under the supervision of a physician, or by another health professional authorized under state law and authorized for Medicaid payment, or designated by the Secretary for this purpose. Services limited to those recommended with respect to pregnant women PHS guidelines published in May 2008 and other services recognized by the Secretary. Includes prescription and nonprescription tobacco cessation agents approved by the FDA, but excludes drugs or biologicals not otherwise covered by Medicaid. Conforms provisions with respect to covered outpatient drugs to prohibit states from excluding in the case of pregnant women smoking cessation drugs recommended by the guidelines. Effective 10/1/2010.

**Sec. 4108. Incentives for prevention of chronic diseases in Medicaid.**

Requires the Secretary to make available grants to states for healthy lifestyle programs under Medicaid. Programs must be for at least 3 years and provide Medicaid beneficiaries incentives to participate in widely available and easily accessible comprehensive evidence-based healthy lifestyle programs and meet certain healthy behaviors targets. Secretary to engage in outreach and education to make states aware of the grants.

Programs to be approved by the Secretary and uniquely suited to the Medicaid population with demonstrated success in helping individuals stop tobacco use, lower cholesterol, lower blood pressure, control or lose weight, or manage diabetes. Programs may also address comorbidities to any of these conditions including depression. State

applications to include a plan for informing Medicaid beneficiaries and providers about the program, including an outreach and education campaign. States may enter into arrangements with Medicaid providers, community and faith-based organizations, public private partnerships, Indian tribes and similar entities or organizations to carry out the programs. Secretary may waive the statewideness requirement for this program, and must assure that state programs are available and accessible to Medicaid beneficiaries. Program participation to have no effect on a Medicaid beneficiary's eligibility or the amount of benefits they receive.

States also to monitor beneficiary participation and validate health outcomes, establish program targets, evaluate program effectiveness and, beginning 1/1/2014, report semiannually to the Secretary on the program and report on preventive services as part of reporting on Medicaid managed care quality measures. Secretary to report to Congress on state initiatives and on whether the program should be extended. Initial report due 1/1/2014 and final report on 7/1/2016. Secretary to arrange for an independent evaluation of the grant program.

Grants to be awarded beginning 1/1/2011 or, if earlier, when the Secretary develops program criteria. Criteria to be developed using the Guide to Community Preventive Services, the Guide to Clinical Preventive Services and the National Registry of Evidence-Based Programs and Practices, and other relevant evidence-based research and resources.

Appropriates \$100 million in funds for 5 year period beginning 1/1/2011. Funds to remain available until expended.

### **Subtitle C—Creating Healthier Communities**

#### **Sec. 4201. Community transformation grants.**

Authorizes such sums for FYs 2010-2014 for a program of competitive grants to state and local governmental agencies and community-based organizations for the implementation, evaluation, and dissemination of evidence-based community preventive health activities. Grant recipients must develop a detailed plan that includes the policy, environmental, programmatic, and as appropriate infrastructure changes needed to promote healthy living and reduce disparities, and use grant funds to implement a variety of programs, policies, and infrastructure improvements to promote healthier lifestyles (e.g., creating healthier school environments, worksite wellness programming and incentives, and reducing racial and ethnic disparities).

#### **Sec. 4202. Healthy aging, living well; evaluation of community-based prevention and wellness programs for Medicare beneficiaries.**

Authorizes such sums for FYs 2010-2014 for a program of grants to state or local health departments and Indian tribes to carry out 5-year pilot programs to provide public health community interventions, screenings, and where necessary, clinical referrals for individuals who are between 55 and 64 years of age. Intervention activities may include efforts to improve nutrition, increase physical activity, reduce tobacco use and substance abuse, improve mental health, and promote healthy lifestyles. Grant funds are also to be used for ongoing health screening to identify risk factors for cardiovascular disease, cancer, stroke, and diabetes. An annual evaluation of the effectiveness of the program is mandated and must consider changes in the prevalence of uncontrolled chronic disease risk factors among new Medicare enrollees (or individuals nearing enrollment).

Allocates \$50 million from the Medicare Trust Funds for an evaluation of community-based prevention and wellness programs, especially those sponsored by the Administration on Aging, and development of a plan for promoting healthy lifestyles and chronic disease self-management for Medicare beneficiaries. Requires a report to Congress by 9/30/2013, including recommendations for such legislation and administrative action as the Secretary determines appropriate.

**Sec. 4203. Removing barriers and improving access to wellness for individuals with disabilities.**

Not later than 3/23/2012, the Architectural and Transportation Barriers Compliance Board must issue regulatory standards to ensure that medical diagnostic equipment used in physicians' offices, clinics, emergency rooms, hospitals, and other medical settings is accessible to, and usable by, individuals with accessibility needs, and allows independent entry to, use of, and exit from the equipment by such individuals to the maximum extent possible. Such equipment includes examination tables, examination chairs (including chairs used for eye examinations or procedures), weight scales, mammography equipment, x-ray machines, and other radiological equipment commonly used for diagnostic purposes by health professionals. The Board must periodical review and, as appropriate, amend such standards.

**Sec. 4204. Immunizations.**

Authorizes such sums for FYs 2010-2014 for grants to states to improve the provision of recommended immunizations for children, adolescents and adults through various evidence-based interventions, including reducing out-of-pocket costs for families for vaccines and their administration. Requires an evaluation of, and a report to Congress on the program. Permanently re-authorizes the state immunization grant program in section 317(j) of the Public Health Service Act. Authorizes the Secretary to negotiate contracts with manufacturers to purchase vaccines for adults and authorizes states to obtain additional quantities of such adult vaccines at the price negotiated by the Secretary.

Requires GAO to submit a report not later than 6/1/2011 on Medicare beneficiary access to routinely recommended vaccines covered under Medicare Part D.

**Sec. 4205. Nutrition labeling of standard menu items at chain restaurants.**

Requires disclosure of information regarding the number of calories of standard menu items on menus and menu boards of restaurants or similar retail food establishments with 20 or more locations doing business under the same name (and for their self-service buffet or cafeteria lines and salad bars), and on vending machines owned or operated by persons with 20 or more vending machines, or posted nearby. Not later than 3/23/2011, the Secretary must promulgate proposed regulations regarding these requirements.

**Sec. 4206. Demonstration project concerning individualized wellness plan.**

Authorizes such sums as necessary for a pilot program involving up to 10 community health centers to test the impact of providing at-risk populations who utilize such centers an individualized wellness plan that is designed to reduce risk factors for preventable conditions. The plan may include such elements as nutritional counseling, stress management, or alcohol and smoking cessation counseling and services, and the risk



factors must include weight, tobacco and alcohol use, exercise rates, nutritional status, and blood pressure.

**Sec. 4207. Reasonable break time for nursing mothers.**

Amends the Fair Labor Standards Act to require employers to provide reasonable break time and an appropriate place for nursing mothers to express breast milk for up to 1 year after the child's birth. The requirement is waived for employers with less than 50 employees if it would impose an undue hardship by causing the employer significant difficulty or expense when considered in relation to the size, financial resources, nature, or structure of the employer's business.

**Subtitle D—Support for Prevention and Public Health Innovation**

**Sec. 4301. Research on optimizing the delivery of public health services.**

Directs the Secretary to provide funding for research examining evidence-based practices relating to prevention, analyzing the translation of interventions from academic to real world settings, and identifying effective strategies for organizing, financing or delivering public health services in real work community settings, including comparing State and local health department structures and systems in terms of effectiveness and cost. Requires an annual report to Congress concerning research activities and findings, but does not authorize or appropriate any new funding.

**Sec. 4302. Understanding health disparities: data collection and analysis.**

Not later than 3/23/2012, requires the Secretary to ensure that any federally conducted or supported health care or public health program, activity or survey (including Current Population Surveys, American Community Surveys, Medicaid and CHIP) collect and report data on race, ethnicity, sex, primary language, and disability status, and other demographic data regarding health disparities. The Secretary's efforts must include surveys of health care providers to identify locations where individuals with disabilities access care, the number of providers with accessible facilities and equipment, and the number of employees of health care providers trained in disability awareness and patient care of individuals with disabilities. The Secretary must also develop national standards for the management of data collected and interoperability and security systems for data management. Collected data must be analyzed to deter and monitor trends in health disparities, and data and analyses reported (for example, through public postings on the HHS Internet websites). The Secretary must ensure that any data collected regarding racial and ethnic minority groups are also collected regarding underserved rural and frontier populations. Authorizes such sums for FYs 2010-2014 for these purposes.

Not later than 9/23/2011, requires the Secretary to submit a report on the Secretary's evaluation of approaches for the collection of data under Medicaid and CHIP that allow for ongoing, accurate, and timely collection and evaluation of data on disparities in health care services and performance on the basis of race, ethnicity, sex, primary language, and disability status, and to implement effective approaches for doing so not later than 3/23/2012. The report must also include recommendations on the most effective strategies and approaches to reporting HEDIS quality measures and other nationally recognized quality performance measures, as appropriate, on the same bases. Not later than 3/23/2014, and every 4 years thereafter, requires the Secretary to submit a report to Congress that includes recommendations for improving the identification of health care disparities within the Medicaid and CHIP programs.

**Sec. 4303. CDC and employer-based wellness programs.**

Directs the CDC to provide employers with technical assistance, consultation, tools and other resources for evaluating such employers' employer-based wellness programs and to train employers on how to evaluate such wellness programs. Not later than 3/23/2012 and at regular intervals thereafter, requires the CDC to conduct a national worksite health policies and programs survey to assess employer-based health policies and programs, followed by a report to Congress that includes recommendations for the implementation of effective employer-based health policies and programs. Directs the Secretary to give priority to evaluations of wellness programs funded through CDC before evaluating privately funded programs unless an entity with such a privately funded program requests such an evaluation. Explicitly prohibits federal workplace wellness requirements or programs.

**Sec. 4304. Epidemiology-Laboratory Capacity Grants.**

Authorizes \$190 million for each of FYs 2010-2013 for an Epidemiology and Laboratory Capacity Grant Program at CDC for grants to state and local health departments and tribal organizations to assist public health agencies in improving surveillance for, and response to, infectious diseases and other conditions of public health importance. Academic centers that assist such departments and tribal organizations may also be eligible for funding. The grants would assist in (1) strengthening epidemiological capacity to identify and monitor the occurrence of infectious diseases and other conditions; (2) enhancing laboratory practice and systems to report test orders and results electronically; (3) improving information systems and exchange; and (4) developing and implementing prevention and control strategies.

**Sec. 4305. Advancing research and treatment for pain care management.**

Not later than 1 year after funds are appropriated, requires the Secretary to enter into an agreement with the Institute of Medicine (or perhaps another appropriate entity) to convene a Conference on Pain that will, among other things, establish an agenda for action in both the public and private sectors that will reduce barriers to appropriate pain care and significantly improve the state of pain care research, education, and clinical care. Not later than 6/30/2011, requires submission of a report to Congress summarizing the Conference's findings and recommendations.

Encourages the Director of NIH to continue and expand, through the Pain Consortium, an aggressive program of basic and clinical research on the causes of and potential treatments for pain. Requires the Pain Consortium to make recommendations on appropriate pain research initiatives annually.

Not later than 3/23/2011, requires the Secretary to establish an Interagency Pain Research Committee to coordinate all efforts within HHS and other Federal agencies that relate to pain research. The Committee will be comprised of: 7 voting Federal representatives; 6 voting non-Federal members appointed from among scientists, physicians, and other health professionals; and 6 voting members appointed from members of the general public, who are representatives of leading research, advocacy, and service organizations for individuals with pain-related conditions. The Committee must meet at least annually and its duties include identifying critical gaps in pain-related research and making recommendations on how best to disseminate information on pain care.

Authorizes such sums for FYs 2010-2012 for grants, cooperative agreements, and contracts to health professions schools, hospices, and other public and private entities for the development and implementation of programs to provide education and training to health care professionals in the diagnosis, treatment, or management of acute or chronic pain. Recipients must agree to provide information and education on specified topics.

**Sec. 4306. Funding for Childhood Obesity Demonstration Project.**

Appropriates \$25 million for the period of FYs 2010-2014 for the Childhood Obesity Demonstration Project originally mandated under the Children's Health Insurance Program Reauthorization Act of 2009. This replaces a current authorization of \$25 million for the period of FYs 2009-2013.

**Subtitle E—Miscellaneous Provisions**

**Sec. 4401. Sense of the Senate concerning CBO scoring (as modified by sec. 10405).**

Provision stricken by section Sec. 10405.

**Sec. 4402. Effectiveness of Federal health and wellness initiatives.**

Requires the Secretary to evaluate, and submit a report to Congress on, whether existing Federal health and wellness initiatives are effective in achieving their stated goals, especially with respect to changes in health status of the American public and specifically on the health status of the Federal workforce. The report must include conclusions concerning the reasons such initiatives have proven successful or not successful.

**Sec. 10406. Amendment relating to waiving coinsurance for preventive services.**

Eliminates cost sharing requirements for Medicare covered preventive services that are recommended (rated A or B) by the U.S. Preventive Services Task Force (the original legislative language is simplified in the Manager's Amendment).

**Sec. 10407. Better diabetes care.**

Requires the Secretary, in collaboration with the Centers for Disease Control and Prevention (CDC) to prepare a national diabetes report card every two years. The report card will be publicly available. In addition, the Secretary will undertake education and training programs targeting diabetes as well as undertake a study of the impact of diabetes on the practice of medicine.

**Sec. 10408. Grants for small businesses to provide comprehensive workplace wellness programs.**

Requires the Secretary to award grants over five years to eligible employers to provide their employees with access to comprehensive workplace wellness programs.

**Sec. 10409. Cures Acceleration Network.**

Provides for the establishment of a program (Cures Acceleration Network) to award grants and contracts to eligible entities to accelerate the development of high need cures, including the development of medical products and behavioral therapies.

**Sec. 10410. Centers of Excellence for Depression.**

Requires the Secretary to award five year grants on a competitive basis to institutions of higher education or public or private nonprofit research institutions to establish national centers of excellence (limited to 30) for depression which shall engage in activities related to the treatment of depressive disorders.

**Sec. 10411. Programs relating to congenital heart disease.**

Allows the Secretary to establish or award a grant to establish the National Congenital Heart Disease Surveillance System the purpose of which is to facilitate further research into the types of heart services patients use and to identify possible areas for educational outreach and prevention.

**Sec. 10412. Automated Defibrillation in Adam's Memory Act.**

Extends the program until 2014 and clarifies the expertise of the clearinghouse administrative organization.

**Sec. 10413. Young women's breast health awareness and support of young women diagnosed with breast cancer.**

Requires the Secretary to conduct a national evidence-based education campaign to increase awareness among young women (15 to 44 years of age) and providers of breast health habits and disease (emphasis on cancer) and to conduct prevention research on breast cancer in younger women.

**TITLE V—HEALTH CARE WORKFORCE****Subtitle A—Purpose and Definitions****Sec. 5001. Purpose.**

The stated purpose of Title V of the Act is to improve access to and the delivery of health care services for all individuals, particularly low income, underserved, uninsured, minority, health disparity, and rural populations by gathering and assessing data on the healthcare workforce; increasing workforce supply; enhancing workforce education and training; and supporting the existing workforce.

**Sec. 5002. Definitions.**

Provides definitions for a variety of terms for purposes of Title V.

**Subtitle B Innovation in the Health care Workforce****Sec. 5101. National Health Care Workforce Commission (as modified by Sec. 10501).**

Establishes a National Health Care Workforce Commission to serve as a resource for Congress, the President, and localities; coordinate activities of the Departments of HHS, Labor, Veterans Affairs, Homeland Security, and Education; develop and evaluate education and training activities; identify barriers to improved federal, state and local coordination and recommend ways to address barriers; and encourage innovations.

The Commission is to be composed of 15 members (each serving 3 year terms – staggered at the start) appointed by the Comptroller General. The initial appointments must be made by September 30, 2010. Membership must include no less than one representative of certain categories, including: the health care workforce and health

professions; employers (including small business and self-employed individuals); third-party payers; experts in health care services and health economics research; consumer representatives; labor unions; state or local workforce investment boards; and educational institutions. Individuals in health professions education or practice may not form the majority. The Commission chairman and vice-chairman will be appointed by the Comptroller General.

The Commission is required to annually submit two reports to Congress – one starting no later than April 1, 2011 to include a review of at least one high priority area, and the other starting no later than October 1, 2011, to include a review of current and projected workforce supply and demand and recommendations on workforce goals, priorities and policies. The Commission is also required to report to Congress on the state health care workforce development grants established by sec. 5102.

Initial high priority topic areas include: workforce planning that maximizes the skill sets of health professionals across disciplines; workforce demands for the enhanced information technology workplace; how to align Medicare and Medicaid graduate medical education policies with national workforce goals; ways to eliminate barriers to entering and staying in primary care; education and training capacity and projected demands for professionals in nursing, oral health, mental health, allied and public health, and emergency medicine; and the geographic distribution of providers compared to state and regional needs.

Specific topics to be included in the annual workforce review include workforce supply and distribution with projected demands for the subsequent 10 and 25 year periods; workforce education and training capacity with projected demands for the subsequent 10 and 25 year periods; education loan and grant programs; implications of new and existing federal policies affecting the workforce; workforce needs of special populations with recommendations on meeting the needs; and recommendations on creating or revising national loan repayment and scholarship programs to require low-income medical students to serve in their home underserved communities.

The Commission is also directed to study effective mechanisms for financing education and training for careers in health care, and make recommendations to Congress and the Departments of Labor and HHS on improving safety, health and worker protections for the health care workforce.

#### **Sec. 5102. State health care workforce development grants.**

Competitive planning and implementation grants are created for the purpose of enabling State partnerships to complete comprehensive planning and to carry out activities leading to coherent and comprehensive health care workforce development strategies at the state and local levels. Grants will support innovative approaches to increase the number of skilled health care workers such as health care career pathways for young people and adults.

HRSA will administer the grants in consultation with the National Health Care Workforce Commission created under sec. 5101.

Planning grants of up to \$150,000 will be available for a one year term. An eligible entity is a state workforce investment board, if membership includes at least one representative from each of the following: health care employer; labor organization; public 2-year institution of higher education; public 4-year institution of higher education;

the recognized state federation of labor; the state public secondary education agency; the state P-16 or P-20 council, if one exists; and a philanthropic organization engaged in health workforce activities. State grantees are required to provide at least a 15% match in cash or in-kind. Grantees must: analyze labor market data in order to create health care career pathways; identify high demand pathways; identify public and private resources for recruitment, education, and retention; describe skill standards for various credentials and licensure; identify federal and state rules that are barriers to developing a comprehensive workforce strategy and a plan to resolve those barriers; and participate in evaluation and reporting activities (states must report to the Administration within 1 year). The Administration must submit a report to Congress on the planning grant program.

Implementation grants will be competitively awarded to state partnerships for 2-year periods (a 3<sup>rd</sup> year is possible for high performing grantees). An eligible grantee will have received and completed the requirements of a planning grant and submitted an application with the information described in the Act. At least 60% of grant funds may be reserved by the state partnerships to competitively award grants for workforce development activities. The Act does not specify a maximum grant amount. State grantees are required to provide at least a 25% match in cash or in-kind. Grantees must: convene regional leadership to engage in workforce development planning; take steps to reduce barriers to a comprehensive and coherent strategy; develop a preliminary statewide strategy; convene partnership members on a regular basis; assist leaders at the regional level to form partnerships; collect and assess data on benchmarks; and participate in the Administration's evaluation and reporting activities (an annual report is required).

Authorizes appropriations of \$8 million and \$150 million, respectively, for planning and implementation grants during FY 2010 and such sums as may be necessary for subsequent years.

#### **Sec. 5103. Health care workforce assessment.**

Establishes the National Center for Health Workforce Analysis (i.e., codifies the existing national center); mandates that the Secretary award grants to, or enter into contracts with, state or other appropriate entities for state and regional workforce data collection and analysis; and increases funding for longitudinal evaluations of individuals participating in federal workforce programs. Authorizes \$7.5 million for each of fiscal years 2010-2014 for the National Center; \$4.5 million for each of fiscal years 2010-2014 for state and regional centers; and such sums as may be necessary for longitudinal evaluations.

#### **Sec. 5104. Interagency Task Force to Assess and Improve Access to health Care in the State of Alaska (added by Sec. 10501).**

Establishes a task force to assess access to health care and develop a strategy for the Federal government to improve delivery of health care to Federal health program beneficiaries in Alaska.

### **Subtitle C—Increasing the Supply of the Health Care Workforce**

#### **Sec. 5201. Federally supported student loan funds.**

Changes the requirement to practice in primary care as a condition for student loans to the lesser of 10 years or until the loan is repaid; changes the interest rate on

noncompliance to a rate of 2% per year greater than the rate the student would pay if compliant. Specifies that the Secretary may not require parental financial information to determine financial need for an independent student.

**Sec. 5202. Nursing student loan program.**

Increases the cap on loan amounts under the Nursing Student Loan program as follows: the annual cap is increased from \$2,500 to \$3,300; the annual cap for each of the final two academic years is increased to from \$4,000 to \$5,200; and the aggregate cap for all years under the program is increased to from \$13,000 to \$17,000. Beginning with fiscal year 2012, the Secretary shall adjust all the caps to reflect increases in the cost-of-attendance. Requires loans made to students enrolling after June 30, 2000 (instead of 1986), to be based on financial need and updates the loan cancellation policy to apply to students receiving loans before September 29, 1995 (instead of 1979).

**Sec. 5203. Health care workforce loan repayment programs.**

Establishes a loan repayment program for pediatric subspecialists and providers of mental and behavioral health services to children and adolescents. Qualified professionals (U.S. citizens or legal U.S. residents) must agree to be employed for a specified period of at least 2 years in a Health Professional Shortage Area or Medically Underserved Area, or to serve a Medically Underserved Population. The Secretary will make payments on the principal and interest of each individual's medical education loans of up to \$35,000 a year for each year of agreed upon service, up to 3 years. Authorizes \$30,000,000 for each fiscal year 2010-2014 for pediatric subspecialists, and \$20,000,000 for each of fiscal years 2010-2013 for child and adolescent mental and behavioral health professionals.

**Sec. 5204. Public health workforce recruitment and retention programs.**

Establishes a loan repayment program for public health students and workers. The Secretary will pay up to \$35,000 per year or, if less, 1/3 of the eligible loan balance, for each year of obligated service in exchange for working at least 3 years at a federal, state, local, or tribal public health agency. Authorizes \$195 million for FY2010 and such sums as may be necessary for FY2011-2015.

**Sec. 5205. Allied health workforce recruitment and retention programs.**

Offers loan repayment to allied health professionals employed at public health agencies or in settings providing health care to patients, including acute care facilities, ambulatory care facilities, residences, and other settings located in Health Professional Shortage Areas, Medically Underserved Areas, or serving Medically Underserved Populations.

**Sec. 5206. Grants for state and local programs.**

Authorizes the Secretary to make grants to, or contract with, educational institutions to award scholarships to mid-career public and allied health professionals employed in public and allied health positions at the federal, state, tribal, or local level so they may receive additional training in public or allied health fields. Authorizes \$60 million for FY2010 and such sums as necessary for FY2011-2015. Allocates 50% of appropriated funds to mid-career public health professionals and 50% to mid-career allied health professionals.

**Sec. 5207. Funding for National Health Service Corps.**

Increases and extends the authorization of appropriations for the National Health Service Corps scholarship and loan repayment program: \$320 million for FY2010; \$414

million for FY2011; \$535 million for FY 2012; \$691 million for FY 2013; \$893 million for FY2014; and \$1.154 billion for FY 2015 (amounts are rounded). For subsequent years the Act provides for a formula-driven increase above the immediate prior year's appropriated amount which takes into account the average percentage increase in the cost of health professions education and the change in the number of individuals residing in Health Professions Shortage Areas.

**Sec. 5208. Nurse-managed health clinics.**

Establishes a new mandatory grant program to pay for the cost of operation of nurse-managed health clinics (NMHC). The NMHC must be associated with a nursing school or department, FQHC, or an independent nonprofit social service agency. To be eligible the NMHC must assure that: nurses are the major providers of services and that at least one nurse holds an executive management position; the NMHC will provide primary care to patients without regard to income or insurance status throughout the grant period; and the NMHC will establish a community advisory committee not later than 90 days after receiving the grant. Authorizes \$50 million for FY2010 and for FY 2011- 2014, such sums as may be necessary.

**Sec. 5209. Elimination of cap on commissioned corps.**

Eliminates the existing cap (2,800) on the number of Commissioned Corps members.

**Sec. 5210. Establishing a Ready Reserve Corps.**

Establishes a Ready Reserve Corps in addition to the Regular Corps within the Commissioned Corps for service in times of national emergency. Ready Reserve Corps members may be called to active duty by the Surgeon General to respond to national emergencies and public health crises; fill critical public health positions left vacant by members of the Regular Corps who have been called to duty elsewhere; and be assigned to isolated, hardship, and medically underserved communities to improve access to health services. Authorizes \$12.5 million for each of FY2010-2014.

**Subtitle D Enhancing Health Care Workforce Education and Training**

**Sec. 5301. Training in family medicine, general internal medicine, general pediatrics, and physician assistantship.**

Authorizes the Secretary to make 5-year grants or enter into contracts with capable entities to plan, develop and operate training programs in primary care; provide financial assistance to trainees and faculty; enhance faculty development in primary care and physician assistant programs; and develop and operate a demonstration program which may include training relevant to patient-centered medical homes. Preference is to be given to programs that establish or expand academic units in the stated primary care fields. The Act also includes a list of priorities for awarding grants or contracts. Authorizes \$125 million for FY2010 and such sums as necessary for FY2011-2014. Allocates 15% of appropriated funds to the physician assistant training programs. Also authorizes \$750 thousand for each of FY2010-2014 for programs that integrate academic units.

**Sec. 5302. Training opportunities for direct care workers.**

Mandates the Secretary to award grants to entities (educational institutions in partnership with long-term care providers) to provide new training opportunities for direct care workers in long-term care settings. Funds are to be used to provide assistance to workers to offset the costs of tuition and fees. To receive assistance, workers must



maintain satisfactory academic progress and agree to work in a long-term care field for at least 2 years after completion. Authorizes \$10 million in funding for the period FY2011-2013.

**Sec. 5303. Training in general, pediatric, and public health dentistry.**

Authorizes the Secretary to make 5-year awards (grants or contracts) to capable entities to develop and support dental training programs, including pediatric programs. Funds may be used for primary care dental training; training providers who plan to teach; pre-doctoral and post-doctoral training, faculty development, dental faculty loan repayment, and provision of financial assistance to practitioners and students in need. Specifies details for loan repayment. Provides a list of priorities for making awards. Authorizes \$30 million for FY2010 and such sums as necessary for FY2011-2015. Allows award funds to be carried over from year to year for up to 3 years.

**Sec. 5304. Alternative dental health care providers demonstration project.**

Authorizes the Secretary to award grants to 15 eligible entities to establish demonstration training programs for alternative dental health care providers to increase access to dental health care services in rural, tribal, and underserved communities. Demonstrations are to begin within 2 years of enactment and terminate no later than 7 years after enactment. Each grant shall be at least \$4 million for the 5-year period. Authorizes such sums as necessary.

**Sec. 5305. Geriatric education and training; career awards; comprehensive geriatric education.**

Requires the Secretary to award grants of \$150,000 to not more than 24 geriatric education centers to offer a fellowship program with short-term intensive courses on geriatrics, chronic care management, and long-term care for medical school faculty and other health professions schools. In addition the grantee must either offer family caregiver and direct care provider training (at no or nominal cost to enrollees) or develop best practice materials on mental disorders, medication safety, and management of dementia among older adults. Authorizes \$10.8 million for the period FY2011-2014.

Also mandates the Secretary to award grants to advanced practice nurses, clinical social workers, pharmacists, or psychology students who are pursuing a doctorate or other advanced degree in geriatrics who agree to teach or practice in the field of geriatrics, long-term care, or chronic care management for a minimum of 5 years. Authorizes \$10 million for the period FY2011-2013.

Expands scope of individuals eligible for geriatric academic career awards to include health professionals with junior faculty appointments in accredited health professions schools. Individuals must commit to spend 75% of total faculty time teaching interdisciplinary education in geriatrics.

Expands the Comprehensive Geriatric Education grant program to award grants to educational institutions that establish traineeships for individuals who are preparing for advanced education nursing degrees in geriatric nursing, long-term care, geropsychiatric nursing, or other nursing areas that specialize in care of the elderly. Authorizes such sums as necessary for FY2010-2014.

**Sec. 5306. Mental and behavioral health education and training grants.**

Authorizes the Secretary to award grants to schools of higher education for the development, expansion, or enhancement of training programs in social work, graduate psychology, professional training in child and adolescent mental health, and preservice or in-service training to paraprofessionals in child and adolescent mental health. At least 4 of the grants for social work education must be awarded to historically black colleges or minority-serving institutions. Provides a list of priorities for grant awards. Authorizes for FY 2010-2013: \$8 million for social work training; \$12 million for graduate psychology training; \$10 million for training in professional child and adolescent mental health and \$5 million for training in paraprofessional child and adolescent work.

**Sec. 5307. Cultural competency, prevention, and public health and individuals with disabilities training.**

Reauthorizes and expands programs to support the development, evaluation, and dissemination of research, demonstration projects, and model curricula for cultural competency, prevention, public health proficiency, reducing health disparities, and aptitude for working with individuals with disabilities training for use in health professions schools and continuing education programs. Authorizes such sums as necessary for FY2010-2015.

**Sec. 5308. Advanced nursing education grants.**

Specifies requirements for midwifery education programs eligible for grants under the Advanced Education Nursing grant program, including requiring accreditation by the American College of Nurse-Midwives Accreditation Commission for Midwifery Education. Eliminates the cap on the number of traineeships for individuals in doctorate programs.

**Sec. 5309. Nurse education, practice, and retention grants.**

Revises the Nurse Education, Practice, and Retention Grant program. Specifies a focus on quality and on coordinated care.

Authorizes two new grant programs to accredited nursing schools or health facilities specifically for nurse retention: one to promote career advancement among nurses and the other for enhanced collaboration and communication among nurses and other health care professionals. Priority in the latter program is given to applicants who have not previously received an award. Authorizes such sums as may be necessary in each of FY2010-2012.

**Sec. 5310. Loan repayment and scholarship program.**

Extends the Nurse Loan Repayment and Scholarship Programs to provide loan repayment for full- or part-time nursing school students who agree to serve a minimum two years as faculty members at an accredited school of nursing.

**Sec. 5311. Nurse faculty loan program.**

Increases the annual cap on loan amounts under the Nursing Faculty Loan program to \$35,500 (from \$30,000) in FY 2010 and FY2011, and substitutes an adjustment to reflect cost-of-attendance instead of the adjustment for inflation for subsequent years. Requires that nursing schools be accredited for program purposes. Extends authorization through FY2014.

Authorizes HRSA to enter into education loan repayment agreements with registered nurses who are U.S. citizens, who hold unencumbered licenses, and who have already

completed, or are currently enrolled in, a master's or doctorate training program for nursing. HRSA would pay up to \$10,000 per year to master's degree recipients and \$20,000 per year to doctorate recipients (capped in total at \$40,000, and \$80,000, respectively) who agree to serve 4 years as a full-time faculty member at an accredited school of nursing. Authorizes such sums as may be necessary in each of FY2010-2014.

**Sec. 5312. Authorization of appropriations for parts B through D of title VIII.**

Authorizes \$338 million for FY2010 to fund Title VIII of the Public Health Service Act nursing programs, and such sums as necessary for FY2011-2016.

**Sec. 5313. Grants to promote the community health workforce.**

Mandates that the Director of the CDC, in collaboration with the Secretary, award grants to states, public health departments, clinics, hospitals, federally qualified health centers, and other nonprofits, or consortia of such entities, to promote positive health behaviors and outcomes in medically underserved communities through the use of community health workers. Community health workers are to provide guidance and social assistance; enhance residents' ability to communicate with providers; provide culturally and linguistically appropriate health or nutrition education; advocate for individual and community health; provide referral and follow-up services; and proactively identify and enroll eligible individual in government or nonprofit programs. Authorizes such sums as may be necessary in each of FY2010-2014

**Sec. 5314. Fellowship training in public health.**

Authorizes the Secretary to address workforce shortages in state and local health departments in applied public health epidemiology and public health laboratory science and informatics. Also authorizes the expansion of the Epidemic Intelligence Service and the CDC Public Health Informatics Fellowship Program. Authorizes \$39.5 million for each of FY2010-2013 of which \$5 million is for the epidemiology fellowship program; \$5 million for the laboratory fellowship program; \$5 million for the Public Health Informatics Fellowship program; and \$24.5 million for expanding the Epidemic Intelligence Service.

**Sec. 5315. United States Public Health Sciences Track.**

Mandates the Secretary to establish, administered by the Surgeon General, a U.S. Public Health Sciences Track to grant advanced degrees emphasizing team-based service, public health epidemiology, and emergency preparedness and response. The program is to be organized to annually graduate at least 150 physicians, 100 dentists, 250 nurses, 100 physician assistants or nurse practitioners, 100 mental and behavior health specialists, 100 public health professionals, and 50 pharmacists. Sites will be selected by the Surgeon General from U.S. academic health centers. Students receive tuition (or tuition remission) and a stipend and are accepted as Commission Corps officers in the U.S. Public Health Service with a 2-year service commitment for each year of school covered. Authorizes the Secretary to transfer from the Public Health and Social Services Emergency Fund such sums as necessary beginning in FY2010.

**Sec. 5316. Demonstration Grants for Family Nurse Practitioner Training Programs. (added by Sec 10501).**

Requires the Secretary to establish a demonstration program for family nurse practitioners to employ and provide 1-year training of nurse practitioners who have graduated from a nurse practitioner program for careers as primary care providers in Federally qualified health centers and nurse-managed health clinics.

## **Subtitle E—Supporting the Existing Health Care Workforce**

### **Sec. 5401. Centers of excellence.**

The Centers of Excellence program, which develops a minority applicant pool to enhance recruitment, training, academic performance and other supports for minorities interested in careers in health, is reauthorized at \$50 million for each of FY2010 through FY2015 and such sums as necessary for each subsequent year. Provides for allocations of appropriated funds among schools meeting various conditions.

### **Sec. 5402. Health care professionals training for diversity.**

Reauthorizes programs providing scholarships for disadvantaged students who commit to work in medically underserved areas as primary care providers, and expands loan repayments for individuals who will serve as faculty in eligible institutions. Faculty loan repayments are increased from \$20,000 to \$30,000 per individual per year of service, and annual program appropriations are authorized at \$5 million for each of FY2010-2014. Authorized appropriations for scholarships for disadvantaged students are increased to \$51 million for FY2010 and such sums as necessary for FY2011-2014. Authorized appropriations for educational assistance for individuals from a disadvantaged background are \$60 million for FY 2010 and such sums as necessary for FY2011-2014.

### **Sec. 5403. Interdisciplinary, community-based linkages.**

Mandates the Secretary to make 2 types of grant awards to Area Health Education Centers (AHECs): Infrastructure Development Awards and Point of Service Maintenance and Enhancement Awards. Grant funds are to be used to recruit individuals from underrepresented minority populations or from disadvantaged or rural backgrounds into the health professions and to implement strategies to foster the development and maintenance of a diverse workforce in underserved areas. Eligible entities for the infrastructure grants include schools of medicine or osteopathic medicine, an incorporated consortium of such schools or the parent institutions of such a school; eligible entities for Point of Service grants are AHECs. An award must be at least \$250,000 and require 50% matching funds in cash or in kind (at least 25% must be in cash). Infrastructure awards can run between 6 years and 12 years. The Act authorizes \$125 million for each of the FY 2010-2014, with at least 35% used for infrastructure grants, at least 60% for point of service grants, up to 1% for AHEC outcomes evaluation, and up to 4% for technical assistance to grantees.

### **Sec. 5404. Workforce diversity grants.**

Expands the Secretary's authority to provide workforce diversity grants for entry into bridge or degree completion programs or for student scholarships and stipend programs for accelerated nursing degree programs. Requires the Secretary to consider recommendations from the National Advisory Council on Nurse Education and Practice and to consult with appropriate nursing associations, including the National Coalition of Ethnic Minority Nurse Associations.

### **Sec. 5405. Primary care extension program.**

Mandates the Secretary to establish a Primary Care Extension Program to educate and provide technical assistance to primary care providers about preventive medicine, health promotion, chronic disease management, mental health and behavioral health, and evidence-based and evidence-informed therapies and techniques. AHRQ will award

competitive planning and program grants to State Hubs which must include, at a minimum, the state health department, state-level entities administering Medicare and Medicaid, and at least one health professions school, and which may include other appropriate entities. Six year grants will be awarded to entities with fully-developed plans for implementing a Hub; 2 year planning grants will be awarded to entities wishing to develop a plan for a Hub. Funds may not be used for direct patient care and no more than 10% may be used for administration. The Act authorizes \$120 million for each of FY 2011-2012 and such other sums as may be necessary for FY 2013 and FY2014.

## **Subtitle F—Strengthening Primary Care and Other Workforce Improvements**

### **Sec. 5501. Expanding access to primary care services and general surgery services (as modified by sec. 10501).**

Effective 1/1/2011 through 12/31/2015, mandates a 10% Medicare bonus payment for primary care services (that is, office and other outpatient visits, nursing facility visits, domiciliary and rest home visits, and home visits) furnished by primary care physicians (family medicine, internal medicine, geriatric medicine, or pediatric medicine), and nurse practitioners, clinical nurse specialists and physician assistants, if at least 60% of their Medicare allowed charges in a prior period were for primary care services. Effective 1/1/2011 through 12/31/2015, mandates a 10% Medicare bonus payment for major surgical procedures (those with a 10- or 90-day global period) for general surgeons providing care in health professional shortage areas (HPSAs). No portion of the increased payments is budget neutral, as section 5501 is amended by section 10501.

### **Sec. 5502. Medicare Federally qualified health center improvements (as modified by sec. 10501).**

Effective 1/1/2011, expands the number of Medicare-covered preventive services at Federally Qualified Health Centers (FQHCs).

Requires the Secretary to design and implement a prospective payment system for Medicare payments to FQHCs for implementation on 10/1/2014. The system will include: i) a process for appropriately describing the services furnished by FQHCs; ii) payment rates for specific payment codes based on these descriptions of services; iii) recognition of the type, intensity, and duration of services; and iv) adjustments, including geographic adjustments, determined appropriate by the Secretary. Directs the Secretary to require FQHCs beginning not later than 1/1/2011 to submit information necessary to design and implement the prospective payment system, including reporting services by HCPCS codes. Requires budget neutrality based on 100 percent of estimated reasonable costs determined without the application of a per visit payment limit or productivity screen. Provides for annual updates using the MEI or, beginning with the second year after implementation, an FQHC market basket, if available.

### **Sec. 5503. Distribution of additional residency positions.**

Reduces the authorized residency level if a hospital's actual residency level for any of the 3 most recent reporting periods is less than its authorized level. The level is reduced by 65% of the difference between the actual and authorized levels. Exempts rural teaching hospitals and certain other teaching hospitals. A hospital may request an increase in its authorized residency level under certain circumstances.

Authorizes an increase in a hospital's residency level but the total of increases granted may not exceed the total decreases in residencies. A qualifying hospital must ensure

that the number of primary care residencies during the 5-year period beginning on the date of the increase is not less than the average over the preceding three years and that at least 75% of the new residency slots are in primary care or general surgery. Failure to maintain requirements results in loss of the additional slots for the hospital and redistribution of those slots to other qualified hospitals. Sets priority in awarding increased slots: 70% for hospitals in lowest quartile of resident-to-population ratios, and 30% for hospitals in high health professional shortage areas or rural areas. Additional residency slots from the redistribution may not exceed 75 per hospital. The increase in residencies must occur by 03/23/2012.

The indirect medical education (IME) payment adjustment for the increased slots is calculated in the same manner as for the existing positions.

**Sec. 5504. Counting resident time in nonprovider settings.**

Effective 1/1/2010, if a hospital incurs the costs of the residency stipends and fringe benefits of residents in non-provider settings, all activities are to count towards the determination of full time equivalency (FTE), regardless of the setting in which the activities are performed. Applies for direct graduate medical education (DGME) and IME determinations of FTE. The Secretary is to implement this provision without reopening hospital cost reports unless a proper appeal on IME or DGME payments is pending on 03/23/2010.

**Sec. 5505. Rules for counting resident time for didactic and scholarly activities and other activities (as modified by section 10501(j)).**

Counts toward the determination of full time equivalency (for DGME and IME) non-direct patient care activities (such as didactic conferences and seminars) in a nonprovider setting in which the primary activity is the care and treatment of patients.

Counts all vacation, sick leave, and other approved leave spent by resident in an approved training program as long as the leave time does not extend the program's duration.

Research activities that are not associated with treatment or diagnosis may not be counted toward the determination of full time equivalency.

Applies generally to cost reporting periods beginning on or after 1/1/1983, and applies to cost reporting periods beginning, for DGME, on or after 1/1/2009, and for IME 1/1/2001. Clarifies that the amendments incorporating the counting rules may not be applied to open settled cost reports unless there is a jurisdictionally proper appeal pending as of 03/23/2010.

**Sec. 5506. Preservation of resident cap positions from closed hospitals.**

Permits the Secretary to redistribute the residency positions of certain hospitals in a state that closed on or after 03/23/2008 to other teaching hospitals in the following priority order: first to hospitals in the same, or contiguous, core-based statistical area; second to hospitals in the same state; third to hospitals in the same region of the country; and, fourth, if necessary, based on redistribution rules under section 5503 above. Requires hospitals to show that positions will likely be filled within three years. Limits increases to the number of slots closed.

**Sec. 5507. Demonstration projects to address health professions workforce needs; extension of family-to-family health information centers.**

Mandates the Secretary of HHS, in consultation with the Secretary of Labor, to establish a demonstration program through competitive grants to provide eligible individuals, including Temporary Assistance for Needy Families recipients and other low-income individuals, with the opportunity to obtain education and training for occupations in the health care field that pay well and are expected to experience labor shortages or be in high demand.

Also mandates the Secretary to award grants to up to 6 states to conduct 3-year demonstration projects to develop core training competencies and certification programs for personal or home care aides. The Act appropriates \$85 million for each year of FY2010-2014, with \$5 million for each year of FY2010-2012 to be used for the personal or home care aide training demonstrations.

Extends the Maternal and Child Health program Family-to-Family Health Information Centers through FY 2012.

**Sec. 5508. Increasing teaching capacity.**

Authorizes the Secretary to award grants to teaching health centers to support new or expanded primary care residency programs. Grants would be for not more than a 3-year term with a maximum grant award of \$500,000. Eligible health centers are community based ambulatory patient care centers that operate a primary care residency program. Priority is given to applications that document an affiliation agreement with an area health education center program. Authorizes \$25 million for FY2010, \$50 million for each year FY2011 and FY2012, and such sums as may be necessary for each fiscal year thereafter. Also appropriates up to \$230 million in funding under the Public Health Service Act for the period FY2011-2015 to cover the indirect and direct graduate medical education expenses of qualifying teaching health centers related to expanded or new programs. The Act provides details on the computation of the direct and indirect amounts. The Secretary is to adjust payments so that the total does not exceed the appropriated amount for the period.

**Sec. 5509. Graduate nurse education demonstration.**

Mandates the Secretary to establish a graduate nurse education demonstration program in Medicare. Up to 5 eligible hospitals or critical access hospitals would receive payment for the reasonable costs (as determined under Medicare regulations) for the clinical instruction expenses attributable to providing advanced practice nurses with requisite skills to provide primary, preventive and transitional care, chronic care management, and other nursing services appropriate for Medicare beneficiaries. Requires that at least half the training occur in non-hospital community care-based settings. Under the demonstration, advanced practice nurses include clinical nurse specialists, nurse practitioners, certified registered nurse anesthetists, and certified nurse midwives. Provides for direct appropriation of \$50 million for each of FY2012-2015. The Secretary is to adjust payments so that the total does not exceed the appropriated amount for each year.

## **Subtitle G – Improving Access to Health Care Services**

### **Sec. 5601. Spending for Federally Qualified Health Centers (FQHCs).**

Authorizes the following appropriations for FQHCs (rounded): FY2010 - \$2.99 billion; FY2011 - \$3.86 billion; FY2012 - \$4.99 billion; FY 2013 - \$6.45 billion; FY2014 - \$7.33 billion; FY2015 - \$8.33 billion. For subsequent fiscal years, the Act authorizes an amount that represents the prior year's appropriation adjusted by an update formula that takes into account the average increase in costs per patient and in the number of patients served.

### **Sec. 5602. Negotiated rulemaking for development of methodology and criteria for designating medically underserved populations and health professions shortage areas.**

Directs the Secretary, in consultation with stakeholders, to establish a comprehensive methodology and criteria for designating medically underserved populations (MUAs) and Health Professional Shortage Areas (HPSAs) through a negotiated rulemaking process. The target date for publication of the interim final rule is July 1, 2010. The final rule, based on consideration of public comment, is due one year later.

### **Sec. 5603. Reauthorization of the Wakefield Emergency Medical Services for Children Program.**

Reauthorizes the program which awards grants to states and medical schools to support the improvement and expansion of emergency medical services for children needing trauma or critical care treatment. The grant period is extended by one year (from 3 to 4 years) with an optional 5<sup>th</sup> year and sets the appropriation amounts at (rounded) \$25 million for FY2010; \$26.3 for FY2011; \$27.6 for FY2012; \$28.9 for FY2013; and \$30.4 for FY2014.

### **Sec. 5604. Co-locating primary and specialty care in community-based mental health settings.**

Mandates the Secretary to award grants and cooperative agreements to eligible entities to establish demonstration projects for providing coordinated and integrated services to special populations through the co-location of primary and specialty care in community-based mental and behavioral health settings. Funds may be used for providing primary care services and the reasonable costs associated with referrals. Up to 15% of funds may be used for information technology and facility modifications. Authorizes \$50 million in FY2010 and such sums as necessary for FY2011-2014.

### **Sec. 5605. Key National Indicators.**

Establishes a Commission on Key National Indicators composed of 8 members appointed equally by the majority and minority leaders of the Senate and the Speaker and minority leader of the House. Members of Congress or federal, state, or local government officials are not eligible. The respective term is for 2 years with one initial appointment for 3 years. The first appointment must be made within 30 days of enactment. Eligible members include those individuals "who have shown a dedication to improving civic dialogue and decision-making through the wide use of scientific evidence and factual information." Two co-chairpersons are to be selected by Commission members.

The Commission shall conduct comprehensive oversight of a newly establish key national indicator system and make recommendations on how to improve such a



system. The Commission is to contract with the National Academy of Sciences for support; the Academy will either create its own institutional capability or partner with an independent private nonprofit organization as an Institute. Not later than 6 months after selection of the co-chairpersons, and annually thereafter, the Commission is to submit a report to the National Academy of Sciences recommending key national indicators. Not later than 1 year after the appointment the co-chairpersons of the commission, and then annually, the Commission must submit a report to Congress which includes recommendations, findings, and conclusions of the Commission on the activities of the National Academy of Science and, if applicable, the designated Institute, related to establishing a key national indicator system. The Academy is also to report to the Commission annually on its activities. GAO is directed to conduct a study of previous work on best practices for a key national indicator system; conduct an annual audit of an Institute, if established; and conduct programmatic assessments of the Institute as necessary. Authorizes appropriations of \$10 million for FY2010; and \$7.5 million for each of FY2011-2018.

**Sec. 5606. State Grants to Health Care Providers Who Provide Services to a High Percentage or Medically Underinsured Populations or Other Special Populations. (added by Sec. 10501).**

A State may award grants to health care providers who treat a high percentage, as determined by such State, of medically underserved populations or other special populations in such State.

**Sec. 10501. Amendments to the Public Health Service Act.**

**Amends Sec. 399V-3 of the PHS Act. National Diabetes Prevention Program.**

Requires the Secretary, acting with the CDC, to establish a national diabetes prevention program targeted at adults who are at high risk for diabetes in order to eliminate the preventable burden of diabetes.

**Amends Sec. 749B of the PHS Act. Rural Physician Training Grants.**

Requires the Secretary to establish a grant program for the purposes of assisting a medical school in recruiting students most likely to practice medicine in underserved rural communities, providing rural-focused training and experience, and increasing the number of medical school graduates who practice in underserved rural communities.

**Amends Sec. 768 to the PHS Act. Preventive Medicine and Public Health Training Grant Program.**

Requires the Secretary to award grants to, or enter into contracts with, eligible entities to provide training to graduate medical residents in preventive medicine specialties.

**Amends Sec. 770(a) of the PHS Act.**

Revises the National Health Service Corps Scholarship Program or Loan Repayment program to reflect participants who pursue completion of their obligation through half-time clinical practice.

**Sec. 10502. Infrastructure to Expand Access to Care.**

Appropriates \$100 million to pay for the construction or renovation of a health facility that provides “research, inpatient tertiary care, or outpatient clinical services.” Such facility must be affiliated with an academic health facility at a public research university that contains a State’s sole public academic medical and dental school. (According to HHS,

there are 11 states that meet this requirement but (as of 3/26/2010) the list has not been made available.)

**Sec. 10503. Community Health Centers and the National Health Service Corps Fund (as amended by Sec. 2302 of HCERA).**

Establishes the Community Health Center Fund to provide for an expanded and sustained national investment in community health centers. Appropriates \$8 billion (FY2011-2015) for the operation of community health centers and \$1.5 billion for the National Health Service Corps. Also appropriates \$1.5 billion for the construction or renovation of community health centers.

**Sec. 10504 of PPACA. Demonstration project to provide access to affordable care.**

Within 6 months of enactment, requires the Secretary to establish a 3 year demonstration project in up to 10 states to provide access to comprehensive health care services to the uninsured at reduced fees. An eligible entity must be a State-based, nonprofit, public-private partnership.

**Subtitle H—General Provisions**

**Sec. 5701. Reports.**

On an annual basis the Secretary shall submit to the appropriate committee of Congress a report on the activities carried out under this title, and the effectiveness of such activities. The Secretary may require reports from those entities receiving funds under this title.

**TITLE VI—TRANSPARENCY AND PROGRAM INTEGRITY**

**Subtitle A—Physician Ownership and Other Transparency**

**Sec. 6001. Limitation on Medicare exception to the prohibition on certain physician referrals for hospitals (as modified by sec. 10601 and by sec. 1106 of HCERA).**

Adds requirements for rural hospitals to qualify for the rural provider exception to the prohibition on certain physician self-referrals due to ownership or investment. Beginning not later than 9/23/2011, only hospitals with physician ownership or investment and a provider agreement in operation on 12/31/2010 and that meet numerous specified requirements are exempt from the prohibition on self-referral. The requirements include an annual report from each such hospital to the Secretary containing a detailed description of the hospital's ownership and investment interests (which information the Secretary is required to publish on the CMS website and update annually); disclosure by the hospital on its website and in any public advertising of the fact that physicians have ownership or investment interests; disclosure to patients concerning any ownership or investment interest of referring or treating physicians; prohibition on the hospital conditioning any physician ownership or investment interests either directly or indirectly on a physician owner or investor making or influencing referrals; limiting the aggregate value of the ownership or investment interests of physician owners or investors to the percentage they represented on 3/23/2010; procedures to disclose to patients if a physician will not be available on the premises to provide services during all hours in which the hospital is providing services to the patient; and various requirements to assure that physicians' ownership or investment interests do not result from special favor

from the hospital (such as loans or other assistance in acquiring ownership) or provide for future favors (such as the opportunity to benefit from or to purchase other business interests related to the hospital). The hospital also could not have converted from an ambulatory surgical center to a hospital on or after 3/23/2010.

Limits the number of operating rooms, procedure rooms, and beds for which the hospital is licensed at any time on or after 3/23/2010 to the number of operating rooms, procedure rooms, and beds for which the hospital is licensed on 3/23/2010. Provides a process to allow qualified hospitals to apply for an exception to the prohibition on expansion. To qualify for an exception, a hospital must either be a high Medicaid facility or satisfy five specified criteria involving location in a state with lower than average bed capacity and higher than average bed occupancy rates; location in a fast-growing county; having average or greater Medicaid percentage of inpatient admissions; and not discriminating against beneficiaries of Federal health care programs and also not permitting physicians practicing at the hospital to discriminate against such beneficiaries. Qualification for an exception on the basis of being a high Medicaid facility requires not being the only hospital in the county and having an annual percentage of Medicaid admissions that is the highest percentage for all hospitals in the county for each of the three most recent years for which data are available.

Capacity increase is limited to facilities on the main campus and cannot exceed 200% of the number of operating rooms, procedure rooms and beds on 3/23/2010. The Secretary must publish final decisions on an expansion request no later than 60 days after receiving a complete application. Secretary must issue regulations governing the exceptions process by 1/1/2012 and implement the process on 2/1/2012. There is no administrative or judicial review of the exceptions process.

Secretary must establish policies and procedures to ensure compliance with these requirements beginning on 9/23/2011. Enforcement efforts may include unannounced site reviews of hospitals. Secretary must conduct compliance audits beginning not later than 5/1/2012.

**Sec. 6002. Transparency reports and reporting of physician ownership or investment interests.**

Requires that, beginning no later than March 31, 2013, covered manufacturers that make a payment or another transfer of value to a physician or a teaching hospital to report annually, in electronic form, specified information on such transactions to the Secretary of HHS. Distributors would not be subject to these reporting requirements.

A payment or transfer of value means a transfer of anything of value. Certain information would be excluded from these reporting requirements.

Manufacturers would be allowed to delay submission of their reports pursuant to certain services furnished as part of a product development agreement, or in connection with a clinical investigation of a new drug, device, biological, or medical supply.

Manufacturers and group purchasing organizations are required to report annually certain information regarding an ownership or investment interest held by a physician (or an immediate family member) in the manufacturer or group purchasing organization during the preceding year. Hospitals not required to report ownership information.

Certain penalties would apply to manufacturers and group purchasing organizations for failure to submit these reports,

Requires establishment of procedures to ensure that information required to be submitted is available through an Internet website.

Preempts, subject to specified exemptions, duplicative state laws.

**Sec. 6003. Disclosure requirements for in-office ancillary services exception to the prohibition on physician self-referral for certain imaging services.**

Requires the written disclosure by the referring physician to the patient of any ownership interest in certain imaging services to which a physician refers a patient and provide the patient with a list of suppliers of the service in the patient's area of residence.

**Sec. 6004. Prescription drug sample transparency.**

Requires drug manufacturers or authorized distributors to report to the Secretary the information they are now required to collect in regard to the drug samples distributed to requesting licensed practitioners.

**Sec. 6005. Pharmacy benefit managers transparency requirements.**

Requires a pharmacy benefit manager (PBM) or a health benefits plan that provides pharmacy benefits management services that contracts with health plans under Medicare or the state Exchanges to report to the Secretary information regarding the mail order rate; the generic dispensing rate by pharmacy type; the aggregate amount of rebates, discounts, or price concessions negotiated by the PBM that are attributable to patient utilization and passed through to the plan sponsor; and the aggregate amount of the payment difference between the amount the health plans pay the PBM and the amount the PBM pays pharmacies, and the number of prescriptions dispensed. All disclosed information would be confidential, except for certain specific purposes.

**Subtitle B—Nursing Home Transparency and Improvement**

**PART I—IMPROVING TRANSPARENCY OF INFORMATION**

**Sec. 6101. Required disclosure of ownership and additional disclosable parties information.**

Requires extensive reporting and disclosure to the Secretary of any ownership or financial interest of at least 5% as well as anyone who exercises financial controls over the facility. Such information to be made available to the public. Effective 90 days after publication of regulations (which are due within 2 years of enactment).

**Sec. 6102. Accountability requirements for skilled nursing facilities and nursing facilities.**

Requires facility compliance and ethics programs to be followed by their employees and agents. Requires the Secretary to develop regulations within two years of enactment, and facilities to comply with regulations within 3 years of enactment. Requires the Secretary to create regulations on quality assurance and performance improvement (QAPI) plans. SNFs required to implement QAPI plans within one year after regulations are promulgated.

**Sec. 6103. Nursing home compare Medicare website.**

Increases the comparative information reported by SNFs that is to be provided on the Nursing Home Compare Medicare website (including standardized staffing data, standardized complaint form, survey and certification information, summary of enforcement action, and summary of staffing-related financial information). The Secretary is required to review accuracy, etc., of information reported on Nursing Home Compare and establish a process to modify same, as appropriate. Also requires addition of consumer rights information page on the website. States are required to submit survey information. SNFs are required to make available to the public, on request, the preceding 3 years of inspection reports. Effective one year after enactment.

**Sec. 6104. Reporting of expenditures.**

Requires SNFs to report expenditures for wages and benefits for direct care staff separately on cost reports submitted beginning 2 years after enactment (3/23/2012). Within 30 months of enactment, expenditure information, arrayed by specified functional accounts (direct care, indirect care, capital assets and administrative service costs), is to be publicly available on request.

**Sec. 6105. Standardized complaint form.**

Requires the Secretary to prepare a standardized complaint form for use by a nursing home resident in filing a complaint with the state. Each state is required to establish a complaint processing program, including a complaint resolution process. Effective not later than 3/23/2010.

**Sec. 6106. Ensuring staffing accountability.**

Within two years of enactment, SNFs are required to electronically submit to the Secretary specified direct care staffing information based on payroll and other verifiable data in a uniform format.

**Sec. 6107. GAO study and report on Five-Star Quality Rating System.**

Within two years of enactment, the GAO shall submit to Congress a report on the CMS Five-Star Quality Rating System for nursing homes.

**PART II—TARGETING ENFORCEMENT****Sec. 6111. Civil money penalties.**

SNFs are given the opportunity to participate in an informal dispute resolution process within 30 days of imposition of a penalty. Under certain circumstances, the Secretary is given the authority to place civil monetary penalties (CMPs) in an escrow account. If a deficiency is self-reported and promptly corrected, the Secretary and states may reduce penalty by up to 50%. No reduction is allowed if the deficiency is a repeat deficiency or is for certain specified serious deficiencies. Authorizes some portion of collected CMPs be used to fund activities that benefit residents.

**Sec. 6112. National independent monitor demonstration project.**

Requires the Secretary to develop, test, and implement a two-year pilot program which uses an independent monitor to oversee interstate and large intrastate chains of SNFs.

**Sec. 6113. Notification of facility closure.**

Within 1 year after enactment, requires the administrator of a nursing facility that is preparing to close to provide written notification no later than 60 days prior to closure to

residents and other parties and to prepare a plan for closing that ensures safe transfer of residents to new facilities. Provides sanctions for failure to comply.

**Sec. 6114. National demonstration projects on culture change and use of information technology in nursing homes.**

Requires the Secretary to conduct two demonstration projects: development of best practices for facilities involved in the culture change movement; and development of best practices in facilities for the use of information technology to improve resident care.

**PART III—IMPROVING STAFF TRAINING**

**Sec. 6121. Dementia and abuse prevention training.**

Requires facilities to include dementia management and patient abuse prevention training as part of pre-employment initial training for permanent and contract or agency staff, and if the Secretary determines appropriate, as part of ongoing in-service training. Effective 3/23/2010.

**Subtitle C—Nationwide Program for National and State Background Checks on Direct Patient Access Employees of Long-term Care Facilities and Providers**

**Sec. 6201. Nationwide program for National and State background checks on direct patient access employees of long-term care facilities and providers.**

Requires the Secretary to establish a nationwide program for national and State background checks on direct patient access employees of certain long-term supports and services facilities or providers. This program is based on the background check pilot program in the Medicare Modernization Act.

**Subtitle D—Patient-Centered Outcomes Research**

**Sec. 6301. Patient-Centered Outcomes Research (as modified by sec. 10602).**

Mandates a new Patient-Centered Outcomes Research Institute as a private, non-profit corporation to assist patients, clinicians, purchasers, and policy makers in making informed health decisions by advancing the quality and relevance of clinical evidence through research and evidence synthesis. The research will compare the health outcomes and clinical effectiveness, risks, and benefits of 2 or more medical treatments, services or items.

Mandates a Board of Governors, which is responsible for carrying out the duties of the Institute. The Board may not delegate certain tasks, including identifying national research priorities, and adopting methodological standards. Board members include the Director of AHRQ and the Director of NIH (or their designees), 3 members representing each of the following groups: (1) patients and health care consumers, (2) private payers, and (3) pharmaceutical, device, and diagnostics manufacturers or developers; 7 members representing physicians and providers, including 4 members representing physicians (at least 1 of whom is a surgeon), 1 nurse, 1 State-licensed integrative health care practitioner, and 1 representative of a hospital; 1 member representing quality improvement or independent health service researchers, and 2 members representing the Federal Government or the states.

The Institute must identify research priorities, establish a research project agenda, adopt methodological standards, provide for a peer-review process for primary research, and

provide for a public comment period of not less than 45 days and not more than 60 days prior to adopting (by majority vote) such priorities, agenda, methodological standards, and peer-review process.

The Institute may appoint permanent or ad hoc expert advisory panels, and must appoint such panels in carrying out randomized clinical trials and in the case of a research study for rare disease. The Institute may include a technical expert of each manufacturer or each medical technology that is included under the relevant topic, project or category for which an expert advisory panel is established. The Institute must also establish a standing methodology committee of not more than 15 members appointed by the Comptroller General (which must also include the Directors of the National Institutes of Health and the Agency for Healthcare Research and Quality or their designees).

The Comptroller General must consider and disclose any conflicts of interest of potential Board appointees and in appointing members of the methodology committee. The Institute must disclose any conflicts of interest of other participants in its processes.

The Institute may not mandate coverage, reimbursement, or other policies for any public or private payer. The reports or research findings may not include practice guidelines, coverage recommendations, payment or policy recommendations. The Secretary of HHS is prohibited from denying Medicare coverage based solely on a study conducted by the Institute, and the Secretary may only use evidence and findings from Institute research to make a Medicare coverage decision if such use is through an iterative and transparent process which includes public comment and considers the effect on subpopulations.

The Secretary is also prohibited from using the Institute's research in determining coverage, or creating reimbursement or incentive programs for a treatment in ways that (1) treat extending the life of an elderly, disabled, or terminally ill patient of lower value than extending the life of others or (2) preclude or discourage an individual from choosing a health care treatment based on how the individual values the tradeoff between extending the length of their life and the risk of disability. The Institute is prohibited from developing or using a dollars-per-quality-adjusted-life-year or other similar methodology. All of the above notwithstanding, the Secretary is not prohibited from using comparative clinical effectiveness research in determining coverage, reimbursement or incentive programs under Medicare based upon comparing differences in the effectiveness of alternative treatments in extending a patient's life due to the patient's age, disability, or terminal illness. The Institute may not allow the subsequent use of data from original research by individuals, entities or instrumentalities that have a financial interest in the results unless approved under a data use agreement with the Institute, and original research may be published in peer-reviewed publications as long as the researcher enters into a data use agreement with the Institute for use of the data from the original research.

Includes provisions intended to ensure transparency and opportunities for stakeholder input. The Institute is expected to work with users of health information technology focused on clinical decision support to promote the timely incorporation of research findings into clinical practice.

The Office of Communication and Knowledge Transfer of AHRQ must broadly disseminate the research findings published by the Institute and other like research.

AHRQ is directed to build capacity for comparative clinical effectiveness research by establishing a grant program. The Secretary is directed to provide for the coordination of relevant Federal health programs to build data capacity for comparative clinical effectiveness research, including the development and use of clinical registries and health outcomes research data networks.

Creates a Patient-Centered Outcomes Research Trust Fund (PCORTF), with contributions from Medicare, private health insurers and self-insured health plans beginning at \$1 per capita for FY 2013, rising to \$2 per capita for FY 2014 (then indexed by the percentage increase in the projected per capita amount of National Health Expenditures for FY 2015 through FY 2019). Additional financing is provided through appropriations, beginning with \$10 million for FY 2010, rising to \$150 million per year for FY 2012 through FY 2019.

**Sec. 6302. Federal coordinating council for comparative effectiveness research.**  
Terminates the Coordinating Council on enactment (3/23/2010).

#### **Subtitle E—Medicare, Medicaid, and CHIP Program Integrity Provisions**

**Sec. 6401. Provider screening and other enrollment requirements under Medicare, Medicaid, and CHIP (as modified by sec. 10603 and sec. 1304 of HCERA).**

Not later than 9/19/2010, mandates screening of all providers and suppliers before the granting of Medicare, Medicaid or CHIP billing privileges, including criminal background checks (screening will apply to those already enrolled in these programs on 3/23/2012). A \$500 application fee per institutional provider (in FY 2010) is imposed to cover screening costs (the fee is indexed by CPI-U). No application fee applies to individual providers. Authorizes a provisional period of enhanced oversight for new providers and suppliers (30-365 days long), such as prepayment review and payment caps, as the Secretary determines appropriate. Authorizes payment adjustments for providers and suppliers with the same tax identification number for past-due obligations. Authorizes a temporary moratorium on enrollment of new providers and suppliers if determined necessary to prevent or combat fraud, waste or abuse (no requirement for Secretary to determine that beneficiary access will not be adversely affected, but states are not required to comply with any temporary moratorium if it would adversely impact Medicaid/CHIP beneficiary access to medical assistance).

Effective 3/23/2011, requires providers or suppliers enrolling or re-enrolling under Medicare, Medicaid, or CHIP to disclose any current or previous affiliation with a provider or supplier that has uncollected debt or with a person or entity that has been suspended or excluded under the program, subject to payment suspension, or has had its billing privileges revoked. Permits Secretary to deny enrollment if a previous affiliation poses an undue risk of fraud, waste or abuse.

For periods beginning after 1/1/2011, requires the Secretary to withhold Medicare payments for 90 days in the case of claims submitted by new durable medical equipment suppliers if the Secretary determines there is a significant risk of fraudulent activity.

Requires providers and suppliers “within a particular industry sector or category” to establish a compliance program to reduce waste, fraud and abuse. The Secretary must specify the core elements of such compliance program. The Secretary must develop an implementation timeline.



Requires states to comply with processes for screening providers and suppliers and other oversight established for Medicare elsewhere in the Act. Requirements include providing for an enhanced period of oversight for new providers and suppliers, disclosure requirements, temporary moratoria on enrolling new providers, except if the state determines it would adversely impact beneficiary access to services, compliance programs, reporting of adverse provider actions, or use of national provider identification.

**Sec. 6402. Enhanced Medicare and Medicaid program integrity provisions (as modified by sec. 1303 of HCERA).**

Requires CMS to complete development of a comprehensive Integrated Data Repository (expands program data sources and data sharing/matching across Federal programs, for the purpose of identifying potential fraud, waste and abuse under Medicare and Medicaid). Authorizes the OIG and the Attorney General to access Medicare, Medicaid and CHIP claims and payment data for purposes of conducting law enforcement and oversight activities.

Requires prompt reporting and repayment of identified Medicare and Medicaid overpayments. The deadline for repayment is the later of (1) the date which is 60 days after the date on which the overpayment was identified or (2) the date any corresponding cost report is due, if applicable.

Mandates unspecified (“appropriate”) administrative penalties for knowing participation by a beneficiary in a health care fraud scheme.

Mandates the promulgation of a regulation that requires, not later than 1/1/2011, all providers and suppliers under Medicare and Medicaid to include their national provider identifier on all applications to enroll in such programs and on all claims submitted for payment under such programs.

Mandates withholding of Federal Medicaid matching payments for states that fail to report enrollee encounter data in the Medicaid Statistical Information System.

Clarifies that Medicare Part D plans may waive the beneficiary copayment for the first generic prescription filled to encourage use of lower-cost generic drugs without violating Federal fraud and abuse provisions. Effective on date specified by the Secretary but in no case earlier than 1/1/2011.

Imposes penalties for false statements on provider or supplier enrollment applications, including managed care organizations and PDP sponsors. Imposes financial penalties on excluded individuals who nevertheless order an item or service covered by a Federal health care program.

Creates the following new exceptions to prohibited offers or transfers of remuneration to beneficiaries (likely to influence their choice of provider or supplier of health care services): (1) any remuneration which promotes access and poses a low risk of harm; (2) the offer or transfer of items or services for free or less than fair market value if they consist of coupons, rebates, or other rewards from a retailer, are available to the general public regardless of health insurance status, and not tied to the provision of other items or services reimbursed under Medicare or a state health care program; (3) the offer or transfer of items or services for free or less than fair market value if not offered as part of

any advertisement or solicitation, not tied to the provision of other services reimbursed under Medicare or a state health care program, are reasonably connected to the medical care of the individual, and provided after determining in good faith that the individual is in financial need; and (4) effective on a date specified by the Secretary (but not earlier than 1/1/2011) the waiver by a PDP or MA-PDP plan of the first fill of a generic drug.

Authorizes program exclusions and financial penalties for any entity making false statements or misrepresenting material facts, including Medicare Part C and D plans, Medicaid managed care organizations, and entities that apply to participate as providers of services or suppliers in such managed care organizations and plans. Applies authority to subpoena witnesses to program exclusion investigations.

Revises the intent requirement under the anti-kickback statute to specify that a person need not have actual knowledge of the law or specific intent to violate the law.

Authorizes the Secretary to require durable medical equipment suppliers and home health agencies to obtain a surety bond in an amount in excess of \$50,000 that is "commensurate with the volume of the billing" of the supplier or agency. Authorizes the Secretary to require other providers and suppliers to obtain a surety bond if the Secretary determines this is appropriate based on the level of risk involved with respect to these providers and suppliers.

Permits the Secretary to suspend payments under Medicare pending investigation of credible allegations of fraud, and to deny Medicaid payments to states failing to suspend Medicaid payments to such individuals.

Increases Health Care Fraud and Abuse Control (HCFAC) funding by \$10 million each year for 10 years, and appropriates an additional \$250 million for FYs 2011-2016 for HCFAC. Permanently indexes amounts appropriated from the HCFAC Fund to HHS, OIG, the FBI, and the Medicare Integrity Program. For fiscal years after FY 2010, indexes Medicaid Integrity Program funding by CPI-U.

Requires Medicare and Medicaid Integrity Program contractors to submit performance statistics and requires the Secretary to conduct periodic evaluations of these contractors.

Permits waivers of program exclusions that the Secretary determines would impose undue hardship on beneficiaries of any Federal health care program (not just Medicare beneficiaries), such as exclusions involving a sole community physician or a sole source of essential specialized services in a community.

#### **Sec. 6403. Elimination of duplication between the Healthcare Integrity and Protection Data Bank and the National Practitioner Data Bank.**

Sunsets the Healthcare Integrity and Protection Data Bank (HIPDB) and transitions to having the National Practitioner Data Bank (NPDB) serve as the central repository for information about adverse actions taken against health care providers. Beefs up state reporting requirements.

**Sec. 6404. Maximum period for submission of Medicare claims reduced to not more than 12 months.**

Effective for services furnished on or after 1/1/2010, reduces the time allowed for submitting Medicare Part A and Part B claims from 36 months to 12 months (claims for services provided before 1/1/2010 must be submitted by 12/31/2010).

**Sec. 6405. Physicians who order items or services required to be Medicare enrolled physicians or eligible professionals (as modified by Sec. 10604).**

Effective 7/1/2010, only a Medicare-enrolled physician can order Medicare-covered home health services, and only a Medicare-enrolled physician or health professional can order Medicare-covered durable medical equipment. The Secretary may expand this requirement to other categories of items or services, including Part D drugs.

**Sec. 6406. Requirement for physicians to provide documentation on referrals to programs at high risk of waste and abuse.**

Effective 1/1/2010, authorizes the Secretary to disenroll from Medicare (for up to 1 year for each act) providers, physicians and suppliers who fail to maintain and, upon request, provide access to, documentation relating to written orders for DME and home health and for referrals for other items and services ordered by such provider, physician or supplier under Medicare, as specified by the Secretary.

**Sec. 6407. Face to face encounter with patient required before physicians may certify eligibility for home health services or durable medical equipment under Medicare (as modified by sec. 10605).**

Effective 1/1/2010, requires physicians certifying or re-certifying the need for Medicare home health services or ordering DME to have a face-to-face encounter with the patient (including through telehealth) during the preceding 6 months or other reasonable timeframe determined by the Secretary. In the case of home health services, the face-to-face encounter may also be conducted by a nurse practitioner, a clinical nurse specialist, a physician assistant, or a certified nurse-midwife. In the case of DME, the face-to-face encounter may also be conducted by a nurse practitioner, a clinical nurse specialist, or a physician assistant. The preceding requirements also apply to Medicaid. The Secretary may expand the policy to other items and services but such expansion would only apply to Medicare.

**Sec. 6408. Enhanced penalties.**

Makes conforming changes to civil monetary penalty provisions in light of other changes being made in the bill. Effective 1/1/2010, imposes financial penalties for submission of false claims data under a Federal health care program.

Effective 1/1/2010, imposes financial penalties for failure to grant timely access to OIG auditors and investigators. Amends current law to ensure timely inspections relating to contracts with Medicare Advantage Organizations.

Effective 1/1/2010, imposes enhanced penalties for Medicare Advantage and Part D marketing violations, including enrolling or transferring individuals without their prior consent.

Effective 1/1/2010, broadens existing penalties relating to investigation obstruction to apply to audit obstruction.

**Sec. 6409. Medicare self-referral disclosure protocol.**

Not later than 9/23/2010, mandates the establishment of a protocol to enable health care providers and suppliers to disclose actual or potential violations of the physician self-referral prohibitions. The Secretary may reduce amounts owed for self-disclosing entities. Not later than 9/23/2011, the Secretary must submit a report to Congress on the implementation of this provision.

**Sec. 6410. Adjustments to the Medicare durable medical equipment, prosthetics, orthotics, and supplies competitive acquisition program.**

Expands the number of metropolitan areas to be included in Round II of DME competitive bidding from 70 to 91 (by including the next 21 largest metropolitan statistical areas by total population), and requires the Secretary to extend the competitive bidding program or apply competitive bid rates to all remaining areas by 2016.

**Sec. 6411. Expansion of the Recovery Audit Contractor (RAC) program.**

Extends the Recovery Audit Contractor (RAC) program to Medicare Parts C and D and Medicaid. RACs must ensure that each Medicare Advantage organization and Part D plan has an anti-fraud plan.

**Subtitle F—Additional Medicaid Program Integrity Provisions**

**Sec. 6501. Termination of provider participation under Medicaid if terminated under Medicare or other State plan.**

Requires states to terminate participation under Medicaid of any provider terminated under another state Medicaid plan or Medicare. Certain existing exceptions to apply. Generally effective 1/1/2011 (see sec. 6508).

**Sec. 6502. Medicaid exclusion from participation relating to certain ownership, control, and management affiliations.**

States must exclude from Medicaid for a period any entity or individual that owns, controls, or manages an entity that has unpaid overpayments determined to be delinquent; whose participation in Medicaid is suspended, excluded or terminated; or who is affiliated with an individual or entity that has been suspended, excluded or terminated. Generally effective 1/1/2011 (see sec. 6508).

**Sec. 6503. Billing agents, clearinghouses, or other alternate payees required to register under Medicaid.**

Requires that any agent, clearinghouse or other alternate payee that submits claims on behalf of a health care provider to register with the state and the Secretary in the form and manner specified by the Secretary. Generally effective 1/1/2011 (see sec. 6508).

**Sec. 6504. Requirement to report expanded set of data elements under MMIS to detect fraud and abuse.**

Amends state requirements for electronic transmission of claims data consistent with the Medicaid Statistical Information System (MSIS) to also require data elements that the Secretary determines are necessary for program integrity, oversight and administration. Applies to data submitted beginning 1/1/2010.

Also amends the requirement that Medicaid managed care organizations maintain sufficient patient encounter data to identify the physician who delivers services to patients,

and to require that the data be provided to the state at a frequency and level of detail to be specified by the Secretary. Effective for contract years beginning on or after 1/1/2010.

**Sec. 6505. Prohibition on payments to institutions or entities located outside of the United States.**

Prohibits states from making payments for Medicaid services to entities or financial institutions outside the U.S. Generally effective 1/1/2011 (see sec. 6508).

**Sec. 6506. Overpayments.**

Extends the time under which states can recover overpayments before a Federal adjustment is made from 60 days to 1 year in the case of fraud. Provides that if recovery of overpayments does not occur within 1 year due to a judgment being under appeal, no adjustment shall be made to state payments until 30 days after the judgment is finalized. Effective 3/23/2010; applies to overpayments discovered on or after 3/23/2010.

Also requires the Secretary to promulgate regulations requiring states to correct federally identified overpayments of an ongoing or recurring nature with new Medicaid Management Information System (MMIS) edits, audits or other appropriate corrective action.

**Sec. 6507. Mandatory State use of national correct coding initiative.**

Requires that states, beginning with claims filed on 10/1/2010 incorporate compatible methodologies of the National Correct Coding Initiative used for Medicare and other methodologies identified by the Secretary to promote proper coding. By 9/1/2010 the Secretary to identify Initiative methodologies compatible with Medicaid claims, identify methodologies that should be incorporated into Medicaid claims for which no Medicare coding methodologies have been established, and notify states of these methodologies and how to incorporate them into Medicaid claims. By 3/1/2011, the Secretary is to provide a report to Congress that includes the notice to states and analysis supporting the methodologies identified for incorporation into Medicaid.

**Sec. 6508. General Effective Date.**

Except as otherwise specified, the effective date for provisions of Subtitle F (sec 6501-6507) are effective 1/1/2011, without regard to whether associated final regulations have been promulgated by that date. In the case of a state for which the Secretary determined that legislation is required to implement the changes, the state will not be regarded as out of compliance before the first day of the first calendar quarter beginning after the close of the first regular session of the state legislature that begins after 3/23/2010. For this purpose, each year of a 2-year legislation session is considered a separate session.

**Subtitle G—Additional Program Integrity Provisions**

**Sec. 6601. Prohibition on false statements and representations.**

Makes employees and agents of Multiple Employer Welfare Arrangements (MEWAs) a type of employer-sponsored health plan involving two or more employers, subject to criminal penalties if they make false statements in their marketing materials.

**Sec. 6602. Clarifying definition.**

Authorizes the Department of Justice to prosecute crimes involving MEWAs.

**Sec. 6603. Development of model uniform report form.**

Requires the Secretary of HHS to request that the National Association of Insurance Commissioners develop a model uniform reporting form for private health insurance issuers seeking to refer suspected fraud and abuse to state insurance departments for investigation, and make recommendations for uniform reporting standards for such referrals.

**Sec. 6604. Applicability of State law to combat fraud and abuse.**

Authorizes the Department of Labor to adopt regulations or issue orders specifying when MEWAs are subject to state insurance regulation.

**Sec. 6605. Enabling the Department of Labor to issue administrative summary cease and desist orders and summary seizures orders against plans that are in financially hazardous condition.**

Authorizes the Department of Labor to issue cease and desist orders against a MEWA if it appears that its conduct is fraudulent, creates an immediate danger to public safety or welfare, or is causing public injury. Also authorizes the Department of Labor to issue seizure orders if it appears that a MEWA is in a financially hazardous condition.

**Sec. 6606. MEWA plan registration with Department of Labor.**

Requires MEWAs to file a registration form with the Department of Labor before enrolling anyone in the plan.

**Sec. 6607. Permitting evidentiary privilege and confidential communications.**

Permits the Department of Labor to allow confidential communication among Federal and state officials relating to the investigation of fraud and abuse without the need to develop Memoranda of Understanding.

**Subtitle H—Elder Justice Act**

**Sec. 6701. Short title of subtitle.**

The “Elder Justice Act of 2009.”

**Sec. 6702. Definitions.**

Defines the terms used in this subtitle using the same definitions in section 2011 of the Social Security Act.

**Sec. 6703. Elder Justice.**

Requires the Secretary, in consultation with the Departments of Justice and Labor, to award grants and carry out activities that provide greater protection to those individuals seeking care in facilities that provide long-term services and supports and provide greater incentives for individuals to train and seek employment at such facilities. Owners, operators, and certain employees of these facilities would be required to report suspected crimes committed at a facility. Owners or operators of such facilities would also be required to submit to the Secretary and to the State written notification of an impending closure of a facility within 60 days prior to the closure. In the notice, the owner or operator would be required to include a plan for transfer and adequate relocation of all residents. Creates an Elder Justice Coordinating Council within HHS and an Advisory Board on Elder Abuse, Neglect, and Exploitation. Requires the Secretary to make grants to eligible entities to establish and operate stationary and mobile forensic centers.

## **Subtitle I—Sense of the Senate Regarding Medical Malpractice**

### **Sec. 6801. Sense of the Senate regarding medical malpractice.**

Expresses the Sense of the Senate that states should be encouraged to develop and test alternatives to the existing civil litigation system with respect to the resolution of medical malpractice claims and that Congress should consider establishing a state demonstration program to evaluate such alternatives.

### **Sec. 10201. GAO Study on Causes of Action.**

Mandates a GAO study of whether the development, recognition, or implementation of any guideline or other standards under 14 specified Medicare, Medicaid, quality of care, prevention, and public health provisions of the bill would result in the establishment of a new cause of action or claim. Provisions include those for Medicaid adult health quality measures and Medicaid adjustments for health care acquired conditions, Medicare improvements to the Physician Quality Reporting Initiative and the Physician Feedback Program, the Medicare Hospital Value-Based Purchase Program, the hospital readmission reduction program, quality measurement development, the Center for Medicare and Medicaid Innovation, and the Task Force on Clinical and Preventive Services. A report on the study is due not later than 3/23/2012.

### **Sec. 10606. Health care fraud enforcement.**

Mandates United States Sentencing Commission review and enhancement of Federal Sentencing Guidelines and policy statements applicable to persons convicted of Federal health care offenses. Specifies that a person need not have actual knowledge of applicable Federal law or specific intent to commit a violation of such law to knowingly commit health care fraud. Enhances subpoena authority under HIPAA and authorizes the Attorney General (or designee) to require by subpoena access to any institution subject to investigation under the Civil Rights and Institutionalized Persons Act or to documents or other materials relating to potential violations of such Act. Such documents and materials may not be used for any purpose other than to protect the rights, privileges, or immunities of persons who reside, have resided, or will reside in any institution, and must be redacted or otherwise altered if used in any publicly available manner so as to prevent the disclosure of any personally identifiable information.

### **Sec. 10607. State demonstration programs to evaluate alternatives to current medical tort litigation.**

Authorizes \$50 million for the 5-fiscal year period beginning with FY 2011 for demonstration grants to states (for a period not to exceed 5 years) for the development, implementation, and evaluation of alternatives to current tort litigation for resolving disputes over injuries allegedly caused by health care providers or health care organizations. States must meet a number of conditions to receive a grant, including providing patients the ability to opt out of or voluntarily withdraw from participating in the alternative at any time. States must establish a scope of jurisdiction for the demonstration (such as Statewide, designated geographic region, a designated area of health care practice, or a designated group of health care providers or health care organizations), but such scope may not be based on a health care payer or patient population. Applications for demonstration grants will be reviewed by a review panel of 9 to 13 individuals appointed by the Comptroller General (with fair representation of: patient advocates; health care providers and health care organizations; attorneys with expertise in representing patients and health care providers; medical malpractice insurers, state officials; and patient safety experts). States receiving grants must submit

annual reports to the Secretary, and the Secretary must, in turn, submit an annual report to Congress that includes a compendium of state reports and an analysis of the activities funded under the demonstration grants. The Secretary must provide technical assistance to states applying for or awarded grants, and may provide initial planning grants of up to \$500,000 per state for the development of demonstration project applications. The Secretary must contract with an appropriate research organization to conduct an overall evaluation of the effectiveness of the grants awarded and annually prepare and submit a report to Congress. Not later than 12/31/2016, the Medicare Payment Advisory Commission and the Medicaid and CHIP Payment and Access Commission must each submit to Congress a report that includes findings and recommendations of each body's independent evaluation of the impact of alternatives to current tort litigation on the Medicare and Medicaid/CHIP programs, respectively (and their beneficiaries).

**Sec. 10608. Extension of medical malpractice coverage to free clinics.**

Effective 3/23/2010, extends Federal Tort Claims Act liability protection to an officer, governing board member, employee, or contractor of a free clinic for any act or omission that occurs on or after that date.

**Sec. 10609. Labeling changes.**

Provides an exception to the general requirement that an abbreviated application for a new drug (ANDA) show that the labeling proposed for the new drug is the same as the labeling approved for the listed referent drug. This exception would apply to a drug otherwise qualified for approval for which the listed referent drug has undergone a labeling change within 60 days of the anticipated ANDA approval provided that: (1) the ANDA sponsor agrees to submit revised labeling within 60 days of the Secretary's requiring changes; (2) the Secretary does not determine that continued use of the unrevised labeling would adversely impact the safe use of the drug; or (3) the labeling revisions do not affect the "Warnings" section of the label.

**Sec. 1301 of HCERA. Community mental health centers.**

Redefines the term "community mental health center" (for purposes of Medicare coverage of partial hospitalization services) to require that at least 40 percent of services must be furnished to individuals not eligible for Medicare. Specifies that a program of partial hospitalization services is one that does not offer services in the patient's home or in an inpatient or residential setting. Provisions apply to items and services furnished on or after 4/1/2011 and are intended to help prevent fraud and abuse.

**Sec. 1302 of HCERA. Medicare prepayment medical review limitations.**

Repeals section 1874A(h) of the Social Security Act, which specified how Medicare contractors should conduct random and non-random pre-payment reviews. This repeal is intended to facilitate additional reviews designed to reduce fraud and abuse.



## **TITLE VII—IMPROVING ACCESS TO INNOVATIVE MEDICAL THERAPIES**

### **Subtitle A—Biologics Price Competition and Innovation**

#### **Sec. 7001. Short title.**

Cites the subtitle as the “Biologics Price Competition and Innovation Act of 2009”. Expresses the sense of the Senate that a biosimilars pathway balancing innovation and consumer interests should be established

#### **Sec. 7002. Approval pathway for biosimilar biological products.**

##### Applications

Authorizes applications for licensure of biosimilar products. A biosimilar product is a biological product that is highly similar to the reference product with no clinically meaningful difference between the biosimilar and the reference product in terms of safety, purity, and potency. A biological product is defined as a protein (other than any chemically synthesized polypeptide). A reference product (brand-name) is the single biological product licensed under §351(a) of the PHS Act against which a biosimilar is evaluated.

An application must contain information demonstrating similarity between products (based on data from studies), use of same mechanisms for action for the conditions of use prescribed (such use previously approved in labeling of reference product), route of administration and dosage form and strength are the same, and that the manufacturing facility meets applicable safety standards. Permits HHS to determine that elements (such as clinical studies) in the application for the licensure of a biological product as biosimilar or interchangeable may be unnecessary.

The biosimilar shall be licensed if HHS determines that the reference product and a biological product are biosimilar or interchangeable. Interchangeable means that the biological product may be substituted for the reference product without the intervention of the health care provider who prescribed the reference product.

Provides for a period of exclusive marketing for the first biosimilar approved (from 1 year to 42 months depending on circumstances) for a reference product and also provides for a 12-year exclusivity period (from the date on which the reference product was first approved) for the reference product.

For biologics for which pediatric studies show health benefits for that population, six months are added to exclusivity periods (for both new and already marketed biologics). Six months also are added to the 7-year exclusivity period for biologics for rare diseases or conditions. Periods are not extended if the biosimilar product is approved within 9 months of the expiration of the exclusivity period for the reference product.

For orphan products, the exclusivity period is the later of the 12-year period under the licensure pathway for biosimilars, or the 7-year period applicable under section 527(a) of the FFDCA.

HHS may publish guidance on the licensure of a biosimilar. If HHS develops guidance, HHS must allow for public comment and input regarding priorities for issuing proposed

guidance before issuance of final guidance. The issuance or lack of guidance does not preclude the review of, or action on, an application for a biosimilar.

#### Patent Protections

Establishes a process (including timelines) for patent notice and patent infringement claims against a subsection (k) applicant by a reference product sponsor for a biosimilar product license. Requires applicant to submit confidential access to information to outside and inside counsel of reference product sponsor. Owners of patent may be granted that access. Imposes duty of confidentiality on persons involved and clarifies that applicant owns confidential information.

Establishes new processes for identifying patents that might be disputed between the reference product sponsor (and interested third parties) and the applicant. Requires reference product and biosimilar product sponsors to develop lists of patents that could be subject to claim of patent infringement and patents that reference product sponsor might license to applicant. Parties to engage in good faith negotiations to resolve issues for 15 days. Absent an agreement on which patents will be actionable, parties simultaneously exchange lists of patents that should be actionable under patent infringement suit. If agreement is achieved, patent infringement suits commence within 30 days. Includes a provision that permits a reference product sponsor to supplement a list in the case of newly issued patents within 30 days of issuance. Requires applicant to notify reference product sponsor 180 days before commercial marketing of biosimilar, and permits reference product sponsor to seek a preliminary injunction for court to decide patent validity. No action for declaratory judgment for patent infringement may be brought after the provision of confidential information by the applicant and before the notice of intent to commercially market the biosimilar. The reference product sponsor may bring such an action if the applicant fails to complete requisite requirements or fails to submit confidential information.

#### Fees for Applications for Biosimilar

Amends section 735(1)(B) of the FDCA to clarify that the authority to impose user fees for the review of applications for approval of biological products under current law also applies to applications for biosimilars. Includes a Sense of the Senate that user fees should be established based on recommendations of Secretary, and requires Secretary to collect data on costs incurred in evaluating biosimilar applications.

#### Enforcement under Patent Infringement

Amends section 271(e)(2) of title 35, United States Code, (relating to patent infringement) to make the filing of a statement by a biosimilar applicant regarding patents identified by the reference product sponsor and other interested parties an act of patent infringement if made before the expiration of the patent of the reference product. Requires reference product sponsors, and permits other interested parties, to identify patents that relate to the biosimilar product that is the subject of the application. The applicant may state its position with respect to those patents. If the applicant responds by asserting that one or more of the patents in question are invalid, unenforceable, or would not be infringed by the proposed biosimilar product, the applicant is deemed to have committed an act of patent infringement that is immediately actionable in the US courts. Alternatively, if the applicant files an application for approval but fails to include the confidential information required, the applicant is deemed to have committed a patent infringement.

In addition to existing remedies, in the case of biosimilar patent infringement, the court is required to order a permanent injunction against the biosimilar for the duration of the patent of the reference product if a final court action is determined in favor of the reference product sponsor.

Also limits remedy available for successful infringement claims that are filed after the applicable 30-day period to reasonable royalties.

Notwithstanding other rights to commence actions for patent infringement, the owner of a patent that was not included in the list of patents that could be subject to action for infringement the reference product sponsor makes available to the applicant, that patent owner has no right to pursue a claim for infringement of that patent.

### **Sec. 7003. Savings.**

Requires that any savings identified by Secretaries of HHS and Treasury by reason of the Biologics Price Competition and Innovation Act be used for deficit reduction.

### **Subtitle B—More Affordable Medicines for Children and Underserved Communities**

#### **Sec. 7101. Expanded participation in 340B program (as modified by 2302 of HCERA).**

Expands the entities that qualify for the PHS sec. 340B program regarding access to discounted prices for drugs, to include: (1) non-PPS children's hospitals and non-PPS free-standing cancer hospitals, (2) critical access hospitals, (3) rural referral centers and sole community hospitals that have a disproportionate share adjustment of 8% or more. Excludes orphan drugs for rare diseases or conditions for these expansion entities.

Note: under section 2302 of HCERA, provisions relating to expansion of the 340B program to inpatient hospitals and permissive use of group purchasing organizations (as added by PPACA) are struck.

#### **Sec. 7102. Improvements to 340B program integrity.**

Establishes new auditing, reporting, and other compliance requirements for the Secretary, and for pharmaceutical manufacturers and 340B covered entities.

For manufacturers, CMS will create a process to verify accuracy of ceiling prices (including spot checks); set up procedures for refunds to covered entities in the case of overcharges; give access to covered entities and State Medicaid agencies to the HHS website for verified ceiling prices; provide for reporting to CMS of rebates, etc.; and develop a mechanism to issue appropriate refunds to entities.

Imposes civil money penalties for violations under regulations established within 180 days and provides for a maximum penalty of \$5,000 per violation under a knowing and intentional standard. Requires manufacturers to furnish quarterly reports of ceiling prices.

For covered entities, to prevent diversion and violations of duplicate discounts and other requirements, HHS must have procedures for entities to annually update information on the HHS website. HHS must verify accuracy of that information; develop more detailed guidance for billing Medicaid for drugs to avoid duplicate discounts; create a single, universal, standardized identification system for manufacturers to identify entity sites; and impose civil money penalties in the form of interest owing on sums for which the

entity is found liable, or exclusion from the program, for knowing and intentional violations.

HHS shall set up an alternative dispute resolution process for claims by manufacturers or covered entities that the other has committed a violation of the program requirements. Includes mandates for procedures to designate officials to hear claims, establish deadlines and rules for discovery, requirements for manufacturer conducted audits of covered entity before initiation of resolution process, permit consolidation of claims. Clarifies that administration resolution is final and binding on parties unless overturned by court of competent jurisdiction.

Provisions apply to drugs dispensed on or after January 1, 2010

**Sec. 7103. GAO study to make recommendations on improving the 340B program.**

Requires GAO report to Congress within 18 months on whether individuals served by covered entities under 340B program are receiving optimal health care services. Recommendations are to include whether the program should be expanded, whether mandatory sales of certain products through the program hinder access to therapies through any provider, and whether income from the program is used by covered entities to further program objectives.

**TITLE VIII—CLASS ACT**

**Sec. 8001. Short Title of Title.**

This title may be cited as the “Community Living Assistance Services and Supports Act” or the “CLASS Act”.

**8002. The Community Living Assistance Services and Supports (CLASS) Act.**

The Community Living Assistance Services and Supports (CLASS) Act is established as Title XXXII of the Public Health Service Act (Sections 3201-3210.)

Enrollment and disenrollment: An individual eligible for enrollment in the CLASS program is someone age 18 or over, who is actively employed, and who is not institutionalized in a health care or correctional facility. The Secretary of HHS, in coordination with the Secretary of Treasury will establish procedures for automatic enrollment of individuals in the CLASS program by their employers. Alternative procedures for enrollment will be established for self-employed individuals, those with more than one employer, and those whose employer does not elect to participate. Employees may opt-out of enrollment. The Secretary will establish biennial individual specific open enrollment periods for individuals who waive enrollment during their initial enrollment period, and disenrollment periods. The Secretary is to issue regulations for exceptions to the minimum earnings requirement.

Premiums: CLASS premiums shall be deducted from wages or self-employment income in accordance with established procedures. Alternative procedures will be established for employees of employers who do not participate and for those who do not earn wages or self-employment income. Premium payments will be deposited in the CLASS Independence Fund. The tax treatment for the CLASS program shall be the same as for qualified long-term care insurance programs.

CLASS premiums amounts paid by enrollees will be based on an actuarial analysis of the 75 year costs for the program to assure program solvency. Nominal premiums of \$5

per month (indexed annually to the CPI-U for each year after 2009) shall be established for individuals below poverty and for full-time students under age 22. The Secretary shall establish procedures for self-attestation and verification of income for those paying the nominal premium. Premiums may include up to 3% to cover program administrative costs. No underwriting shall be used to determine the premium or prevent enrollment in the program. Monthly premiums shall remain the same for an individual active enrollee for as long as the enrollee is in the program, with the following exceptions: premiums can be increased as necessary if the Secretary determines that the CLASS Independence Fund is projected to be insufficient for the next 20 year period (the increase shall not apply to those paying the nominal premium; those age 65 and over; those who have paid premiums for at least 20 years; or those not actively employed); individuals with a 90 day lapse in premium payments will have their premium adjusted to their age at reenrollment but will receive credit for premiums paid if reenrollment occurs within 5 years of the lapse; individuals who cease to be full-time students; and individuals reenrolling after a 5 year lapse shall pay a monthly 1% penalty or an amount determined actuarially sound by the Secretary.

CLASS Independence Benefit Plan: The Secretary of HHS, in consultation with actuaries and experts, is to develop at least 3 actuarially sound benefit plan alternatives. The CLASS Independence Advisory Council shall evaluate the alternative benefit plans and recommend to the Secretary of HHS the one which best balances price and benefits as the one to be designated as the CLASS benefit plan offered to the public. The Secretary shall designate the CLASS Independence Benefit Plan by October 1, 2010, in a final rule that allows for public comment.

Benefits eligibility: To be eligible for benefits an individual must: be an active enrollee in the CLASS program; have paid CLASS premiums for at least 60 months; have earned income of at least the amount one must have in order to be credited with a quarter of Social Security coverage for at least 3 calendar years during the 60 month period; and have paid CLASS premiums for at least 24 consecutive months if a lapse of premium payments of more than 3 months has occurred.

Benefit triggers: Benefits trigger upon a determination by a licensed health care practitioner that the individual has a functional limitation expected to last for at least 90 continuous days. The functional limitation must consist of one of the following: an inability to perform at least the minimum (2 or 3) activities of daily living (ADL) required under the plan; the individual requires substantial supervision due to cognitive impairment; or the individual has a functional limitation similar to, as prescribed in regulations, the above situations. Beneficiaries must recertify eligibility periodically by submitting medical evidence of continued eligibility and submitting records of expenditures attributable to the cash benefit during the preceding year.

By January 1, 2012, the Secretary of HHS will establish an eligibility assessment system, enter into an agreement with the protection and advocacy system for each state, and enter in an agreement with public and private entities to provide counseling. The Secretary shall promulgate regulations to develop an expedited nationally equitable eligibility determination process, as certified by a licensed health care practitioner, an appeals process and a redetermination process, including whether an active enrollee is eligible for cash benefit and, if so, the amount of benefit. An enrollee is presumptively eligible if the enrollee has applied for and attested to be eligible for the maximum cash benefit available under the CLASS plan; is a patient in a hospital, nursing facility, or

mental institution, and is in the process of discharge from the facility within 60 days or is within 60 days after discharge. CLASS benefits shall be disregarded for purposes of determining eligibility for other government programs.

Cash benefits: The minimum cash benefit is an average of \$50 per day. There will be between 2 and 6 benefit levels, based on a scale of functional ability. The benefit is paid daily or weekly and is not subject to lifetime or aggregate limits. The benefits must allow for coordination with any supplemental benefits purchased through a health insurance Exchange. Benefit payments for a beneficiary will be deposited into a Life Independence Account established by the Secretary for the individual. The cash benefits shall be used to purchase nonmedical services and supports the beneficiary needs to maintain independence at home or in a residential setting in the community, including, but not limited to, home modification, assistive technology, accessible transportation, homemaker services, respite care, personal assistance, home care aides, and nursing support. Funds may also be used to obtain assistance with decision-making concerning medical care. Institutionalized Medicaid beneficiaries and PACE enrollees shall retain 5% of their cash benefit (50% for home and community-based care) and in both cases the remainder is applied toward the State's costs for care. Medicaid is secondary payor. CLASS funds may not be claimed by the state as Medicaid matching funds.

Account funds shall be electronically managed, including crediting of deposits of benefits, accessing funds through debit cards, and accounting for beneficiary withdrawals. Beneficiaries may opt to defer daily or weekly payments and receive a lump sum later for up to a year, but may not roll over benefits from year-to-year.

Benefits also include advocacy services and advice and assistance counseling. The agreement with a state shall require the Protection and Advocacy System to assign a counselor to each eligible beneficiary to provide information on access to the appeals process, assistance with annual recertification and notification; and other assistance as required by regulation. The agreements with entities to provide advice and assistance counseling shall require the entity to assign each beneficiary a counselor to provide information regarding accessing and coordinating long-term care services and supports; possible eligibility for other benefits and services; development of a service and support plan; information about the Assistive Technology Act of 1998 programs; and other services required by regulation.

CLASS Independence Fund ("Fund"): The Fund is established in the U.S. Treasury. The Secretary of Treasury is the trustee of the Fund and shall invest and manage the Fund in the same manner as the Medicare Part B (SMI) Trust Fund. The Board of Trustees for the Fund shall consist of the Secretaries Treasury, Labor and HHS, and 2 public trustees (from different political parties) nominated to 4-year terms by the President and confirmed by the Senate.

The Board must report to Congress by April 1 of each year on the status of the Fund and on its expected status for the subsequent and next 2 fiscal years. The report to Congress must include a statement of Fund assets and disbursements during the preceding fiscal year; an estimate of expected income and disbursements for the current and each of the next 2 fiscal years; a statement of the actuarial status of the Fund for the current year and each of the next 2 fiscal years, and as projected over the next 75 years; and an actuarial opinion by the Chief Actuary of the Centers for Medicare and Medicaid

Services (CMS) certifying that the methods used are generally acceptable and the cost estimates are reasonable. If the Board determines that the Fund is not actuarially sound and that premium increases will not be sufficient to resolve shortages, it is to make recommendations for necessary legislative action including whether to adjust premiums or to impose a moratorium on enrollment.

CLASS Independence Advisory Council ("Council"): The Council shall be composed of up to 15 members who are not federal employees, are appointed by the President, and a majority of whom are representative of CLASS program participants. Members shall serve overlapping 3-year terms and shall not be eligible to serve more than 2 terms. The President is to appoint the Chairman. Duties of the Council include advising the Secretary on matters of general policy and regulations related to the CLASS benefit plan, the determination of premiums, and the financial solvency of the program. FACA shall apply.

Beginning 1/1/2014 the Secretary of HHS shall submit an annual report to Congress that includes for the fiscal year: enrollment; eligible beneficiaries; amount of cash benefit payments; instances of fraud or abuse; and recommendations for administrative or legislative action necessary to improve the program, ensure solvency or prevent fraud and abuse.

The Inspector General of HHS is to submit an annual report to the Secretary of HHS and to Congress on waste, fraud, and abuse in the CLASS program including the eligibility determination process; payment of cash benefits; quality assurance and protection against waste, fraud and abuse; and recoupment of unpaid and accrued benefits.

Information on the CLASS program is to be included in the National Clearinghouse for Long-term Care Information.

State requirements: Each state is required, within 2 years of enactment, to assess the extent to which entities are serving or have the capacity to serve as fiscal agents for, employers of, and providers of employment-related benefits for personal care attendant workers who provide care for CLASS beneficiaries, including in rural and underserved areas; create entities to ensure an adequate supply of such workers; and ensure that the creation of such entities will not negatively alter or impede existing programs.

Personal Care Attendants Workforce Advisory Panel ("Panel"): The Panel is to be established within 90 days of enactment by the Secretary of HHS to examine and advise on workforce issues related to personal care attendant workers including adequacy of the number of such workers, their compensation, and access to their services. Members appointed to the Panel shall include individuals with disabilities of all ages and their representatives; seniors and their representatives; workforce and labor representatives; representatives of home and community-based service providers; representatives of assisted living providers.

The CLASS Act is effective on enactment.

## **TITLE IX--REVENUE PROVISIONS**

### **Subtitle A – Revenue Offset Provisions**

#### **Sec. 9001. Excise tax on high cost employer-sponsored health coverage (as modified by sec. 1401 of HCERA).**

Imposes an excise tax on health insurance issuers and plan administrators (including government plans) of 40% of the amount by which the aggregate value of employer-sponsored health benefits for an employee (including former employees, surviving spouses and other primary insured individuals) exceeds a threshold amount: \$10,200/self-only coverage and \$27,500/other than self-only coverage, multiplied by the health cost adjustment factor and increased by the age and gender excess premium amount.

The health cost adjustment factor is equal to 100% plus the amount, if any, by which the per employee increase in the cost of coverage under the Blue Cross/Blue Shield (BC/BS) standard benefit option under the Federal Employees Health Benefits Plan (FEHBP) for the period 2010 to 2018 exceeds 55% (using the 2010 benefits package). For 2019, the thresholds, as established for 2018, are indexed annually to the CPI-U plus one percentage point, rounded to the nearest \$50. For 2020 and beyond, the thresholds are indexed to the CPI-U rounded to the nearest \$50.

The age and gender adjustment is equal to the amount by which the premium cost of the FEHBP BC/BS standard option priced for the age and gender of the employer's employees exceeds, if at all, such coverage priced for the age and gender of the national workforce.

Thresholds are increased by \$1,650/self-only coverage and \$3,450/other than self-only coverage for certain retirees and individuals in high risk professions. Eligible retirees are those age 55 and older who are not Medicare eligible and are receiving employer-sponsored retiree coverage. Employees in high risk professions are defined as those working for an employer with a majority of employees engaged in a high risk profession or employed to repair or install electrical or telecommunications lines. High risk professions include law enforcement, fire protection, out-of-hospital emergency medical care, longshore work, construction, mining, agriculture (excluding food processing), forestry, and fishing. Retirees with at least 20 years employment in these professions are also eligible for the increased threshold.

The tax is paid by the plan administrator for self-insured group plans, health flexible spending arrangements (FSAs), or health reimbursement arrangements (HRAs). If an employer acts as plan administrator or makes contributions to a health spending account (HSA) or Archer medical savings account (MSA), the employer pays the tax.

Aggregate value of all employer-sponsored health coverage is defined as that which is excludable as gross income to the employee including health insurance, FSAs or HRAs, HSA or Archer MSA contributions, and supplementary coverage (including on-site medical clinics offering more than a de minimis amount of medical care, and executive physical programs) without regard to whether the cost is paid by the employer (and excludable by the employee) or by the employee with after tax dollars. The following employer-sponsored coverage is not included: coverage for treatment of the mouth or



eye provided under a separate policy, long term care insurance, accident/disability coverage, workers' compensation insurance, general liability and automobile liability insurance, supplements to liability insurance, automobile medical insurance, credit-only insurance, and other similar medical care coverage that is secondary or incidental to other insurance. Specific disease or fixed hospital or other indemnity insurance is excepted unless any portion of the coverage is employer-provided.

The value of coverage is calculated in same manner as that used to determine COBRA premiums. Separate individual and family premiums must be calculated for this purpose. The value of an FSA is equal to dollar amount of salary reduction for the year. If FSA reimbursement exceeds salary reduction, COBRA methods apply. To determine value for retirees, employers may treat pre-65 and post-65 retirees together.

The excise tax is allocated among all insurers providing benefits to employees based on the ratio of the value of the benefits provided by the insurer to the total benefits provided by the employer to the employee. Employers are to notify insurers of the amounts subject to the excise tax; the insurers pay the tax to IRS. Provides for penalties and interest for underreporting. All or part of the penalty may be waived by the Secretary of Treasury for showing reasonable cause or if a correction is made within 30 days. The excise tax is not deductible for federal income tax purposes.

Effective for taxable years beginning after 12/31/2017.

**Sec. 9002. Inclusion of cost of employer-sponsored health coverage on W-2.**

Requires employers to disclose the aggregate value of all applicable employer-sponsored health benefits provided to an employee (excluding FSA salary reduction contributions), whether paid by the employer or the employee, on the employee's annual W-2 form. Applicable coverage includes coverage to which the high cost health coverage excise tax applies.

Effective for taxable years after 12/31/2010.

**Sec. 9003. Distributions for medicine qualified only if for prescribed drug or insulin.**

Conforms the definition of medicine expenses for employer-sponsored coverage (including HRAs, FSAs, HSAs, and Archer MSAs) to that used for the itemized tax medical deduction, to include insulin and any prescribed drug, except that medicine expenses are deductible without regard to whether or not the medicine is available without a prescription (i.e., over-the-counter). Thus, costs for over-the-counter medicines obtained without a prescription may not be reimbursed on a tax-free basis through FSAs, HRAs, HSAs, or Archer MSAs.

Effective for amounts paid through HSAs and Archer MSAs and for expenses incurred for FSAs and HRAs for taxable years after 12/31/2010.

**Sec. 9004. Increase in additional tax on distributions from HSAs and Archer MSAs not used for qualified medical expenses.**

Increases the additional tax on HSA and Archer MSA distributions that are not used for qualified medical expenses to 20% of the disbursed amount (from current law 10% for HSAs and 15% for Archer MSAs).

Effective for taxable years after 12/31/2010.

**Sec. 9005. Limitation on health flexible spending arrangements (FSAs) under cafeteria plans (as modified by sec. 1403 of HCERA).**

Limits salary reductions for a taxable year to an employee's health FSA through a cafeteria plan to \$2,500. Indexes the limit amount to the CPI-U for years after December 31, 2013, rounded to the next lowest multiple of \$50.

Effective for taxable years after 12/31/2012.

**Sec. 9006. Expansion of information reporting requirements.**

Requires businesses to report to the Treasury payments made to any single payee (except for non-profit corporations) that aggregate to \$600 or more in a year, including gross proceeds paid for property or services.

Effective for payments made after 12/31/2011.

**Sec. 9007. Additional requirements for charitable hospitals.**

Establishes additional new requirements for §501(c)(3) hospitals (applies separately to each hospital facility within an organization): (1) conduct a community health needs assessment at least once every 3 years and adopt an implementation strategy to address identified needs; (2) adopt, implement, and publicize a written financial assistance policy which includes eligibility criteria for financial assistance including free and discounted care, the basis for calculating patient charges, the method for applying for financial assistance, and actions that may be taken in cases of non-payment, and includes a written policy to provide emergency care (as defined for Medicare) to all individuals regardless of their eligibility for financial assistance; (3) limit charges for medically necessary care to patients who qualify for financial assistance to no more than amounts generally billed to insured patients and prohibit the use of gross charges; (4) not to engage in extraordinary collection actions before making reasonable efforts to determine if the individual qualifies for financial assistance. Requires the Treasury Secretary to review a hospital's community benefit activities at least once every 3 years.

Requires hospitals to submit annually to the IRS a description of how needs are being addressed and reasons why if any needs are not being met, and audited financial statements. Imposes an excise tax of up to \$50,000 on organizations failing to comply with these requirements.

The Secretary of Treasury, in consultation with the Secretary of HHS, is to annually report to Congress on levels of charity care, bad debt expenses, unreimbursed costs for services to means tested and non-means tested government programs, and the costs of community benefit activities incurred by tax-exempt hospitals. Requires the Treasury Secretary, in consultation with the Secretary of HHS, to report to Congress within 5 years after enactment on the trends in these charitable costs.

Effective for taxable years beginning after enactment, except the community needs assessment requirement is effective 2 years after enactment and the excise tax applies to failures occurring after enactment.

**Sec. 9008. Imposition of annual fee on branded prescription pharmaceutical manufacturers and importers (as modified by sec. 1404 of HCERA).**

Imposes an annual aggregate sector fee on manufacturers or importers of branded prescription drugs, including foreign corporations. The aggregate sector fee is \$2.5 billion for 2011, \$2.8 billion for 2012 and 2013, \$3 billion for 2014-2016, \$4 billion for 2017, and \$4.1 billion for 2018, and \$2.8 billion for 2019 and years thereafter. Includes prescription drugs and biologics sold to or covered by government programs (Medicare Parts B and D, Medicaid, VA, DOD, and TRICARE). Orphan drugs are excluded.

Fees will be apportioned to each entity based on the entity's share of the total annual branded drug sales taken into account. Takes into account 0% of sales up to \$5 million, 10% of sales between \$5 million and \$125 million, 40% of sales between \$125 million and \$225 million, 75% for sales between \$225 million and \$400 million, and 100% of sales over \$400 million.

Fees will be credited to the Medicare Part B trust fund. Fees are not deductible for U.S. income tax purposes. Requires the Secretaries of the respective programs to report annually to the Treasury data on drug sales for their programs.

Effective for calendar years beginning after December 31, 2010.

**Sec. 9009. Imposition of annual fee on medical device manufacturers and importers (sec. 9009 repealed and replaced by sec. 1405 of HCERA).**

Imposes a tax on the sale of taxable medical devices by a manufacturer, producer, or importer equal to 2.3% of the sales price. Taxable medical devices include any device as defined in Section 201(h) of the Federal Food, Drug, and Cosmetic Act intended for humans. Exempted are eyeglasses, contact lenses, hearing aids and any other device determined by the Secretary of HHS to be a type which is generally purchased by the general public at retail for individual use. Certain manufacturers' exemptions for excise taxes do not apply.

Effective for sales made after December 31, 2012.

**Sec. 9010. Imposition of annual fee on health insurance providers (as modified by sec. 1406 of HCERA).**

Imposes an annual aggregate fee on health insurance providers. Includes any entity that provides health insurance for U.S. health risk, including foreign corporations. Excludes employers that self-insure health benefits and governmental entities. Exempts certain non-profit insurers that receive more than 80% of gross revenue from governmental programs. Also exempts accident-only, disability-only, specified disease, fixed indemnity, long-term care, and Medicare supplemental insurance from the fee.

The aggregate annual fee is: \$8 billion for 2014, \$11.3 billion for 2015 and for 2016, \$13.9 billion for 2017, and \$14.3 billion for 2018. For years after 2018 the amount is indexed to the rate of health insurance premium growth. The fee is to be apportioned among providers based on their relative market share for the prior year. Market share is based on aggregate net U.S. health insurance premiums for the preceding calendar year. Taken into account for calculating market share are 50% of net premiums between \$25 million and \$50 million and 100% of net premiums over \$50 million.

Requires insurance providers to file an annual report with the Treasury Department. Imposes penalties for failure to comply or understatement of net premiums. Fees are not deductible for U.S. income tax purposes.

Effective for calendar years beginning after 2013; based on net premiums for calendar years beginning after 2012.

**Sec. 9011. Study and report of effect on veterans health care.**

Requires the Secretary for Veterans Affairs to study the effects of the sector fees on manufacturers and importers of branded drugs, manufacturers and importers of medical devices, and health insurance providers on the costs of care for veterans and their access to prescription drugs and medical devices. Study results to be reported to Congress by 12/31/2012.

Effective upon enactment.

**Sec. 9012 (as modified by sec. 1407 of HCERA). Elimination of deduction for expenses allocable to Medicare Part D subsidy**

Revises the rules for deductions for retiree drug expenses so that employers may deduct retiree prescription drug expenses only to the extent that the amount is reduced by the amount of excludable federal Medicare Part D subsidies received for prescription drugs.

Effective for taxable years beginning after 12/31/2012.

**Sec. 9013. Modification of itemized deduction for medical expenses.**

Increases the threshold for the itemized deduction of medical expenses from 7.5% to 10% of adjusted gross income (AGI). Retains the 7.5% threshold for Individuals age 65 and older through 2016.

Effective for taxable years after 12/31/2012.

**Sec. 9014. Limitation on excessive remuneration paid by certain health insurance providers.**

Limits the deductibility of compensation paid to individuals by insurance providers. Applies to all insurance issuers for taxable years after 2012. Applies to issuers if at least 25% of gross premium income is from insurance plans that meet the minimum essential benefit requirements. Deductions are limited to \$500,000 per individual per year. Applies to all officers, employees and workers and service providers performing services for or on behalf of the insurance provider. Includes rules for deferred compensation. Excludes employers with self-insured plans.

Effective for remuneration paid in taxable years after 2012 for services performed in taxable years after 2009.

**Sec. 9015. Additional hospital insurance tax on high-income taxpayers (including unearned income Medicare contribution from Sec. 1402 of HCERA).**

Section 9015 increases the Medicare HI tax by 0.9 percentage points on wages in excess of \$200,000 (\$250,000 for couples filing jointly, \$125,000 for married individuals filing separately). Also applies to self-employed earnings. Includes rules for collection of the tax by employers.

Sec. 1402 of HCERA imposes a 3.8% Medicare contribution tax on individuals, estates, or trusts of the lesser of net investment income or the excess of modified adjusted gross income over the threshold amount. The threshold amount is \$250,000 for joint returns, \$125,000 for married filing separately, or \$200,000 for any other case. The tax applies to a trade or business if the trade or business is a passive activity for the taxpayer or it consists of trading financial instruments or commodities. Investment income does not include distributions from qualified retirement plans or amounts subject to SECA taxes. The tax is subject to the individual estimated tax provisions and is not deductible for federal income tax purposes.

Effective for taxable years beginning after 2012.

**Sec. 9016. Modification of section 833 treatment of certain health organizations.**

Requires that BCBS organizations have a medical loss ratio of at least 85% in order to qualify for their special Section 833 current law tax benefits (including the deduction of 25% of claims and expenses and the exception from the reduced deduction for unearned premium reserves).

Effective for taxable years after 2009.

**Sec. 9017. Excise tax on indoor tanning services.**

Imposes a 10% tax on amounts paid by individuals for indoor tanning services. Indoor tanning services are defined as services employing any electronic product designed to induce skin tanning and which incorporate one or more ultraviolet lamps and are intended for the irradiation of an individual by ultraviolet radiation, with wavelengths in air between 200 and 400 nanometers. Any phototherapy service performed by a licensed medical professional is not included. The tax is to be paid by the individual receiving the service, collected by the provider at time of payment for the service, and remitted by the provider to the IRS on a quarterly basis. The Secretary is given discretion over the manner of the payment.

The provision applies to services performed on or after July 1, 2010.

**Subtitle B – Other Provisions**

**Sec. 9021. Exclusion of health benefits provided by Indian tribal governments.**

Provides an exclusion from gross income for the value of specified Indian tribe health benefits.

Effective for health benefits and coverage provided after enactment.

**Sec. 9022. Establishment of simple cafeteria plans for small businesses.**

Establishes new SIMPLE cafeteria plan rules for eligible small businesses. Defines an eligible small employer as one who employed an average of 100 or fewer employees on business days during either of the 2 preceding years. Specifies rules for an employer that did not exist throughout the preceding year. If an employer was eligible for any year and maintained a simple cafeteria plan for its employees, then, for each subsequent year during which the employer continues, without interruption, to maintain the cafeteria plan, the employer is deemed to be an eligible small employer. Eligibility ceases for subsequent years when the employer has an average of 200 or more employees on business days during any year.

*Minimum contribution rules include:* (1) the employer provides benefits equal to at least 2% of each eligible employee's compensation for the plan year; or (2) the value of employer-paid benefits is at least 6% of each eligible employee's compensation for the plan year or, if less, twice the amount of the salary reduction amount for the year of each eligible employee who is not a highly compensated or a key employee and who participates in the plan.

Effective for taxable years beginning after 12/31/2010.

**Sec. 9023. Qualifying therapeutic discovery project credit.**

Establishes a 2-year tax credit program for therapeutic discovery projects. Entities with 250 or fewer employees could receive a credit for 50% of qualified investment costs in therapeutic discovery projects. Projects are defined as those designed to treat or prevent chronic conditions, develop molecular diagnostics or develop products, processes, or technology to further the administration of therapeutics. The provision allocates \$1 billion during the two-year period 2009 through 2010 for the program. Includes a process and criteria for certifying projects by Secretary of the Treasury. Allows the Secretary of Treasury to make grants in lieu of tax credits and details the process and rules for grants. Provides rules for interaction with other federal tax and grant provisions.

The provision applies to expenditures paid or incurred after 12/31/2008, in taxable years beginning after 12/31/2008.

**NOTE: The following revenue measures are not directly related to health care, and not summarized:**

**Sec. 1408 of HCERA: Elimination of unintended application of cellulosic biofuel producer credit.**

**Sec. 1409 of HCERA: Codification of economic substance doctrine and imposition of penalties.**

**Sec. 1410 of HCERA: Time for payment of corporate estimated taxes.**