RESPONSIBLE REFORM
FOR THE MIDDLE CLASS
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# The Patient Protection and Affordable Care Act

# Section-by-Section Analysis

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

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

**Sec. 1001. Amendments to the Public Health Service Act.**

**Sec. 2711. No lifetime or annual limits.** Prohibits all plans from establishing lifetime or unreasonable annual limits on the dollar value of benefits.

**Sec. 2712. Prohibition on rescissions.** Prohibits all plans from rescinding coverage except in instances of fraud or misrepresentation.

**Sec. 2713. Coverage of preventive health services.** Requires all plans to cover preventive services and immunizations recommended by the U.S. Preventive Services Task Force and the CDC, and certain child preventive services recommended by the Health Resources and Services Administration, without any cost-sharing.

**Sec. 2714. Extension of dependent coverage.** Requires all plans offering dependent coverage to allow unmarried individuals until age 26 to remain on their parents' health insurance.

**Sec. 2715. Development and utilization of uniform explanation of coverage documents and standardized definitions.** Requires the Secretary to develop standards for use by health insurers in compiling and providing an accurate summary of benefits and explanation of coverage. The standards must be in a uniform format, using language that is easily understood by the average enrollee, and must include uniform definitions of standard insurance and medical terms. The explanation must also describe any cost-sharing, exceptions, reductions, and limitations on coverage, and examples to illustrate common benefits scenarios.

**Sec. 2716. Prohibition of discrimination based on salary.** Employers that provide health coverage will be prohibited from limiting eligibility for coverage based on the wages or salaries of full-time employees.

**Sec. 2717. Ensuring quality of care.** Requires the Secretary to develop guidelines for use by health insurers to report information on initiatives and programs that improve health outcomes through the use of care coordination and chronic disease management, prevent hospital readmissions and improve patient safety, and promote wellness and health.

**Sec. 2718. Bringing down the cost of health care coverage.** Health insurance companies will be required to report publicly the percentage of total premium revenue that is expended on clinical services, and quality rather than administrative costs. Health insurance companies will be required to refund each enrollee by the amount by which premium revenue expended by the health insurer for non-claims costs exceeds 20 percent in the group market and 25 percent in the individual market. The requirement to provide a refund expires on December 31, 2013, but the requirement to report percentages continues.

**Sec. 2719. Appeals process.** Health insurers will be required to implement an effective process for appeals of coverage determinations and claims.

**Sec. 1002. Health insurance consumer information.** The Secretary shall award grants to States to enable them (or the Exchange) to establish, expand, or provide support for offices of health insurance consumer assistance or health insurance ombudsman programs. These independent offices will assist consumers with filing complaints and appeals, educate consumers on their rights and responsibilities, and collect, track, and quantify consumer problems and inquiries. Provides $30 million in funding and is effective upon the date of enactment of the bill.

**Sec. 1003. Ensuring that consumers get value for their dollars.** For plan years beginning in 2010, the Secretary and States will establish a process for the annual review of increases in premiums for health insurance coverage. Requires States to make recommendations to their Exchanges about whether health insurance issuers should be excluded from participation in the Exchanges based on unjustified premium increases. Provides $250 million in funding to States from 2010 until 2014 to assist States in reviewing and, if appropriate under State law, approving premium increases for health insurance coverage and in providing information and recommendations to the Secretary.

**Sec. 1004. Effective dates.** Except for sections 1002 and 1003 (effective upon the date of enactment of this Act), this subtitle shall become effective for plan years beginning on or after the date that is 6 months after the date of enactment of this Act.

***Subtitle B – Immediate Action to Make Coverage More Affordable and More Available***

**Sec. 1101. Immediate access to insurance for people with a preexisting condition.** Enacts a temporary insurance program with financial assistance for those who have been uninsured for several months and have a pre-existing condition. Ensures premium rate limits for the newly insured population. Provides up to $5 billion for this program, which terminates when the American Health Benefit Exchanges are operational in 2014. Also establishes a transition to the Exchanges for eligible individuals.

**Sec. 1102. Reinsurance for early retirees.** Establishes a temporary reinsurance program to provide reimbursement to participating employment-based plans for part of the cost of providing health benefits to retirees (age 55-64) and their families. The program reimburses participating employment-based plans for 80 percent of the cost of benefits provided per enrollee in excess of $15,000 and below $90,000. The plans are required to use the funds to lower costs borne

directly by participants and beneficiaries, and the program incentivizes plans to implement programs and procedures to better manage chronic conditions. The act appropriates $5 billion for this fund and funds are available until expended.

**Sec. 1103. Immediate information that allows consumers to identify affordable coverage options.** Establishes an Internet portal for beneficiaries to easily access affordable and comprehensive coverage options. This information will include eligibility, availability, premium rates, cost sharing, and the percentage of total premium revenues spent on health care, rather than administrative expenses, by the issuer.

**Sec. 1104. Administrative simplification.** Accelerates HHS adoption of uniform standards and operating rules for the electronic transactions that occur between providers and health plans that are governed under the Health Insurance Portability and Accountability Act (such as benefit eligibility verification, prior authorization and electronic funds transfer payments). Establishes a process to regularly update the standards and operating rules for electronic transactions and requires health plans to certify compliance or face financial penalties collected by the Treasury Secretary. The goal of this section is to make the health system more efficient by reducing the clerical burden on providers, patients, and health plans.

**Sec. 1105. Effective dates.** Provides that this subtitle is effective upon 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.**

**Sec. 2701. Fair health insurance premiums.** Establishes that premiums in the individual and small group markets may vary only by family structure, geography, the actuarial value of the benefit, age (limited to a ratio of 3 to 1), and tobacco use (limited to a ratio of 1.5 to 1).

**Sec. 2702. Guaranteed availability of coverage.** Each health insurance issuer must accept every employer and individual in the State that applies for coverage, permitting annual and special open enrollment periods for those with qualifying lifetime events.

**Sec. 2703. Guaranteed renewability of coverage.** Requires guaranteed renewability of coverage regardless of health status, utilization of health services or any other related factor.

**Sec. 2704. Prohibition of preexisting condition exclusions or other discrimination based on health status.** No group health plan or insurer offering group or individual coverage may impose any pre-existing condition exclusion or discriminate against those who have been sick in the past.

**Sec. 2705. Prohibiting discrimination against individual participants and beneficiaries based on health status.** No group health plan or insurer offering group or individual

coverage may set eligibility rules based on health status, medical condition, claims experience, receipt of health care, medical history, genetic information, evidence of insurability – including acts of domestic violence or disability. Permits employers to vary insurance premiums by as much as 30 percent for employee participation in certain health promotion and disease prevention programs. Authorizes a 10-State demonstration to apply such a program in the individual market.

**Sec. 2706. Non-discrimination in health care.** Prohibits discrimination against health care providers acting within the scope of their professional license and applicable State laws.

**Sec. 2707. Comprehensive health insurance coverage.** Requires health insurance issuers in the small group and individual markets to include coverage which incorporates defined essential benefits, provides a specified actuarial value, and requires all health plans to comply with limitations on allowable cost-sharing.

**Sec. 2708. Prohibition on excessive waiting periods.** Prohibits any waiting periods for group or individual coverage which exceed 90 days.

**Part II – Other Provisions**

**Sec. 1251. Preservation of right to maintain existing coverage.** Allows any individual enrolled in any form of health insurance to maintain their coverage as it existed on the date of enactment.

**Sec. 1252. Rating reforms must apply uniformly to all health insurance issuers and group health plans.** Standards and requirements adopted by States must be applied uniformly to all plans in each relevant insurance market in a State.

**Sec. 1253. Effective dates.** All provisions in this subtitle take effect on January 1, 2014.

***Subtitle D – Available Coverage for All Americans***

**Part I—Establishment of Qualified Health Plans**

**Sec. 1301. Qualified health plan defined.** Requires qualified health plans to be certified by Exchanges, provide the essential health benefits package, and be offered by licensed insurers that offer at least one qualified health plan at the silver and gold levels.

**Sec. 1302. Essential health benefits requirements.** Defines an essential health benefits package that covers essential health benefits, limits cost-sharing, and has a specified actuarial value (pays for a specified percentage of costs), as follows:

1. For the individual and small group markets, requires the Secretary to define essential health benefits, which must be equal in scope to the benefits of a typical employer plan.
2. For all plans in all markets, prohibits out-of-pocket limits that are greater than the limits for Health Savings Accounts. For the small group market, prohibits deductibles that are

greater than $2,000 for individuals and $4,000 for families. Indexes the limits and deductible amounts by the percentage increase in average per capita premiums.

3. For the individual and small group markets, requires one of the following levels of coverage, under which the plan pays for the specified percentage of costs:

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| Bronze: | 60 percent |
| Silver: | 70 percent |
| Gold: | 80 percent |
| Platinum: | 90 percent |

In the individual market, a catastrophic plan may be offered to individuals who are under the age of 30 or who are exempt from the individual responsibility requirement because coverage is unaffordable to them or they have a hardship. A catastrophic plan must cover essential health benefits and at least 3 primary care visits, but must require cost-sharing up to the HSA out-of-pocket limits. Also, if an insurer offers a qualified health plan, it must offer a child-only plan at the same level of coverage.

**Sec. 1303. Special rules.**

Voluntary Choice of Coverage of Abortion Services. Abortion cannot be a mandated benefit as part of a minimum benefits package. A qualified health plan would determine whether it will cover: no abortions, only those abortions allowed under Hyde (rape, incest and life endangerment), or abortions beyond those allowed by Hyde.

No Federal Funds for Abortion Coverage in the Community Health Insurance Option. The Secretary may not determine that the public plan provide coverage for abortions beyond those allowed by Hyde unless the Secretary: 1) is in compliance with the provision prohibiting the use of Federal funds to pay for abortions (beyond those allowed by Hyde); 2) guarantees that, according to three different accounting standards, no Federal funds will be used; and (3) takes all necessary steps to ensure that the United States does not bear the insurance risk for abortions that do not meet the Hyde exceptions in the public plan.

States may require the coverage of additional benefits in the Community Health Insurance Option, but must assume costs associated with covering these benefits. A State may elect to require coverage of abortions beyond those allowed by Hyde only if no Federal funds are used for this coverage. The U.S. Government may not bear the insurance risk for a State's required coverage of abortions beyond those allowed by Hyde.

Abortions currently permitted by Hyde shall be covered in the Community Health Insurance Option to the same extent as they are under Medicaid.

Assured Availability of Varied Coverage through the Exchanges. The Secretary would ensure that in each State Exchange, at least one plan provides coverage of abortions beyond those permitted by Hyde and at least one plan does not provide coverage of abortions beyond those permitted by Hyde.

Prohibition on the Use of Federal Funds. No tax credit or cost-sharing credits may be used to pay for abortions beyond those permitted by the Hyde Amendment.

Segregation of Funds. Issuers of plans that offer coverage for abortion beyond those permitted by the Hyde amendment must segregate from any premium and cost-sharing credits an amount of each enrollee's private premium dollars that is determined by the Secretary to be sufficient to cover the provision of those services.

Actuarial Value of Optional Service Coverage. The Secretary would be required to estimate, on an average actuarial basis, the basic per enrollee, per month cost of including coverage of abortions beyond those permitted by the Hyde Amendment. In making such estimates, the Secretary may take into account the impact of including such coverage on overall costs, but may not consider any cost reduction estimated to result from providing such abortions, such as prenatal care. In making the estimate, the Secretary would also be required to estimate the costs as if coverage were included for the entire covered population, but the costs could not be estimated at less than $1 per enrollee, per month.

Provider Conscience Protections. No individual health care provider or health care facility may be discriminated against because of a willingness or an unwillingness, if doing so is contrary to the religious or moral beliefs of the provider or facility, to provide, pay for, provide coverage of, or refer for abortions.

Application of State and Federal Laws. State laws regarding the prohibition of or requirement of coverage or funding for abortions and State laws involving abortion-related procedural requirements are not preempted. The provision similarly provides that Federal conscience protections and abortion-related antidiscrimination laws would not be affected by the bill. The rights and obligations of employees and employers under Title VII of the Civil Rights Act of 1964 would also not be affected by the bill. In addition, this bill does not affect State or Federal laws, including section 1867 of the Social Security Act (EMTALA), requiring health care providers to provide emergency services.

**Sec. 1304. Related definitions.** Defines the small group market as the market in which a plan is offered by a small employer that employs 1-100 employees. Defines the large group market as the market in which a plan is offered by a large employer that employs more than 100 employees. Before 2016, a State may limit the small group market to 50 employees. Defines a State as one of the 50 States and the District of Columbia.

**Part II—Consumer Choices and Insurance Competition through Health Benefit Exchanges**

**Sec. 1311. Affordable choices of health benefit plans.** Requires the Secretary to award grants, available until 2015, to States for planning and establishment of American Health Benefit Exchanges. By 2014, requires States to establish an American Health Benefit Exchange that facilitates the purchase of qualified health plans and includes a SHOP Exchange for small businesses. Requires the Secretary to:

- Establish certification criteria for qualified health plans, requiring such plans to meet marketing requirements, ensure a sufficient choice of providers, include essential community providers in their networks, be accredited on quality, implement a quality

improvement strategy, use a uniform enrollment form, present plan information in a standard format, and provide data on quality measures.
- Develop a rating system for qualified health plans and a model template for an Exchange's Internet portal.
- Determine an initial and annual open enrollment period, as well as special enrollment periods for certain circumstances.

Allows States to require benefits in addition to essential health benefits, but States must defray the cost of such additional benefits. Requires Exchanges to certify qualified health plans, operate a toll-free hotline and Internet website, rate qualified health plans, present plan options in a standard format, inform individuals of eligibility for Medicaid and CHIP, provide an electronic calculator to calculate plan costs, and grant certifications of exemption from the individual responsibility requirement. Beginning in 2015, requires Exchanges to be self-sustaining and allows them to charge assessments or user fees. Allows Exchanges to certify qualified health plans if they meet certification criteria and offering them is in the interests of individuals and employers. Allows regional or interstate Exchanges if the States agree to, and the Secretary approves, such Exchanges. Requires Exchanges to award grants to Navigators that educate the public about qualified health plans, distribute information on enrollment and tax credits, facilitate enrollment, and provide referrals on grievances, complaints, or questions.

**Sec. 1312. Consumer choice.** Allows qualified individuals, defined as individuals who are not incarcerated and who are lawfully residing in a State, to enroll in qualified health plans through that State's Exchange. Allows qualified employers to offer a choice of qualified health plans at one level of coverage; small employers qualify to do so, and States may allow large employers to qualify beginning in 2017. Requires insurers to pool the risk of all enrollees in all plans (except grandfathered plans) in each market, regardless of whether plans are offered through Exchanges. Requires the offering of only qualified health plans though Exchanges to Members of Congress and their staff. Requires the Secretary to establish procedures under which States may allow agents or brokers to enroll individuals in qualified health plans and assist them in applying for tax credits and cost-sharing reductions.

**Sec. 1313. Financial integrity.** Requires Exchanges to keep an accurate accounting of all expenditures and submit annual accounting reports to the Secretary. Requires Exchanges to cooperate with Secretarial investigations and allows for Secretarial audits of Exchanges. If the Secretary finds serious misconduct in a State, allows the Secretary to rescind up to 1 percent of Federal payments to the State. Subjects Federal payments related to Exchanges to the False Claims Act, with increased damages.

**Part III—State Flexibility Relating to Exchanges**

**Sec. 1321. State flexibility in operation and enforcement of Exchanges and related requirements.** Requires the Secretary, in consultation with NAIC, to set standards for Exchanges, qualified health plans, reinsurance, and risk adjustment. Requires States to implement these standards by 2014. If the Secretary determines before 2013 that a State will not have an Exchange operational by 2014, or will not implement the standards, requires the

Secretary to establish and operate an Exchange in the State and to implement the standards. Presumes that a State operating an Exchange before 2010 meets the standards, and establishes a process for the State to come into compliance with the standards.

**Sec. 1322. Federal program to assist establishment and operation of nonprofit, member-run health insurance issuers.** Requires the Secretary to award loans for start-up costs and grants to meet solvency requirements, until July 1, 2013, to member-run nonprofits that will offer qualified health plans. Establishes an Advisory Board with members appointed by the Comptroller General, to terminate by 2016. Prohibits health insurance issuers that existed on July 16, 2009 or governmental organizations from qualifying for the program. Allows participants to form a private purchasing council to enter into collective purchasing arrangements for items and services, but which may not set provider payment rates. Prohibits government representatives from serving on the board of directors of participants or the council. Appropriates $6 billion for the CO-OP program, and exempts participants from taxation.

**Sec. 1323. Community health insurance option.** Requires the Secretary to offer a Community Health Insurance Option as a qualified health plan through Exchanges. Allows States to enact a law to opt out of offering the option. Requires the option to cover only essential health benefits; States may require additional benefits, but must defray their cost. Requires the Secretary to set geographically adjusted premium rates that cover expected costs. Requires the Secretary to negotiate provider reimbursement rates, but they must not be higher than average rates paid by private qualified health plans. Subjects the option to State and Federal solvency standards and to State consumer protection laws. Establishes a Start-Up Fund to provide loans for initial operations, to be repaid with interest within 10 years. Authorizes the Secretary to contract with nonprofits for the administration of the option.

**Sec. 1324. Level playing field.** Requires qualified health plans offered under the CO-OP program, as a Community Health Insurance Option, or as a nationwide plan, to be subject to all Federal and State laws that apply to private health insurers.

**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.** Allows States to contract, through a competitive process that includes negotiation of premiums, cost-sharing, and benefits, with standard health plans for individuals who are not eligible for Medicaid or other affordable coverage and have income below 200 percent of the Federal Poverty Level (FPL). Requires the Secretary to certify that participating individuals do not have to pay more in premiums and cost-sharing than they would have paid under qualified health plans, and that the plans cover essential health benefits. Requires the Secretary to transfer to participating States 85 percent of the tax credits and cost-sharing reductions that would have been provided to individuals enrolled in standard health plans if they were enrolled in qualified health plans.

**Sec. 1332. Waiver for State innovation.** Beginning in 2017, allows States to apply for a waiver for up to 5 years of requirements relating to qualified health plans, Exchanges, cost-

sharing reductions, tax credits, the individual responsibility requirement, and shared responsibility for employers. Requires States to enact a law and to comply with regulations that ensure transparency. Requires the Secretary to provide to a State the aggregate amount of tax credits and cost-sharing reductions that would have been paid to residents of the State in the absence of a waiver. Requires the Secretary to determine that the State plan for a waiver will provide coverage that is at least as comprehensive and affordable, to at least a comparable number of residents, as this title would provide; and that it will not increase the Federal deficit.

**Sec. 1333. Provisions relating to offering of plans in more than one State.** By July 1, 2013, requires the Secretary, in consultation with NAIC, to issue regulations for interstate health care choice compacts, which can be entered into beginning in 2016. Under such compacts, qualified health plans could be offered in all participating States, but insurers would still be subject to the consumer protection laws of the purchaser's State. Insurers would be required to be licensed in all participating States (or comply as if they were licensed), and to clearly notify consumers that a policy may not be subject to all the laws and regulations of the purchaser's State. Requires States to enact a law to enter into compacts and Secretarial approval, but only if the Secretary determines that the compact will provide coverage that is at least as comprehensive and affordable, to at least a comparable number of residents, as this title would provide; and that it will not increase the Federal deficit or weaken enforcement of State consumer protection laws.

Allows insurers in the individual and small group markets to offer a qualified health plan nationwide, which is subject to only the State benefit mandate laws of the State in which the plans are issued; but requires such plans to provide the essential benefits package. Allows States to enact a law to opt out of allowing the offering of nationwide plans. Requires insurers to file plan forms with each State in which they will offer nationwide plans for review.

**Part V—Reinsurance and Risk Adjustment**

**Sec. 1341. Transitional reinsurance program for individual and small group markets in each State.** For 2014, 2015, and 2016, requires States to establish a nonprofit reinsurance entity that collects payments from insurers in the individual and group markets and makes payments to such insurers in the individual market that cover high-risk individuals. Requires the Secretary to establish Federal standards for the determination of high-risk individuals, a formula for payment amounts, and the contributions required of insurers, which must total $25 billion over the 3 years.

**Sec. 1342. Establishment of risk corridors for plans in individual and small group markets.** Requires the Secretary to establish risk corridors for qualified health plans in 2014, 2015, and 2016. If a plan's costs (other than administrative costs) exceed 103 percent of total premiums, the Secretary makes payments to the plan to defray the excess. If a plan's costs (other than administrative costs) are less than 97 percent of total premiums, the plan makes payments to the Secretary.

**Sec. 1343. Risk adjustment.** Requires States to assess charges on health plans with enrollees of lower-than-average risk, and to provide payments to health plans with enrollees of higher-than-

average risk. Risk adjustment applies to plans in the individual and small group markets, but not to grandfathered health plans.

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

### Part I – Premium Tax Credits and Cost-Sharing Reductions

**Sec. 1401. Refundable tax credit providing premium assistance for coverage under a qualified health plan.** Amends the Internal Revenue Code to provide tax credits to assist with the cost of health insurance premiums.

> **Sec. 36B. Refundable credit for coverage under a qualified health plan.** The premium assistance credit amount is calculated on sliding scale starting at two percent of income for those at or above 100 percent of poverty and phasing out to 9.8 percent of income for those at 400 percent of poverty. The reference premium is the second lowest cost silver plan available in the individual market in the rating area in which the taxpayer resides. The premium assistance credits do not take into account benefits mandated by States. Employees offered coverage by an employer under which the plan's share of the total allowed costs of benefits provided under the plan is less than 60 percent of such costs or the premium exceeds 9.8 percent of the employee's income are eligible for the premium assistance credit. This section also provides for reconciliation of the premium assistance credit amount at the end of the taxable year and for a study on the affordability of health insurance coverage by the Comptroller General.

**Sec. 1402. Reduced cost-sharing for individuals enrolling in qualified health plans.** The standard out-of-pocket maximum limits ($5,950 for individuals and $11,900 for families) would be reduced to one-third for those between 100-200 percent of poverty, one-half for those between 200-300 percent of poverty, and to two-thirds for those between 300-400 percent of poverty. The plan's share of total allowed costs of benefits would be increased to 90 percent for those between 100-150 percent of poverty (i.e., the individual's liability is limited to 10 percent on average) and to 80 percent for those between 150-200 percent of poverty (i.e., the individual's liability is limited to 20 percent on average). The cost-sharing assistance does not take into account benefits mandated by States.

**Sec. 1411. Procedures for determining eligibility for Exchange participation, premium tax credits and reduced cost-sharing, and individual responsibility exemptions.** The Secretary shall establish a program for determining whether an individual applying for coverage in the individual market by a qualified health plan offered through an Exchange, or who is claiming a premium tax credit or reduced cost-sharing, is a citizen or national of the United States or an alien lawfully present in the United States and meets the income and coverage requirements; whether an individual's coverage under an employer-sponsored health benefits plan is treated as unaffordable; and whether to grant a certification attesting that, for purposes of the individual responsibility requirement, an individual is entitled to an exemption from either the individual responsibility requirement or the penalty imposed by such section.

**Sec. 1412. Advance determination and payment of premium tax credits and cost-sharing reductions.** Allows for the advanced payment of premium assistance tax credits and cost-sharing reductions for eligible individuals. Prohibits any Federal payments to individuals who are not lawfully present in the United States.

**Sec. 1413. Streamlining of procedures for enrollment through an Exchange and State Medicaid, CHIP, and health subsidy programs.** Requires the Secretary to establish a system for the residents of each State to apply for enrollment in, receive a determination of eligibility for participation in, and continue participation in, applicable State health subsidy programs. The system will ensure that if any individual applying to an Exchange is found to be eligible for Medicaid or a State children's health insurance program (CHIP), the individual is enrolled for assistance under such plan or program.

**Sec. 1414. Disclosures to carry out eligibility requirements for certain programs.** Allows for limited disclosure of tax return information to Exchanges or State agencies to carry out eligibility requirements for certain programs listed in the Act.

**Sec. 1415. Premium tax credit and cost-sharing reduction payments disregarded for Federal and Federally-assisted programs.** Precludes the premium assistance tax credits and cost-sharing reductions from being counted as income for purposes of determining eligibility for any Federal program or under any State or local program financed in whole or in part with Federal funds.

**Part II – Small Business Tax Credit**

**Sec. 1421. Credit for employee health insurance expenses of small businesses.** Amends the Internal Revenue Code to provide tax credits to small employers.

> **Sec. 45R. Employee health insurance expenses of small employers.** Provides a sliding scale tax credit to small employers with fewer than 25 employees and average annual wages of less than $40,000 that purchase health insurance for their employees. The full credit will be available to employers with 10 or fewer employees and average annual wages of less than $20,000. To be eligible for a tax credit, the employer must contribute at least 50 percent of the total premium cost or 50 percent of a benchmark premium. In 2011 through 2013, eligible employers can receive a small business tax credit for up to 35 percent of their contribution toward the employee's health insurance premium. Tax-exempt small businesses meeting the above requirements are eligible for tax credits of up to 25 percent of their contribution. In 2014 and beyond, eligible employers who purchase coverage through the State Exchange can receive a tax credit for two years of up to 50 percent of their contribution. Tax-exempt small businesses meeting the above requirements are eligible for tax credits of up to 35 percent of their contribution.

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

**Part I – Individual Responsibility**

**Sec. 1501. Requirement to maintain minimum essential coverage.** Contains findings of Congress related to the individual responsibility requirement.

> **Sec. 5000A. Requirement to maintain minimum essential coverage.** Requires individuals to maintain minimum essential coverage beginning in 2014. Failure to maintain coverage will result in a penalty of $95 in 2014, $350 in 2015, $750 in 2016 and indexed thereafter. For those under the age of 18, the applicable penalty will be one-half of the amounts listed above. Exceptions to the individual responsibility requirement to maintain minimum essential coverage are made for religious objectors, individuals not lawfully present, and incarcerated individuals. Exemptions from the penalty will be made for those who cannot afford coverage, taxpayers with income under 100 percent of poverty, members of Indian tribes, those who have received a hardship waiver and those who were not covered for a period of less than three months during the year.

**Sec. 1502. Reporting of health insurance coverage.** Amends the Internal Revenue Code to require the reporting of health insurance coverage.

> **Sec. 6055. Reporting of health insurance coverage.** Requires the reporting of coverage by individuals, employers, and governmental units.

**Part II – Employer Responsibilities**

**Sec. 1511. Automatic enrollment for employees of large employers.** Requires employers with more than 200 employees to automatically enroll new full-time employees in coverage (subject to any waiting period authorized by law) with adequate notice and the opportunity for an employee to opt out of any coverage the individual or employee was automatically enrolled in.

**Sec. 1512. Employer requirement to inform employees of coverage options.** Requires that an employer provide notice to their employees informing them of the existence of an Exchange. Also, if the employer plan's share of the total allowed costs of benefits provided under the plan is less than 60 percent of such costs, that the employee may be eligible for a premium assistance tax credit and cost sharing reduction. Finally, if the employee purchases a qualified health plan through the Exchange, the employee will lose the employer contribution (if any) to any health benefits plan offered by the employer and that all or a portion of such contribution may be excludable from income for Federal income tax purposes.

**Sec. 1513. Shared responsibility for employers.** Requires an employer with more than 50 full-time employees that does not offer coverage and has at least one full-time employee receiving the premium assistance tax credit to make a payment of $750 per full-time employee. An employer with more than 50 full-time employees that requires a waiting period before an employee can enroll in health care coverage will pay $400 for any full-time employee in a 30-60 day waiting period and $600 for any full-time employee in a 60-90 day waiting period. An employer with more than 50 employees that does offer coverage but has at least one full-time employee receiving the premium assistance tax credit will pay the lesser of $3,000 for each of

those employees receiving a tax credit or $750 for each of their full-time employees total. The Secretary of Labor shall conduct a study to determine whether employees' wages are reduced by reason of the application of the assessable payments.

**Sec. 1514. Reporting of employer health insurance coverage.** Requires large employers to report to the Secretary whether it offers to its full-time employees (and their dependents) the opportunity to enroll in minimum essential coverage under an eligible employer-sponsored plan, the length of any applicable waiting period, the lowest cost option in each of the enrollment categories under the plan, and the employer's share of the total allowed costs of benefits provided under the plan. The employer must also report the number and names of full-time employees receiving coverage.

**Sec. 1515. Offering of exchange-participating qualified health plans through cafeteria plans.** Amends the Internal Revenue Code related to cafeteria plans.

> **Sec. 125(f)(3). Certain exchange-participating health plans not qualified.** Plans provided through the exchange will not be an eligible benefit under an employer-sponsored cafeteria plan, except in the case of qualified employers (i.e., small employers, and, after 2017, large employers in electing states) offering a choice of plans to their employees through the exchange.

***Subtitle G—Miscellaneous Provisions***

**Sec. 1551. Definitions.** Applies the definitions contained in section 2791 of the Public Health Service Act to this title.

**Sec. 1552. Transparency in government.** Not later than 30 days after the date of enactment of this Act, the HHS Secretary shall publish on the HHS website a list of all of the authorities provided to the Secretary under this Act.

**Sec. 1553. Prohibition against discrimination on assisted suicide.** Prevents the Federal government, and any State or local government or health care provider that receives Federal financial assistance from subjecting any individual or institutional health care entity to discrimination on the basis that the entity does not provide assisted suicide, euthanasia, or mercy killing.

**Sec. 1554. Access to therapies.** Prevents the HHS Secretary from promulgating certain regulations limiting access to health care services.

**Sec. 1555. Freedom not to participate in Federal health insurance programs.** Provides that no individual, company, business, nonprofit entity, or health insurance issuer shall be required to participate in any Federal health insurance program created under this Act.

**Sec. 1556. Equity for certain eligible survivors.** Provides for improvements to the Black Lung Benefits Act.

**Sec. 1557. Nondiscrimination.** Protects individuals against discrimination under the Civil Rights Act, the Education Amendments Act, the Age Discrimination Act, and the Rehabilitation Act, through exclusion from participation in or denial of benefits under any health program or activity.

**Sec. 1558. Protection for employees.** Amends the Fair Labor Standards Act to ensure that no employer shall discharge or in any manner discriminate against any employee with respect to his or her compensation, terms, conditions, or other privileges of employment because the employee has received a premium tax credit or for other reasons.

**Sec. 1559. Oversight.** The Inspector General of the Department of HHS shall have oversight authority with respect to the administration and implementation of this title as it relates to such Department.

**Sec. 1560. Rules of construction.** Nothing in this title shall be construed to modify, impair, or supersede the operation of any antitrust laws. Nothing in this title shall modify or limit the application of the exemption for Hawaii's Prepaid Health Care Act under ERISA. Nothing in this title shall be construed 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.

**Sec. 1561. Health information technology enrollment standards and protocols.** Requires the development of standards and protocols to promote the interoperability of systems for enrollment of individuals in Federal and State health and human services programs. These standards shall allow for electronic data matching, and electronic documentation. The Secretary may require State or other entities to incorporate such standards as a condition of receiving Federal health information technology funds.

**Sec. 1562. Conforming amendments.** Provides for technical and conforming amendments.

## TITLE II – ROLE OF PUBLIC PROGRAMS

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

**Sec. 2001. Medicaid coverage for the lowest income populations.**

Eligibility. Creates a new State option to provide Medicaid coverage through a State plan amendment beginning on January 1, 2011. Eligible individuals include: all non-elderly, non-pregnant individuals who are not entitled to Medicare (e.g., childless adults and certain parents). Creates a new mandatory Medicaid eligibility category for all such "newly-eligible" individuals with income at or below 133 percent of the Federal Poverty Level (FPL) beginning January 1, 2014. Also, as of January 1, 2014, the mandatory Medicaid income eligibility level for children ages six to 19 changes from 100 percent FPL to 133 percent FPL. States have the option to

provide Medicaid coverage to all non-elderly individuals above 133 percent of FPL through a State plan amendment.

Benefits. Newly-eligible, non-elderly, non-pregnant individuals would receive benchmark or benchmark-equivalent coverage consistent with the requirements of section 1937 of the Social Security Act. Benchmark and benchmark-equivalent coverage would be required to provide at least essential benefits (as defined for the Exchange) and prescription drugs and mental health services would be added to the list of services that must be covered at actuarial equivalence.

Increased Federal assistance. From 2014 through 2016, the Federal government will pay 100 percent of the cost of covering newly-eligible individuals. In 2017 and 2018, States that initially covered less of the newly-eligible population (called "Other States") would receive more assistance than those States that covered at least some non-elderly, non-pregnant individuals ("Expansion States"). Other States would receive a Federal Medical Assistance Percentage (FMAP) increase for services provided to newly-eligible individuals of 34.3 and 33.3 percentage points in 2017 and 2018, respectively. Expansion States would receive 30.3 and 31.3 percentage points in 2017 and 2018, respectively. Beginning in 2019 and thereafter, all States would receive an FMAP increase of 32.3 percentage points for such services.

Maintenance of income eligibility. States would be required to maintain the same income eligibility levels through December 31, 2013 for all adults. This "maintenance of effort" (MOE) requirement would be extended through September 30, 2019 for all children currently covered in Medicaid or CHIP. Between January 1, 2011 and January 1, 2014, a State would be exempt from the MOE requirement for optional, non-pregnant, non-disabled, adult populations whose family income is above 133 percent of FPL if the State certifies to the Secretary that the State is currently experiencing a budget deficit or projects to have a budget deficit in the following State fiscal year.

**Sec. 2002. Income eligibility for nonelderly determined using modified gross income.** Beginning January 1, 2014, States would be required to use modified gross income to determine Medicaid eligibility, the same measure used in the State Exchanges. Income disregards and asset tests would no longer apply in Medicaid, except for long-term services and supports. Existing Medicaid income counting rules would continue to apply for certain exempted groups including (1) individuals that are eligible for Medicaid through another program, (2) the elderly or Social Security Disability Insurance (SSDI) program beneficiaries, (3) the medically needy, (4) enrollees in a Medicare Savings Program, and (5) the disabled.

**Sec. 2003. Requirement to offer premium assistance for employer-sponsored insurance.** Requires States to offer premium assistance and wrap-around benefits to all Medicaid beneficiaries who are offered employer-sponsored insurance (ESI) if it is cost-effective to do so, based on current law requirements.

**Sec. 2004. Medicaid coverage for former foster care children.** Allows all individuals below the age of 25 who were formerly in foster care for at least six months to be eligible for

Medicaid. Children who qualify for Medicaid through this eligibility pathway would receive all benefits under Medicaid, including EPSDT.

**Sec. 2005. Payments to territories.** Increases the spending caps for the territories by 30 percent and the applicable FMAP by five percentage points – to 55 percent – beginning on January 1, 2011 and for each fiscal year thereafter. Beginning in 2014, payments made to the territories with respect to amounts expended for medical assistance for newly eligible individuals would not count against the spending caps.

**Sec. 2006. Special adjustment to FMAP determination for certain States recovering from a major disaster.** Reduces projected decreases in Medicaid funding for States that have experienced major, statewide disasters.

**Sec. 2007. Medicaid Improvement Fund rescission.** Rescinds funds available in the Medicaid Improvement Fund (MIF) for fiscal years 2014 through 2018.

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

**Sec. 2101. Additional Federal financial participation for CHIP.** Upon enactment, States would be required to maintain income eligibility levels for CHIP through September 30, 2019. From fiscal year 2014 to 2019, States would receive a 23 percentage point increase in the CHIP match rate, subject to a cap of 100 percent. CHIP-eligible children who cannot enroll in CHIP due to Federal allotment caps would be eligible for tax credits in the State Exchange.

**Sec. 2102. Technical corrections.** Makes technical corrections to selected provisions in the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) and the American Recovery and Reinvestment Act of 2009 (ARRA).

***Subtitle C – Medicaid and CHIP Enrollment Simplification***

**Sec. 2201. Enrollment Simplification and coordination with State Health Insurance Exchanges.** Allows individuals to apply for and enroll in Medicaid, CHIP or the Exchange through a State-run website. Requires State Medicaid and CHIP programs and the Exchange to coordinate enrollment procedures to provide seamless enrollment for all programs.

**Sec. 2202. Permitting hospitals to make presumptive eligibility determinations for all Medicaid eligible populations.** Allows any hospital the option, based off preliminary information, to provide Medicaid services during a period of presumptive eligibility to members of all Medicaid eligibility categories.

***Subtitle D – Improvements to Medicaid Services***

**Sec. 2301. Coverage for freestanding birth center services.** Requires coverage of services provided by free-standing birth centers.

**Sec. 2302. Concurrent care for children.** Allows children who are enrolled in either Medicaid or CHIP to receive hospice services without foregoing curative treatment related to a terminal illness.

**Sec. 2303. State eligibility option for family planning services.** Adds a new optional categorically-needy eligibility group to Medicaid comprised of (1) non-pregnant individuals with income up to the highest level applicable to pregnant women covered under Medicaid or CHIP, and (2) individuals eligible under the standards and processes of existing section 1115 waivers that provide family planning services and supplies. Benefits would be limited to family planning services and supplies, including related medical diagnostic and treatment services.

**Sec. 2304. Clarification of definition of medical assistance.** Clarifies that "medical assistance" encompasses both payment for services provided and the services themselves.

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

**Sec. 2401. Community First Choice Option.** Establishes an optional Medicaid benefit through which States could offer community-based attendant services and supports to Medicaid beneficiaries with disabilities who would otherwise require the level of care offered in a hospital, nursing facility, or intermediate care facility for the mentally retarded.

**Sec. 2402. Removal of barriers to providing home and community-based services.** Removes barriers to providing HCBS by giving States the option to provide more types of HCBS through a State plan amendment to individuals with higher levels of need, rather than through a waiver, and to extend full Medicaid benefits to individuals receiving HCBS under a State plan amendment.

**Sec. 2403. Money Follows the Person Rebalancing Demonstration.** Extends the Money Follows the Person Rebalancing Demonstration through September 30, 2016 and changes the eligibility rules for individuals to participate in the demonstration project by requiring that individuals reside in an inpatient facility for not less than 90 consecutive days.

**Sec. 2404. Protection for recipients of home and community-based services against spousal impoverishment.** Requires States to apply spousal impoverishment rules to beneficiaries who receive HCBS. This provision would apply for a five-year period beginning on January 1, 2014.

**Sec. 2405. Funding to expand State Aging and Disability Resource Centers.** Appropriates, to the Secretary of HHS, $10 million for each of FYs 2010 through 2014 to carry out Aging and Disability Resource Center (ADRC) initiatives.

**Sec. 2406. Sense of the Senate regarding long-term care.** Expresses the Sense of the Senate that during the 111th Congress, Congress should address long-term services and supports in a comprehensive way that guarantees elderly and disabled individuals the care they need, in the community as well as in institutions.

## ***Subtitle F – Medicaid Prescription Drug Coverage***

**Sec. 2501. Prescription drug rebates.** The flat rebate for single source and innovator multiple source outpatient prescription drugs would increase from 15.1 percent to 23.1 percent, except the rebate for clotting factors and outpatient drugs approved by the Food and Drug Administration exclusively for pediatric indications would increase to 17.1 percent. The basic rebate percentage for multi-source, non-innovator drugs would increase from 11 percent to 13 percent. Drug manufacturers would also be required to pay rebates for drugs dispensed to Medicaid beneficiaries who receive care from a Medicaid managed care organization (MCO). Total rebate liability would be limited to 100 percent of the average manufacturer price (AMP). Additional revenue generated by these increases will be remitted to the federal government.

**Sec. 2502. Elimination of exclusion of coverage of certain drugs.** Beginning with drugs dispensed on January 1, 2014, smoking cessation drugs, barbiturates, and benzodiazepines would be removed from Medicaid's excludable drug list.

**Sec. 2503. Providing adequate pharmacy reimbursement.** Requires the Secretary to calculate the Federal upper limit (FUL) as no less than 175 percent of the weighted average (determined on the basis of utilization) of the most recently reported monthly average manufacturer prices for pharmaceutically and therapeutically equivalent multiple source drugs available nationally through commercial pharmacies.

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

**Sec. 2551. Disproportionate share hospital payments.** Reduces States' disproportionate share hospital (DSH) allotments by 50 percent once the rate of uninsurance in a State decreases by 45 percent (low DSH States would receive a 25 percent reduction). As the rate of uninsurance continues to decline, the States' DSH allotments would be reduced by a corresponding amount. At no time could a State's DSH allotment be reduced by more than 65 percent compared to its FY2012 allotment.

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

**Sec. 2601. 5-year period for demonstration projects.** Clarifies that Medicaid waivers for coordinating care for dual eligible beneficiaries could be authorized for as long as five years.

**Sec. 2602. Providing Federal coverage and payment coordination for dual eligible beneficiaries.** Requires the Secretary to establish a Federal Coordinated Health Care Office (CHCO) within CMS by March 1, 2010. The purpose of the CHCO would be to bring together officials of the Medicare and Medicaid programs to (1) more effectively integrate benefits under those programs, and (2) improve the coordination between the Federal and State governments for individuals eligible for benefits under both Medicare and Medicaid (dual eligibles) to ensure that dual eligibles have full access to the items and services to which they are entitled.

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

**Sec. 2701. Adult health quality measures.** Directs the Secretary of HHS to develop a set of quality measures for Medicaid eligible adults that is similar to the quality measurement program for children enacted in the Children's Health Insurance Program Reauthorization Act of 2009. The Secretary and the States will report on the development of and improvements to the quality measurement program on a regular basis.

**Sec. 2702. Payment adjustment for health care-acquired conditions.** Prohibits Medicaid payment for services related to a health care-acquired condition. The Secretary will develop a list of health care-acquired conditions for Medicaid based on those defined under Medicare as well as current State practices.

**Sec. 2703. State option to provide health homes for enrollees with chronic conditions.** Provide States the option of enrolling Medicaid beneficiaries with chronic conditions into a health home. Health homes would be composed of a team of health professionals and would provide a comprehensive set of medical services, including care coordination.

**Sec. 2704. Demonstration project to evaluate integrated care around a hospitalization.** Establishes a demonstration project, in up to eight States, to study the use of bundled payments for hospital and physicians services under Medicaid.

**Sec. 2705. Medicaid global payment system demonstration project**. Establishes a demonstration project, in coordination with the CMS Innovation Center, in up to five States that would allow participating States to adjust their current payment structure for safety net hospitals from a fee-for-service model to a global capitated payment structure.

**Sec. 2706. Pediatric Accountable Care Organization demonstration project.** Establishes a demonstration project that allows qualified pediatric providers to be recognized and receive payments as Accountable Care Organizations (ACO) under Medicaid. The pediatric ACO would be required to meet certain performance guidelines. Pediatric ACOs that met these guidelines and provided services at a lower cost would share in those savings.

**Sec. 2707. Medicaid emergency psychiatric demonstration project.** Requires the Secretary of HHS to establish a three-year Medicaid demonstration project in up to eight States. Participating States would be required to reimburse certain institutions for mental disease (IMDs) for services provided to Medicaid beneficiaries between the ages of 21 and 65 who are in need of medical assistance to stabilize an emergency psychiatric condition.

## ***Subtitle J – Improvements to the Medicaid and CHIP Payment and Access Commission***

**Sec. 2801. MACPAC assessment of policies affecting all Medicaid beneficiaries.** Clarifies the topics to be reviewed by the Medicaid and CHIP Payment and Access Commission (MACPAC) including Federal Medicaid and CHIP regulations, additional reports of State-

specific data, and an assessment of adult services in Medicaid. The provision would also authorize $11 million to fund MACPAC for FY2010.

***Subtitle K – Protections for American Indians and Alaska Natives***

**Sec. 2901. Special rules relating to Indians.** Prohibits cost-sharing for Indians enrolled in a qualified health benefit plan in the individual market through a State Exchange. Also, facilities operated by the Indian Health Service (IHS) and Indian, Tribal, and Urban Indian facilities (I/T/Us) would be added to the list of agencies that could serve as an "Express Lane" agency able to determine Medicaid and CHIP eligibility.

**Sec. 2902. Elimination of sunset for reimbursement for all Medicare Part B services furnished by certain Indian hospitals and clinics.** Removes the sunset provision, allowing IHS and I/T/U services to continue to be reimbursed by Medicare Part B.

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

**Sec. 2951. Maternal, infant, and early childhood home visiting programs.** Provides funding to States, tribes, and territories to develop and implement one or more evidence-based Maternal, Infant, and Early Childhood Visitation model(s). Model options would be targeted at reducing infant and maternal mortality and its related causes by producing improvements in prenatal, maternal, and newborn health, child health and development, parenting skills, school readiness, juvenile delinquency, and family economic self-sufficiency.

**Sec. 2952. Support, education, and research for postpartum depression**. Provides support services to women suffering from postpartum depression and psychosis and also helps educate mothers and their families about these conditions. Provides support for research into the causes, diagnoses, and treatments for postpartum depression and psychosis.

**Sec. 2953. Personal responsibility education.** Provides $75 million per year through FY2014 for Personal Responsibility Education grants to States for programs to educate adolescents on both abstinence and contraception for prevention of teenage pregnancy and sexually transmitted infections, including HIV/AIDS. Funding is also available for 1) innovative teen pregnancy prevention strategies and services to high-risk, vulnerable, and culturally under-represented populations, 2) allotments to Indian tribes and tribal organizations, and 3) research and evaluation, training, and technical assistance.

**Sec. 2954. Restoration of funding for abstinence education.** Appropriates $50 million per year through FY 2014 for abstinence education.

**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.** Enables children aging out of the foster care system to have the opportunity to designate a medical power of attorney prior to emancipation from foster care. States must supply information and an opportunity for the child to designate another individual to make medical

decisions on their behalf should they be unable to participate in such decision making process as part of the transition process for children expected to age out of the foster care system.

## 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.** The proposal would establish a value-based purchasing program for hospitals starting in FY2013. Under this program, a percentage of hospital payment would be tied to hospital performance on quality measures related to common and high-cost conditions, such as cardiac, surgical and pneumonia care. Quality measures included in the program (and in all other quality programs in this title) will be developed and chosen with input from external stakeholders.

**Sec. 3002. Improvements to the physician quality reporting initiative.** Extends through 2014 payments under the PQRI program, which provide incentives to physicians who report quality data to Medicare. Creates appeals and feedback processes for participating professionals in PQRI. Establishes a participation pathway for physicians completing a qualified Maintenance of Certification program with their specialty board of medicine. Beginning in 2014, physicians who do not submit measures to PQRI will have their Medicare payments reduced.

**Sec. 3003. Improvements to the physician feedback program.** Expands Medicare's physician resource use feedback program to provide for development of individualized reports by 2012. Reports will compare the per capita utilization of physicians (or groups of physicians) to other physicians who see similar patients. Reports will be risk-adjusted and standardized to take into account local health care costs.

**Sec. 3004. Quality reporting for long-term care hospitals, inpatient rehabilitation hospitals, and hospice programs.** Establishes a path toward value-based purchasing for long-term care hospitals, inpatient rehabilitation facilities, and hospice providers by requiring the Secretary to implement quality measure reporting programs for these providers in FY2014. Providers under this section who do not successfully participate in the program would be subject to a reduction in their annual market basket update.

**Sec. 3005. Quality reporting for PPS-exempt cancer hospitals.** Establishes a quality measure reporting program for PPS-exempt cancer hospitals beginning in FY2014. Providers under this section who do not successfully participate in the program would be subject to a reduction in their annual market basket update.

**Sec. 3006. Plans for a value-based purchasing program for skilled nursing facilities and home health agencies.** Directs the Secretary to submit a plan to Congress by FY2012 outlining how to effectively move these providers into a value-based purchasing payment system.

**Sec. 3007. Value-based payment modifier under the physician fee schedule.** Directs the Secretary of HHS to develop and implement a budget-neutral payment system that will adjust Medicare physician payments based on the quality and cost of the care they deliver. Quality and cost measures will be risk-adjusted and geographically standardized. The Secretary will phase-in the new payment system over a 2-year period beginning in 2015.

**Sec. 3008. Payment adjustment for conditions acquired in hospitals.** Starting in FY2015, hospitals in the top 25th percentile of rates of hospital acquired conditions for certain high-cost and common conditions would be subject to a payment penalty under Medicare. This provision also requires the Secretary to submit a report to Congress by January 1, 2012 on the appropriateness of establishing a healthcare acquired condition policy related to other providers participating in Medicare, including nursing homes, inpatient rehabilitation facilities, long-term care hospitals, outpatient hospital departments, ambulatory surgical centers, and health clinics.

**Part II – National Strategy to Improve Health Care Quality**

**Sec. 3011. National strategy.** Requires the Secretary to establish and update annually a national strategy to improve the delivery of health care services, patient health outcomes, and population health. Establishes, not later than January 1, 2011, a Federal health care quality internet website.

**Sec. 3012. Interagency Working Group on Health Care Quality.** Requires the President to convene an Interagency Working Group on Health Care Quality comprised of Federal agencies to collaborate on the development and dissemination of quality initiatives consistent with the national strategy.

**Sec. 3013. Quality measure development.** Authorizes $75 million over 5 years for the development of quality measures at AHRQ and the Centers for Medicare and Medicaid Services (CMS). Quality measures developed under this section will be consistent with the national strategy.

**Sec. 3014. Quality measurement.** Provides $20 million to support the endorsement and use of endorsed measures by the HHS Secretary for use in Medicare, reporting performance information to the public, and in health care programs.

**Sec. 3015. Data Collection; Public Reporting.** Requires the Secretary to collect and aggregate consistent data on quality and resource use measures from information systems used to support health care delivery to implement the public reporting of performance information.

**Part III – Encouraging Development of New Patient Care Models**

**Sec. 3021. Establishment of Center for Medicare and Medicaid Innovation within CMS.** Establishes within the Centers for Medicare and Medicaid Services (CMS) a Center for Medicare & Medicaid Innovation. The purpose of the Center will be to research, develop, test, and expand innovative payment and delivery arrangements to improve the quality and reduce the cost of care

provided to patients in each program. Dedicated funding is provided to allow for testing of models that require benefits not currently covered by Medicare. Successful models can be expanded nationally.

**Sec. 3022. Medicare shared savings program.** Rewards Accountable Care Organizations (ACOs) that take responsibility for the costs and quality of care received by their patient panel over time. ACOs can include groups of health care providers (including physician groups, hospitals, nurse practitioners and physician assistants, and others). ACOs that meet quality-of-care targets and reduce the costs of their patients relative to a spending benchmark are rewarded with a share of the savings they achieve for the Medicare program.

**Sec. 3023. National pilot program on payment bundling.** Direct the Secretary to develop a national, voluntary pilot program encouraging hospitals, doctors, and post-acute care providers to improve patient care and achieve savings for the Medicare program through bundled payment models. Requires the Secretary to establish this program by January 1, 2013 for a period of five years. Before January 1, 2016, the Secretary is also required to submit a plan to Congress to expand the pilot program if doing so will improve patient care and reduce spending.

**Sec. 3024. Independence at home demonstration program.** Creates a new demonstration program for chronically ill Medicare beneficiaries to test a payment incentive and service delivery system that utilizes physician and nurse practitioner directed home-based primary care teams aimed at reducing expenditures and improving health outcomes.

**Sec. 3025. Hospital readmissions reduction program.** Beginning in FY2012, this provision would adjust payments for hospitals paid under the inpatient prospective payment system based on the dollar value of each hospital's percentage of potentially preventable Medicare readmissions for the three conditions with risk adjusted readmission measures that are currently endorsed by the National Quality Forum. Also, provides the Secretary authority to expand the policy to additional conditions in future years and directs the Secretary to calculate and make publicly available information on all patient hospital readmission rates for certain conditions.

**Sec. 3026. Community-based care transitions program.** Provides funding to hospitals and community-based entities that furnish evidence-based care transition services to Medicare beneficiaries at high risk for readmission.

**Sec. 3027. Extension of gainsharing demonstration.** The Deficit Reduction Act of 2005 authorized a demonstration to evaluate arrangements between hospitals and physicians designed to improve the quality and efficiency of care provided to beneficiaries. This provision would extend the demonstration through September 30, 2011 and extend the date for the final report to Congress on the demonstration to September 30, 2012. It would also authorize an additional $1.6 million in FY2010 for carrying out the demonstration.

## ***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.** Replaces the scheduled 21 percent payment reduction to the Medicare physician fee schedule for 2010 with a 0.5 percent positive update.

**Sec. 3102. Extension of the work geographic index floor and revisions to the practice expense geographic adjustment under the Medicare physician fee schedule.** Extends a floor on geographic adjustments to the work portion of the fee schedule through the end of 2010, with the effect of increasing practitioner fees in rural areas. Also provides immediate relief to areas negatively impacted by the geographic adjustment for practice expenses, and requires the Secretary of HHS to improve the methodology for calculating practice expense adjustments beginning in 2012.

**Sec. 3103. Extension of exceptions process for Medicare therapy caps.** Extends the process allowing exceptions to limitations on medically necessary therapy until December 31, 2010.

**Sec. 3104. Extension of payment for technical component of certain physician pathology services.** Extends a provision that directly reimburses qualified rural hospitals for certain clinical laboratory services through the end of 2010.

**Sec. 3105. Extension of ambulance add-ons.** Extends bonus payments made by Medicare for ground and air ambulance services in rural and other areas through the end of 2010.

**Sec. 3106. Extension of certain payment rules for long-term care hospital services and of moratorium on the establishment of certain hospitals and facilities.** Extends Sections 114 (c) and (d) of the Medicare, Medicaid and SCHIP Extension Act of 2007 by one year.

**Sec. 3107. Extension of physician fee schedule mental health add-on.** Increases the payment rate for psychiatric services by 5 percent for two years, through the end of 2010.

**Sec. 3108. Permitting physician assistants to order post-hospital extended care services.** Authorizes physician assistants to order skilled nursing care services in the Medicare program beginning in 2011.

**Sec. 3109. Exemption of certain pharmacies from accreditation requirements.** Allows pharmacies with less than 5 percent of revenues from Medicare DMEPOS billings to be exempt from accreditation requirements until the Secretary of HHS develops pharmacy-specific standards.

**Sec. 3110. Part B special enrollment period for disabled TRICARE beneficiaries.** Creates a twelve-month special enrollment period for military retirees, their spouses (including widows/widowers) and dependent children, who are otherwise eligible for TRICARE and entitled to Medicare Part A based on disability or ESRD, but who have declined Part B.

**Sec. 3111. Payment for bone density tests.** Restores payment for dual-energy x-ray

absorptiometry (DXA) services furnished during 2010 and 2011 to 70 percent of the Medicare rate paid in 2006.

**Sec. 3112. Revision to the Medicare Improvement Fund.** Eliminates the remaining funds in the Medicare Improvement Fund.

**Sec. 3113. Treatment of certain complex diagnostic laboratory tests.** Creates a demonstration program to test the impact of direct payments for certain complex laboratory tests on Medicare quality and costs.

**Sec. 3114. Improved access for certified nurse-midwife services**. Increases the payment rate for certified nurse midwives for covered services from 65 percent of the rate that would be paid were a physician performing a service to the full rate.

**PART II – Rural Protections**

**Sec. 3121. Extension of outpatient hold harmless provision.** Extends the existing outpatient hold harmless provision through the end of FY2010 and would allow Sole Community Hospitals with more than 100 beds to also be eligible to receive this adjustment through the end of FY2010.

**Sec. 3122. Extension of Medicare reasonable costs payments for certain clinical diagnostic laboratory tests furnished to hospital patients in certain rural areas.** Reinstates the policy included in the Medicare Modernization Act of 2003 (P.L. 108-173) that provides reasonable cost reimbursement for laboratory services provided by certain small rural hospitals from July 1, 2010 to July 1, 2011.

**Sec. 3123. Extension of the Rural Community Hospital Demonstration Program.** Extends the program for one year and expands eligible sites to additional States and additional rural hospitals.

**Sec. 3124. Extension of the Medicare-dependent hospital (MDH) program.** Extends the Medicare-dependent hospital program by one year through October 1, 2012. It would also require HHS to study whether certain urban hospitals should qualify for the MDH program.

**Sec. 3125. Temporary improvements to the Medicare inpatient hospital payment adjustment for low-volume hospitals.** Expands the program providing a temporary adjustment to inpatient hospital payments for certain low-volume hospitals through FY2012 and would modify eligibility requirements regarding distance from another facility and number of eligible discharges.

**Sec. 3126. Improvements to the demonstration project on community health integration models in certain rural counties.** The Medicare Improvements for Patients and Providers Act (MIPPA, P.L. 110-275) authorized a demonstration project that will allow eligible rural entities to test new models for the delivery of health care services in rural areas. This provision will

expand the demonstration to allow additional counties to participate and will also allow physicians to participate in the demonstration project.

**Sec. 3127. MedPAC study on adequacy of Medicare payments for health care providers serving in rural areas.** This provision would require MedPAC to review payment adequacy for rural health care providers serving the Medicare program, including an analysis of the rural payment adjustments included in this legislation and beneficiaries' access to care in rural communities.

**Sec. 3128. Technical correction related to critical access hospital services.** This provision clarifies that CAHs can continue to be eligible to receive 101 percent of reasonable costs for providing outpatient care regardless of eligible billing method the facility uses and for providing qualifying ambulance services.

**Sec. 3129. Extension of and revisions to Medicare rural hospital flexibility program.** This provision extends the Flex Grant program through 2012 and will allow Flex grant funding to be used to support rural hospitals' efforts to implement delivery system reform programs, such as value-based purchasing programs, bundling, and other quality programs.

**Part III – Improving Payment Accuracy**

**Sec. 3131. Payment adjustments for home health care.** This provision would direct the Secretary to improve payment accuracy through rebasing home health payments starting in 2013 based on an analysis of the current mix of services and intensity of care provided to home health patients. The provision would also establish a 10 percent cap on the amount of reimbursement a home health provider can receive from outlier payments and would reinstate an add-on payment for rural home health providers from April 1, 2010 through 2015. In addition, it would require the Secretary to submit a report to Congress by March 1, 2011 on recommended payment reforms related to serving patients with varying severity of illness or to improve beneficiary access to care.

**Sec. 3132. Hospice reform.** This provision would require the Secretary to update Medicare hospice claims forms and cost reports by 2011. Based on this information, the Secretary would be required to implement changes to the hospice payment system to improve payment accuracy in FY2013. The Secretary would also impose certain requirements on hospice providers designed to increase accountability in the Medicare hospice program.

**Sec. 3133. Improvement to Medicare disproportionate share hospital (DSH) payments.** This provision would require the Secretary to update hospital payments to better account for hospitals' uncompensated care costs. Starting in FY2015, hospitals' Medicare Disproportionate Share Hospital (DSH) payments would be reduced to reflect lower uncompensated care costs relative to increases in the number of insured.

**Sec. 3134. Misvalued codes under the physician fee schedule.** Directs the Secretary to regularly review fee schedule rates for physician services paid for by Medicare, including

services that have experienced high growth rates. Strengthens the Secretary's authority to adjust fees schedule rates that are found to be misvalued or inaccurate.

**Sec. 3135. Modification of equipment utilization factor for advanced imaging services.** Increases the practice expense units for imaging services from a presumed utilization rate of 50 percent to 65 percent for 2010 through 2012, 70 percent in 2013, and 75 percent thereafter. Excludes low-tech imaging such as ultrasound, x-rays and EKGs from this adjustment. Also adjusts the technical component discount on single session imaging studies on contiguous body parts from 25 percent to 50 percent.

**Sec. 3136. Revision of payment for power-driven wheelchairs.** Eliminates the option for Medicare to purchase power-driven wheelchairs with a lump-sum payment at the time the chair is supplied. Medicare would continue to make the same payments for power-driven chairs over a 13-month period. Purchase option for complex rehabilitative power wheelchairs would be maintained.

**Sec. 3137. Hospital wage index improvement.** Extends reclassifications under section 508 of the Medicare Modernization Act (P.L 108-173) through the end of FY2010. In addition, requires the Secretary to provide recommendations to Congress on ways to comprehensively reform the Medicare wage index system by December 31, 2011. Also directs the Secretary to restore the reclassification thresholds used to determine hospital reclassifications to the percentages used in FY2009, starting in FY2011 until the first fiscal year that is on or after the date the Secretary submits the report to Congress on reforming the wage index system.

**Sec. 3138. Treatment of certain cancer hospitals.** Directs the Secretary to study whether existing cancer hospitals that are exempt from the inpatient prospective payment system have costs under the outpatient prospective payment system (OPPS) that exceed costs of other hospitals, and to make an appropriate payment adjustment under OPPS based on that analysis.

**Sec. 3139. Payment for biosimilar biological products.** Sets the add-on payment rate for biosimilar products reimbursement under Medicare Part B at 6 percent of the average sales price of the brand biological product.

**Sec. 3140. Medicare hospice concurrent care demonstration program.** Directs the Secretary to establish a three-year demonstration program that would allow patients who are eligible for hospice care to also receive all other Medicare covered services during the same period of time. The demonstration would be conducted in up to 15 hospice programs in both rural and urban areas and would evaluate the impacts of the demonstration on patient care, quality of life and spending in the Medicare program.

**Sec. 3141. Application of budget neutrality on a national basis in the calculation of the Medicare hospital wage index floor.** Starting on October 1, 2010, the provision would require application of budget neutrality associated with the effect of the imputed rural and rural floor to be applied on a national, rather than State-specific basis through a uniform, national adjustment to the area wage index.

**Sec. 3142. HHS study on urban Medicare-dependent hospitals.** Requires the Secretary to conduct a study on the need for additional Medicare payments for certain urban Medicare-dependent hospitals paid under the inpatient prospective payment system.

## ***Subtitle C – Provisions Related to Part C***

**Sec. 3201. Medicare Advantage payment**. Sets Medicare Advantage payment based on the average of the bids from Medicare Advantage plans in each market. Creates performance bonus payments based on a plan's level of care coordination and care management and achievement on quality rankings. Provides a four-year transition to new benchmarks beginning in 2011. Provides a longer transition of the amount of extra benefits available from plans to beneficiaries in certain areas where the level of extra benefits available is highest relative to other areas.

**Sec. 3202. Benefit protection and simplification.** Prohibits Medicare Advantage plans from charging beneficiaries cost sharing for covered services that is greater than what is charged under the traditional fee-for-service program. Requires plans that provide extra benefits to give priority to cost sharing reductions, wellness and preventive care, and then benefits not covered under Medicare.

**Sec. 3203. Application of coding intensity adjustment during MA payment transition.** Extends HHS authority to adjust risk scores in Medicare Advantage for observed differences in coding patterns relative to traditional fee-for-service.

**Sec. 3204. Simplification of annual beneficiary election periods.** Provides extra time for CMS, Medicare Advantage plans and prescription drug plans to process enrollment paperwork during annual enrollment periods and eliminates a duplicative open enrollment period for Medicare Advantage plans. Allows beneficiaries to disenroll from a Medicare Advantage plan and return to the traditional fee-for-service program from January 1 to March 15 of each year.

**Sec. 3205. Extension for specialized MA plans for special needs individuals.** Extends the SNP program through 2013 and requires SNPs to be NCQA approved. Allows HHS to apply a frailty payment adjustment to fully-integrated, dual-eligible SNPs that enroll frail populations. Requires HHS to transition beneficiaries enrolled in SNPs that do not meet statutory target definitions and requires dual-eligible SNPs to contract with State Medicaid programs beginning 2013. Also requires an evaluation of Medicare Advantage risk adjustment for chronically ill populations.

**Sec. 3206. Extension of reasonable cost contracts**. Extends the period of time for which cost plans may operate in areas that have other health plan options.

**Sec. 3207. Technical correction to MA private fee-for-service plans.** Allows employer-sponsored private fee-for-service plans authorized under 1857(i)(2) with current enrollment to use, beginning 2011, a CMS service area waiver available to employer and union group health plans that are coordinated care plans.

**Sec. 3208. Making senior housing facility demonstration permanent.** Allows demonstration plans that serve residents in continuing care retirement communities to operate under the Medicare Advantage program.

**Sec. 3209. Authority to deny plan bids.** Authorizes the HHS Secretary to deny bids submitted by Medicare Advantage and prescription plans, beginning in 2011, that propose to significantly increase beneficiary cost sharing or decrease benefits offered under the plan.

**Sec. 3209. Development of new standards for certain Medigap plans.** Requires HHS to request NAIC revisions to the standards for benefit packages classified as "C" and "F" so that these packages include nominal cost sharing that encourages the use of appropriate Part B physician services.

***Subtitle D – Medicare Part D Improvements for Prescription Drug Plans and MA–PD Plans***

**Sec. 3301. Medicare coverage gap discount program**. Requires drug manufacturers to provide a 50 percent discount to Part D beneficiaries for brand-name drugs and biologics purchased during the coverage gap beginning July 1, 2010.

**Sec. 3302. Improvement in determination of Medicare part D low-income benchmark premium**. Removes Medicare Advantage rebates and quality bonus payments from the calculation of the low-income subsidy benchmark.

**Sec. 3303. Voluntary de minimis policy for subsidy-eligible individuals under prescription drug plans and MA–PD plans.** Allows Part D plans that bid a nominal amount above the regional low-income subsidy (LIS) benchmark to absorb the cost of the difference between their bid and the LIS benchmark in order to remain a $0 premium LIS plan.

**Sec. 3304. Special rule for widows and widowers regarding eligibility for low-income assistance**. Allows the surviving spouse of an LIS-eligible couple to delay LIS redetermination for one year after the death of a spouse.

**Sec. 3305. Improved information for subsidy-eligible individuals reassigned to prescription drug plans and MA–PD plans**. Requires HHS, beginning in 2011, to transmit formulary and coverage determination information to subsidy-eligible beneficiaries who have been automatically reassigned to a new Part D low-income subsidy plan.

**Sec. 3306. Funding outreach and assistance for low-income programs.** Provides $45 million for outreach and education activities to State Health Insurance Programs, Administration on Aging, Aging Disability Resource Centers and the National Benefits Outreach and Enrollment.

**Sec. 3307. Improving formulary requirements for prescription drug plans and MA–PD plans with respect to certain categories or classes of drugs.** Codifies the current six classes of clinical concern, removes the criteria specified in section 176 of MIPPA that would have been

used by HHS to identify protected classes of drugs and gives the Secretary authority to identify classes of clinical concern through rulemaking.

**Sec. 3308. Reducing part D premium subsidy for high-income beneficiaries**. Reduces the Part D premium subsidy for beneficiaries with incomes above the Part B income thresholds.

**Sec. 3309. Elimination of cost sharing for certain dual-eligible individuals**. Eliminates cost sharing for beneficiaries receiving care under a home and community-based waiver program who would otherwise require institutional care.

**Sec. 3310. Reducing wasteful dispensing of outpatient prescription drugs in long-term care facilities under prescription drug plans and MA-PD plans.** Requires Part D plans to develop drug dispensing techniques to reduce prescription drug waste in long-term care facilities.

**Sec. 3311. Improved Medicare prescription drug plan and MA–PD plan complaint system**. Requires the Secretary to develop and maintain a plan complaint system to handle complaints regarding Medicare Advantage and Part D plans or their sponsors.

**Sec. 3312. Uniform exceptions and appeals process for prescription drug plans and MA–PD plans.** Requires Part D plans to use a single, uniform exceptions and appeals process.

**Sec. 3313. Office of the Inspector General studies and reports**. Requires the OIG to conduct a study comparing prescription drug prices paid under the Medicare Part D program to those paid under State Medicaid programs.

**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.** Allows drugs provided to beneficiaries by AIDS Drug Assistance Programs or the Indian Health Service to count toward the annual out-of-pocket threshold.

**Sec. 3315. Immediate reduction in coverage gap for 2010**. Increases the initial coverage limit in the standard Part D benefit by $500 for 2010.

***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.** Incorporates a productivity adjustment into the market basket update for inpatient hospitals, home health providers, nursing homes, hospice providers, inpatient psychiatric facilities, long-term care hospitals and inpatient rehabilitation facilities beginning in various years and implements additional market basket reductions for certain providers. It would also incorporate a productivity adjustment into payment updates for Part B providers who do not already have such an adjustment.

**Sec. 3402. Temporary adjustment to the calculation of part B premiums.** For higher-income

beneficiaries who pay a higher Part B premium rate, freezes the income thresholds at 2010 levels through 2019.

**Sec. 3403. Independent Medicare Advisory Board.** Creates an independent, 15-member Medicare Advisory Board tasked with presenting Congress with comprehensive proposals to reduce excess cost growth and improve quality of care for Medicare beneficiaries. In years when Medicare costs are projected to be unsustainable, the Board's proposals will take effect unless Congress passes an alternative measure that achieves the same level of savings. Congress would be allowed to consider an alternative provision on a fast-track basis. The Board would be prohibited from making proposals that ration care, raise taxes or Part B premiums, or change Medicare benefit, eligibility, or cost-sharing standards.

***Subtitle F—Health Care Quality Improvements***

**Sec. 3501. Health care delivery system research; Quality improvement technical assistance.** Builds on the Center for Quality Improvement and Patient Safety of the Agency for Healthcare Research and Quality (AHRQ) to support research, technical assistance and process implementation grants. Grants funded under this section will identify, develop, evaluate, disseminate, and provide training in innovative methodologies and strategies for quality improvement practices in the delivery of health care services.

**Sec. 3502. Grants or contracts to establish community health teams to support the patient-centered medical home.** Creates a program to establish and fund the development of community health teams to support the development of medical homes by increasing access to comprehensive, community based, coordinated care.

**Sec. 3503. Grants to implement 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 medical 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. Office of 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. Program facilitates care by assisting individuals coordinate health services and provider referrals, assist community organizations in helping individuals receive better access to care, information on clinical trials, and conduct outreach to health disparity populations.

**Sec. 3511. Authorization of appropriations.**

## 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.** Creates an interagency council dedicated to promoting healthy policies at the Federal level. The Council shall consist of representatives of Federal agencies that interact with Federal health and safety policy, including the departments of HHS, Agriculture, Education, Labor, Transportation, and others. The Council will establish a national prevention and health promotion strategy and develop interagency working relationships to implement the strategy. The Council will report annually to Congress on the health promotion activities of the Council and progress in meeting goals of the national strategy.

**Sec. 4002. Prevention and Public Health Fund.** Establishes a Prevention and Public Health Investment Fund. The goal of the Investment Fund is to provide an expanded and sustained national investment in prevention and public health programs to improve health and help restrain the rate of growth in private and public sector health care costs. This will involve a dedicated,

stable funding stream for prevention, wellness and public health activities authorized by the Public Health Service Act.

**Sec. 4003. Clinical and community preventive services.** Expands the efforts of, and improves the coordination between, two task forces which provide recommendations for preventive interventions. The U.S. Preventive Services Task Force is an independent panel of experts in primary care and prevention that systematically reviews the evidence of effectiveness of clinical preventive services such as colorectal cancer screening or aspirin to prevent heart disease, and develops recommendations for their use. The Community Preventive Services Task Force uses a public health perspective to review the evidence of effectiveness of population-based preventive services such as tobacco cessation, increasing physical activity and preventing skin cancer, and develops recommendations for their use.

**Sec. 4004. Education and outreach campaign regarding preventive benefits.** Directs the Secretary to convene a national public/private partnership for the purposes of conducting a national prevention and health promotion outreach and education campaign. The goal of the campaign is to raise awareness of activities to promote health and prevent disease across the lifespan. The Secretary will conduct a national media campaign on health promotion and disease prevention focusing on nutrition, physical activity, and smoking cessation using science-based social research. The Secretary shall also maintain a web-based portal that provides informational guidelines on health promotion and disease prevention to health care providers and the public as well as a personalized prevention plan tool for individuals to determine their disease risks and obtain tailored guidance on health promotion and disease prevention. In addition, the Secretary will provide guidance and relevant information to States and health care providers regarding preventive and obesity-related services that are available to Medicaid enrollees, including obesity screening and counseling for children and adults. Each State would be required to design a public awareness campaign to educate Medicaid enrollees regarding availability and coverage of such services.

***Subtitle B – Increasing Access to Clinical Preventive Services***

**Sec. 4101. School-based health centers.** Authorizes a grant program for the operation and development of School-Based Health Clinics, which will provide comprehensive and accessible preventive and primary health care services to medically underserved children and families. Appropriates $50 million each year for fiscal years 2010 through 2013 for expenditures for facilities and equipment.

**Sec. 4102. Oral healthcare prevention activities.** Establishes an oral healthcare prevention education campaign at CDC focusing on preventive measures and targeted towards key populations including children and pregnant women. Creates demonstration programs on oral health delivery and strengthens surveillance capacity.

**Sec. 4103. Medicare coverage of annual wellness visit providing a personalized prevention plan.** Provides coverage under Medicare, with no co-payment or deductible, for an annual wellness visit and personalized prevention plan services. Such services would include a

comprehensive health risk assessment. The personalized prevention plan would take into account the findings of the health risk assessment and include elements such as: a five- to ten-year screening schedule; a list of identified risk factors and conditions and a strategy to address them; health advice and referral to education and preventive counseling or community-based interventions to address modifiable risk factors such as physical activity, smoking, and nutrition.

**Sec. 4104. Removal of barriers to preventive services in Medicare.** This section would waive beneficiary coinsurance requirements for most preventive services, requiring Medicare to cover 100 percent of the costs. Services for which no coinsurance or deductible would be required are the personalized prevention plan services and any covered preventive service if it is recommended with a grade of A or B by the U.S. Preventive Services Task Force.

**Sec. 4105. Evidence-based coverage of preventive services in Medicare.** This section would authorize the Secretary to modify the coverage of any currently covered preventive service in the Medicare program to the extent that the modification is consistent with U.S. Preventive Services Task Force recommendations and the services are not used for diagnosis or treatment. The Secretary will also conduct a provider and beneficiary outreach program regarding covered preventive services. This section also authorizes a Government Accountability Office (GAO) study of the utilization of and payment for Medicare covered preventive services, the use of health information technology in coordinating such services, and whether there are barriers to the utilization of such services.

**Sec. 4106. Improving access to preventive services for eligible adults in Medicaid.** The current Medicaid State option to provide other diagnostic, screening, preventive, and rehabilitation services would be expanded to include: (1) any clinical preventive service recommended with a grade of A or B by the U.S. Preventive Services Task Force and (2) with respect to adults, immunizations recommended by the Advisory Committee on Immunization Practices (ACIP) and their administration. States that elect to cover these additional services and vaccines, and also prohibit cost-sharing for such services and vaccines, would receive an increased Federal medical assistance percentage (FMAP) of one percentage point for these services.

**Sec. 4107. Coverage of comprehensive tobacco cessation services for pregnant women in Medicaid.** States would be required to provide Medicaid coverage for counseling and pharmacotherapy to pregnant women for cessation of tobacco use. Such services would include diagnostic, therapy and counseling services, and prescription and nonprescription tobacco cessation agents approved by the Food and Drug Administration for cessation of tobacco use by pregnant women. This section would also prohibit cost-sharing for these services.

**Sec. 4108. Incentives for prevention of chronic diseases in Medicaid.** The Secretary would award grants to States to provide incentives for Medicaid beneficiaries to participate in programs providing incentives for healthy lifestyles. These programs must be comprehensive and uniquely suited to address the needs of Medicaid eligible beneficiaries and must have demonstrated success in helping individuals lower or control cholesterol and/or blood pressure, lose weight,

quit smoking and/or manage or prevent diabetes, and may address co-morbidities, such as depression, associated with these conditions.

***Subtitle C – Creating Healthier Communities***

**Sec. 4201. Community transformation grants.** This section authorizes the Secretary to award competitive grants to eligible entities for programs that promote individual and community health and prevent the incidence of chronic disease. Communities can carry out programs to prevent and reduce the incidence of chronic diseases associated with overweight and obesity, tobacco use, or mental illness; or other activities that are consistent with the goals of promoting healthy communities.

**Sec. 4202. Healthy aging, living well; evaluation of community-based prevention and wellness programs for Medicare beneficiaries.** The goal of this program is to improve the health status of the pre-Medicare-eligible population to help control chronic disease and reduce Medicare costs. The CDC would provide grants to States or large local health departments to conduct pilot programs in the 55-to-64 year old population. Pilot programs would evaluate chronic disease risk factors, conduct evidence-based public health interventions, and ensure that individuals identified with chronic disease or at-risk for chronic disease receive clinical treatment to reduce risk. Pilot programs would be evaluated for success in controlling Medicare costs in the community. Additionally, the Centers for Medicare & Medicaid Services (CMS) would conduct a comprehensive assessment of community-based disease self-management programs that help control chronic diseases. The Secretary would then develop a plan for improving access to such services for Medicare beneficiaries.

**Sec. 4203. Removing barriers and improving access to wellness for individuals with disabilities.** Requires the Access Board to establish standards for accessibility of medical diagnostic equipment to individuals with disabilities.

**Sec. 4204. Immunizations.** Authorizes States to purchase adult vaccines under CDC contracts. Currently, 23 States purchase vaccines under CDC contracts. These contracts for adult vaccines provide savings that range from 23-69 percent compared to the private sector cost. Authorizes a demonstration program to improve immunization coverage. Under this program, CDC will provide grants to States to improve immunization coverage of children, adolescents, and adults through the use of evidence-based interventions. States may use funds to implement interventions that are recommended by the Community Preventive Services Task Force, such as reminders or recalls for patients or providers, or home visits. Reauthorizes the Immunization Program in Section 317 of the Public Health Service Act. This section would also require a GAO study and report to Congress on coverage of vaccines under Medicare Part D and the impact on access to those vaccines.

**Sec. 4205. Nutrition labeling of standard menu items at chain restaurants.** This initiative represents a compromise between the Menu Education and Labeling (MEAL) Act, sponsored by Senator Harkin, and the Labeling Education and Nutrition (LEAN) Act, sponsored by Senators Carper and Murkowski. Under the terms of the compromise, a restaurant that is part of a chain

with 20 or more locations doing business under the same name (other restaurants are exempt) would be required to disclose calories on the menu board and in a written form, available to customers upon request, additional nutrition information pertaining to total calories and calories from fat, as well as amounts of fat, saturated fat, cholesterol, sodium, total carbohydrates, complex carbohydrates, sugars, dietary fiber, and protein.

**Sec. 4206. Demonstration project concerning individualized wellness plan.** This pilot program provides at-risk populations who utilize community health centers with a comprehensive risk-factor assessment and an individualized wellness plan designed to reduce risk factors for preventable conditions.

**Sec. 4207. Reasonable break time for nursing mothers.** This initiative would amend the Fair Labor Standard Act to require employers to provide break time and a place for breastfeeding mothers to express milk. This would not apply to an employer with fewer than 50 employees, and there are no monetary damages.

***Subtitle D – Support for Prevention and Public Health Innovation***

**Sec. 4301. Research on optimizing the delivery of public health services.** The Secretary, acting through the Director of CDC, shall provide funding for research in the area of public health services and systems. This research shall include examining best practices relating to prevention, analyzing the translation of interventions from academic institutions to clinics and communities, and identifying effective strategies for delivering public health services in real world settings. CDC shall annually report research findings to Congress.

**Sec. 4302. Understanding health disparities; data collection and analysis.** Ensures that any ongoing or new Federal health program achieve the collection and reporting of data by race, ethnicity, primary language and any other indicator of disparity. The Secretary shall analyze data collected to detect and monitor trends in health disparities and disseminate this information to the relevant Federal agencies.

**Sec. 4303. CDC and employer-based wellness programs.** Requires the CDC to study and evaluate best employer-based wellness practices and provide an educational campaign and technical assistance to promote the benefits of worksite health promotion to employers.

**Sec. 4304. Epidemiology-Laboratory Capacity Grants.** Establishes a program at the CDCthat awards grants to assist State, local, and tribal public health agencies in improving surveillance for and responses to infectious diseases and other conditions of public health importance. Amounts received under the grants shall be used to strengthen epidemiologic capacity, enhance laboratory practices, improve information systems, and develop outbreak control strategies. Requires the Director of the CDC to issue national standards on information Exchange systems to public health entities for the reporting of infectious diseases and other conditions of public health importance in consultation with the National Coordinator for Health Information Technology.

**Sec. 4305. Advancing research and treatment for pain care management.** Authorizes an Institute of Medicine Conference on Pain Care to evaluate the adequacy of pain assessment, treatment, and management; identify and address barriers to appropriate pain care; increase awareness; and report to Congress on findings and recommendations. Also authorizes the Pain Consortium at the National Institutes of Health to enhance and coordinate clinical research on pain causes and treatments. Establishes a grant program to improve health professionals' understanding and ability to assess and appropriately treat pain.

**Sec. 4306. Funding for childhood obesity demonstration project.** The Children's Health Insurance Program Reauthorization Act of 2009 included several provisions designed to improve the quality of care under Medicaid and CHIP. This law directed the Secretary to initiate a demonstration project to develop a comprehensive and systematic model for reducing childhood obesity. This section appropriates $25 million for the childhood obesity demonstration project and adjusts the demonstration time period to fiscal years 2010 through 2014.

### ***Subtitle E – Miscellaneous Provisions***

**Sec. 4401. Sense of the Senate concerning CBO scoring.** This provision expresses the sense of the Senate that the Congress should work with the Congressional Budget Office to develop better methodologies for scoring prevention and wellness programs given that results may occur outside the 5 and 10 year budget windows.

**Sec. 4402. Effectiveness of Federal health and wellness initiatives.** The Secretary of Health and Human Services will evaluate the effectiveness of existing Federal health and wellness initiatives. The Secretary will consider whether such programs are effective in achieving their stated goals and evaluate their effect on the health and productivity of the Federal workforce.

## TITLE V—HEALTH CARE WORKFORCE

### ***Subtitle A--Purpose and Definitions***

**Sec. 5001. Purpose.**

**Sec. 5002. Definitions.**

### ***Subtitle B--Innovations in the Health Care Workforce***

**Sec. 5101. National health care workforce commission**. Establishes a national commission tasked with reviewing health care workforce and projected workforce needs. The overall goal of the Commission is to provide comprehensive, unbiased information to Congress and the Administration about how to align Federal health care workforce resources with national needs. Congress will use this information when providing appropriations to discretionary programs or in restructuring other Federal funding sources.

**Sec. 5102. State health care workforce development grants**. Competitive 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.

**Sec. 5103. Health care workforce assessment**. Codifies the existing national center and establishes several regional centers for health workforce analysis to collect, analyze, and report data related to Title VII (of the Public Health Service Act) primary care workforce programs. The centers will coordinate with State and local agencies collecting labor and workforce statistical information and coordinate and provide analyses and reports on Title VII to the Commission.

***Subtitle C--Increasing the Supply of the Health Care Workforce***

**Sec. 5201. Federally supported student loan funds**. Eases current criteria for schools and students to qualify for loans, shorten payback periods, and decreases the non-compliance provision to make the primary care student loan program more attractive to medical students.

**Sec. 5202. Nursing student loan program**. Increases loan amounts and updates the years for nursing schools to establish and maintain student loan funds.

**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 who are or will be working in a Health Professional Shortage Area, Medically Underserved Area, or with a Medically Underserved Population.

**Sec. 5204. Public health workforce recruitment and retention program**. Offers loan repayment to public health students and workers in exchange for working at least 3 years at a federal, state, local, or tribal public health agency.

**Sec. 5205. Allied health workforce recruitment and retention program**. 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 States and local programs**. Awards scholarships to mid-career public and allied health professionals employed in public and allied health positions at the Federal, State, tribal, or local level to receive additional training in public or allied health fields.

**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 for FY10-15.

**Sec. 5208. Nurse-managed health clinics**. Strengthens the health care safety-net by creating a $50 million grant program administered by HRSA to support nurse-managed health clinics.

**Sec. 5209. Elimination of cap on commissioned corps**. Eliminates the artificial cap on the number of Commissioned Corps members, allowing the Corps to expand to meet national public health needs.

**Sec. 5210. Establishing a Ready Reserve Corps**. Establishes a Ready Reserve Corps within the Commissioned Corps for service in times of national emergency. Ready Reserve Corps members may be called to active duty to respond to national emergencies and public health crises and to fill critical public health positions left vacant by members of the Regular Corps who have been called to duty elsewhere.

***Subtitle D--Enhancing Health Care Workforce Education and Training***

**Sec. 5301. Training in family medicine, general internal medicine, general pediatrics, and physician assistantship**. Provides grants to develop and operate training programs, provide financial assistance to trainees and faculty, enhance faculty development in primary care and physician assistant programs, and to establish, maintain, and improve academic units in primary care. Priority is given to programs that educate students in team-based approaches to care, including the patient-centered medical home.

**Sec. 5302. Training opportunities for direct care workers**. Authorizes funding over three years to establish new training opportunities for direct care workers providing long-term care services and supports.

**Sec. 5303. Training in general, pediatric, and public health dentistry**. Reinstates dental funding in Title VII of the Public Health Service Act. Allows dental schools and education programs to use grants for pre-doctoral training, faculty development, dental faculty loan repayment, and academic administrative units.

**Sec. 5304. Alternative dental health care provider demonstration project**. Authorizes the Secretary to award grants to establish training programs for alternative dental health care providers to increase access to dental health care services in rural, tribal, and underserved communities.

**Sec. 5305. Geriatric education and training; career awards; comprehensive geriatric education.** Authorizes funding to geriatric education centers to support training in geriatrics, chronic care management, and long-term care for faculty in health professions schools and family caregivers; develop curricula and best practices in geriatrics; expand the geriatric career awards to advanced practice nurses, clinical social workers, pharmacists, and psychologists; and establish traineeships for individuals who are preparing for advanced education nursing degrees in geriatric nursing.

**Sec. 5306. Mental and behavioral health education and training grants**. Awards grants to schools for the development, expansion, or enhancement of training programs in social work, graduate psychology, professional training in child and adolescent mental health, and pre-service or in-service training to paraprofessionals in child and adolescent mental health.

**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 model curricula for cultural competency, prevention, and public health proficiency and aptitude for working with individuals with disabilities training for use in health professions schools and continuing education programs.

**Sec. 5308. Advanced nursing education grants**. Strengthens language for accredited Nurse Midwifery programs to receive advanced nurse education grants in Title VIII of the Public Health Service Act.

**Sec. 5309. Nurse education, practice, and retention grants**. Awards grants to nursing schools to strengthen nurse education and training programs and to improve nurse retention.

**Sec. 5310. Loan repayment and scholarship program.** Adds faculty at nursing schools as eligible individuals for loan repayment and scholarship programs.

**Sec. 5311. Nurse faculty loan program**. Establishes a Federally-funded student loan repayment program for nurses with outstanding debt who pursue careers in nurse education. Nurses agree to teach at an accredited school of nursing for at least 4 years within a 6-year period.

**Sec. 5312. Authorization of appropriations for parts B through D of title VIII**. Authorizes $338 million to fund Title VIII of the Public Health Service Act nursing programs.

**Sec. 5313. Grants to promote the community health workforce**. Authorizes the Secretary to award grants to States, public health departments, clinics, hospitals, Federally qualified health centers, and other nonprofits to promote positive health behaviors and outcomes in medically underserved areas through the use of community health workers. Community health workers offer interpretation and translation services, provide culturally appropriate health education and information, offer informal counseling and guidance on health behaviors, advocate for individual and community health needs, and can provide some direct primary care services and screenings.

**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.

**Sec. 5315. United States Public Health Sciences Track**. Directs the Surgeon General to establish a U.S. Public Health Sciences Track to train physicians, dentists, nurses, physician assistants, mental and behavior health specialists, and public health professionals emphasizing team-based service, public health, epidemiology, and emergency preparedness and response in

affiliated institutions. Students receive 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.

***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 150 percent of 2005 appropriations, $50 million.

**Sec. 5402. Health professions training for diversity**. Provides 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. Funding is increased from $37 to $51 million for 2009 through 2013.

**Sec. 5403. Interdisciplinary, community-based linkages**. Authorizes funding to establish community-based training and education grants for Area Health Education Centers (AHECs) and Programs. Two programs are supported - Infrastructure Development Awards and Points of Service Enhancement and Maintenance Awards - targeting individuals seeking careers in the health professions from urban and rural medically underserved communities.

**Sec. 5404. Workforce diversity grants.** Expands the allowable uses of nursing diversity grants to include completion of associate degrees, bridge or degree completion program, or advanced degrees in nursing, as well as pre-entry preparation, advanced education preparation, and retention activities.

**Sec. 5405. Primary care extension program**. Creates a Primary Care Extension Program to educate and provide technical assistance to primary care providers about evidence-based therapies, preventive medicine, health promotion, chronic disease management, and mental health. The Agency for Healthcare Research and Quality (AHRQ) will award planning and program grants to State hubs including, at a minimum, the State health department, State-level entities administering Medicare and Medicaid, and at least one health professions school. These State hubs may also include Quality Improvement Organizations, AHECs, and other quality and training organizations.

***Subtitle F – Strengthening Primary Care and Other Workforce Improvements***

**Sec. 5501. Expanding access to primary care services and general surgery services.** Beginning in 2011, provides primary care practitioners, as well as general surgeons practicing in health professional shortage areas, with a 10 percent Medicare payment bonus for five years. Half of the cost of the bonuses would be offset through an across-the-board reduction in all other services.

**Sec. 5502. Medicare Federally qualified health center improvements.** Directs the Secretary

of Health and Human Services to develop and implement a prospective payment system (PPS) for Medicare-covered services furnished by Federally Qualified Health Centers (FQHCs). Additionally, adds remaining Medicare-covered preventive services to the list of services eligible for reimbursement when furnished by an FQHC.

**Sec. 5503. Distribution of additional residency positions.** Beginning July 1, 2011, directs the Secretary to redistribute residency positions that have been unfilled for the prior three cost reports and directs those slots for training of primary care physicians. In distributing the residency slots under this section, special preference will be given to programs located in States with a low physician resident to general population ratio and to programs located in States with the highest ratio of population living in a health professional shortage area (HPSA) relative to the general population.

**Sec. 5504. Counting resident time in outpatient settings and allowing flexibility for jointly operated residency training programs.** Modifies rules governing when hospitals can receive indirect medical education (IME) and direct graduate medical education (DGME) funding for residents who train in a non-provider setting so that any time spent by the resident in a non-provider setting shall be counted toward DGME and IME if the hospital incurs the costs of the stipends and fringe benefits.

**Sec. 5505. Rules for counting resident time for didactic and scholarly activities and other activities.** Modifies current law to allow hospitals to count resident time spent in didactic conferences toward IME costs in the provider (i.e., hospital) setting and toward DGME in the non-provider (i.e., non-hospital) setting.

**Sec. 5506. Preservation of resident cap positions from closed hospitals.** Directs the Secretary to redistribute medical residency slots from a hospital that closes on or after the date that is two years before enactment of the this legislation based on certain criteria.

**Sec. 5507. Demonstration project to address health professions workforce needs; extension of family-to-family health information centers.** Establishes a demonstration grant program through competitive grants to provide aid and supportive services to 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. The demonstration grant is to serve low-income persons including recipients of assistance under State Temporary Assistance for Needy Families (TANF) programs.

Also establishes a demonstration program to competitively award grants for up to six States for three years to develop core training competencies and certification programs for personal and home care aides. Extends funding for family-to-family health information centers at $5 million for FY2010 through FY2012.

**Sec. 5508. Increasing teaching capacity.** Directs the Secretary to establish a grant program to support new or expanded primary care residency programs at teaching health centers and authorizes $25 million for FY2010, $50 million for FY2011 and FY2012 and such sums as may

be necessary for each fiscal year thereafter to carry out such program. Also provides $230 million in funding under the Public Health Service Act to cover the indirect and direct expenses of qualifying teaching health centers related to training primary care residents in certain expanded or new programs.

**Sec. 5509. Graduate nurse education demonstration program.** This provision directs the Secretary to establish a demonstration program to increase graduate nurse education training under Medicare and authorizes $50 million to be appropriated from the Medicare Hospital Insurance Trust Fund for each of the fiscal years 2012 through 2015 for such purpose.

### ***Subtitle G--Improving Access to Health Care Services***

**Sec. 5601. Spending for Federally Qualified Health Centers (FQHCs)**. Authorizes the following appropriations: FY2010 - $2.98B; FY2011 - $3.86B; FY2012 - $4.99B; FY 2013 - $6.44B; FY2014 - $7.33B; FY2015 - $8.33B.

**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 and Health Professional Shortage Areas.

**Sec. 5603. Reauthorization of Wakefield Emergency Medical Services for Children Program**. Reauthorizes program to award grants to States and medical schools to support the improvement and expansion of emergency medical services for children needing trauma or critical care treatment.

**Sec. 5604. Co-locating primary and specialty care in community-based mental health settings.** Authorizes $50 million in grants for coordinated and integrated services through the co-location of primary and specialty care in community-based mental and behavioral health settings.

**Sec. 5605. Key national indicators**. Establishes a Commission on Key National Indicators to conduct a comprehensive oversight of a newly established key national indicators system, with a required annual report to Congress.

## 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.** Prohibits physician-owned hospitals that do not have a provider agreement prior to February 1, 2010, to participate in Medicare. Such hospitals that have a provider agreement prior to February 1, 2010, could continue to participate in Medicare under certain requirements addressing conflict of interest, bona fide investments, and patient safety issues, and expansion limitations.

**Sec. 6002. Transparency reports and reporting of physician ownership or investment interests.** Requires drug, device, biological and medical supply manufacturers to report transfers of value made to a physician, physician medical practice, a physician group practice, and/or a teaching hospital. Duplicative State or local laws would be preempted by Federal law, however, Federal preemption would not occur for State or local laws that are beyond the scope of this section.

**Sec. 6003. Disclosure requirements for in-office ancillary services exception to the prohibition on physician self-referral for certain imaging services**. Adds an additional requirement to the Medicare in-office ancillary exception that requires the referring physician to inform the patient in writing that the individual may obtain the specified service from a person other than the referring physician, a physician who is a member of the same group practice as the referring physician, or an individual who is directly supervised by the physician or by another physician in the group practice.

**Sec. 6004. Prescription drug sample transparency.** Requires prescription drug manufacturers and distributors to report to the Secretary information pertaining to drug samples currently being collected internally, as required under the Federal Food, Drug and Cosmetic Act.

**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 contract with health plans under Medicare or the Exchange to report to the Secretary information regarding the generic dispensing rate: the rebates, discounts, or price concessions negotiated by the PBM and the payment difference between health plans and PBMs and the PBMs and pharmacies. 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 that skilled nursing facilities (SNFs) under Medicare and nursing facilities (NFs) under Medicaid make available on request by the Secretary, the Inspector General of the Department of Health and Human Services, the States, and the State long-term care ombudsman, information on ownership, including a description of the governing body and organizational structure of the facility and information regarding additional disclosable parties.

**Sec. 6102. Accountability requirements for skilled nursing facilities and nursing facilities.** Requires SNFs and NFs to implement a compliance and ethics program to be followed by the facility's employees and its agents within 36 months of enactment, and requires the Secretary to evaluate this program and report the results to Congress.

**Sec. 6103. Nursing home compare Medicare website.** Requires the Secretary to publish the following information on the Nursing Home Compare Medicare website: standardized staffing

data, links to State internet websites regarding State survey and certification programs, the model standardized complaint form, a summary of substantiated complaints, and the number of adjudicated instances of criminal violations by a facility or its employee.

**Sec. 6104. Reporting of expenditures.** Requires the Secretary to modify cost reports for SNFs to require reporting of expenditures on wages and benefits for direct care staff, breaking out registered nurses, licensed professional nurses, certified nurse assistants, and other medical and therapy staff.

**Sec. 6105. Standardized complaint form.** Requires the Secretary to develop a standardized complaint form for use by residents (or a person acting on a resident's behalf) in filing complaints with a State survey and certification agency and a State long-term care ombudsman program. States would also be required to establish complaint resolution processes.

**Sec. 6106. Ensuring staffing accountability.** Requires the Secretary to develop a program for facilities to report staffing information in a uniform format based on payroll data, and to also take into account services provided by any agency or contract staff.

**Sec. 6107. GAO study and report on Five-Star Quality Rating System.** Requires the Government Accountability Office to conduct a study on the Five-Star Quality Rating System which would include an analysis of the systems implementation and any potential improvements to the system.

**Part II – Targeting Enforcement**

**Sec. 6111. Civil money penalties.** Provides the Secretary with authority to reduce civil monetary penalties (CMPs) from the level that they would otherwise be by 50 percent for certain facilities that self-report and promptly correct deficiencies within ten calendar days of imposition. For CMPs that are cited at the level of actual harm and immediate jeopardy, the Secretary would be provided with the authority to place CMPs in an escrow account following completion of the informal dispute resolution process, or the date that is 90 days after the date of the imposition of the CMP, whichever is earlier. If the facility's appeal is successful, the CMP, with interest, would be returned to the facility. If the appeal is unsuccessful, some portion of the proceeds may be used to fund activities that benefit facility residents.

**Sec. 6112. National independent monitor demonstration project.** Directs the Secretary to establish a demonstration project within one year of enactment for developing, testing and implementing a national independent monitor program to conduct oversight of interstate and large intrastate chains. The HHS OIG would evaluate the demonstration project after two years.

**Sec. 6113. Notification of facility closure.** Requires the administrator of a facility that is preparing to close to provide written notification to residents, legal representatives of residents or other responsible parties, the State, the Secretary and the long-term ombudsman program in advance of the closure by at least 60 days. Facilities would be required to prepare a plan for closing the facility by a specified date that is provided to the State, which must approve it and

ensure the safe transfer of residents to another facility or alternative setting that the State finds appropriate in terms of quality, services and location, taking into consideration the needs and best interests of each resident.

**Sec. 6114. National demonstration projects on culture change and use of information technology in nursing homes.** Requires the Secretary to conduct two facility-based demonstration projects that would develop best practice models in two areas. The first would be designed to identify best practices in facilities that are involved in the "culture change" movement, including the development of resources where facilities may be able to access information in order to implement culture change. The second demonstration would focus on development of best practices in information technology that facilities are using to improve resident care.

**Part III – Improving staff training**

**Sec. 6121. Dementia and abuse prevention training.** Requires facilities to include dementia management and 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.

***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.** Establishes a private, nonprofit entity (the Patient-Centered Outcomes Research Institute) governed by a public-private sector board appointed by the Comptroller General to identify priorities for and provide for the conduct of comparative outcomes research. Requires the Institute to ensure that subpopulations are appropriately accounted for in research designs. Prohibits any findings to be construed as mandates on practice guidelines or coverage decisions and contains patient safeguards to protect against discriminatory coverage decisions by HHS based on age, disability, terminal illness, or an individual's quality of life preference. Provides funding for the Institute and authorizes and provides funding for the Agency for Health Research and Quality to disseminate research findings of the Institute, as well as other government-funded research, to train researchers in comparative research methods and to build data capacity for comparative effectiveness research.

**Sec. 6302. Federal coordinating council for comparative effectiveness research.** Upon date of enactment, this provision would sunset the Federal Coordinating Council created in the American Recovery and Reinvestment Act of 2010 (P.L. 111-5).

***Subtitle E – Medicare, Medicaid, and CHIP Program Integrity Provisions***

**Sec. 6401. Provider screening and other enrollment requirements under Medicare, Medicaid, and CHIP.**

Provider Screening. Requires that the Secretary, in consultation with the HHS Office of Inspector General (HHS OIG), establish procedures for screening providers and suppliers participating in Medicare, Medicaid, and CHIP. The Secretary would be required to determine the level of screening according to the risk of fraud, waste, and abuse with respect to each category of provider or supplier. At a minimum, all providers and suppliers would be subject to licensure checks. The Secretary would have the authority to impose additional screening measures based on risk, including fingerprinting, criminal background checks, multi-State data base inquiries, and random or unannounced site visits. An application fee of $200 for individual practitioners and $500 for institutional providers and suppliers would be imposed to cover the costs of screening each time they re-verify their enrollment (every five years).

Disclosure Requirements. Providers and suppliers enrolling or re-enrolling in Medicare, Medicaid, or CHIP would be subject to new disclosure requirements. Applicants would be required to disclose current or previous affiliations with any provider or supplier that has uncollected debt, has had their payments suspended, has been excluded from participating in a Federal health care program, or has had their billing privileges revoked. The Secretary would be authorized to deny enrollment in these programs if these affiliations pose an undue risk to a program.

Compliance Programs. By a date determined by the Secretary, certain providers and suppliers would be required to establish a compliance program. The requirements for the compliance program would be developed by the Secretary and the HHS OIG.

**Sec. 6402. Enhanced Medicare and Medicaid program integrity provisions.**

Integrated Data Repository. Requires CMS to include in the integrated data repository (IDR) claims and payment data from the following programs: Medicare (Parts A, B, C, and D), Medicaid, CHIP, health-related programs administered by the Departments of Veterans Affairs (VA) and Defense (DOD), the Social Security Administration, and the Indian Health Service (IHS).

Access to Data. The Secretary would be required to enter into data-sharing agreements with the Commissioner of Social Security, the Secretaries of the VA and DOD, and the Director of the IHS to help identity fraud, waste, and abuse. The Committee Bill would grant the HHS OIG and the Department of Justice (DOJ) access to the IDR for the purposes of conducting law

enforcement and oversight activities consistent with applicable privacy, security, and disclosure laws.

Overpayments. Requires that overpayments be reported and returned within 60 days from the date the overpayment was identified or by the date a corresponding cost report was due, whichever is later.

National Provider Identifier. Requires the Secretary to issue a regulation mandating that all Medicare, Medicaid, and CHIP providers include their NPI on enrollment applications.

Medicaid Management Information System. Authorizes the Secretary to withhold the Federal matching payment to States for medical assistance expenditures when the State does not report enrollee encounter data in a timely manner to the State's Medicaid Management Information System (MMIS).

Permissive Exclusions. Subjects providers and suppliers to exclusion for providing false information on any application to enroll or participate in a Federal health care program.

Civil Monetary Penalties. Expands the use of Civil Monetary Penalties (CMPs) to excluded individuals who order or prescribe an item or service, make false statements on applications or contracts to participate in a Federal health care program, or who know of an overpayment and do not return the overpayment. Each violation would be subject to CMPs of up to $50,000.

Testimonial Subpoena Authority. The Secretary would be able to issue subpoenas and require the attendance and testimony of witnesses and the production of any other evidence that relates to matters under investigation or in question by the Secretary.

Surety Bonds. Requires that the Secretary take into account the volume of billing for a DME supplier or home health agency when determining the size of the surety bond. The Secretary would have the authority to impose this requirement on other providers and suppliers considered to be at risk by the Secretary.

Payment Suspensions. Authorizes the Secretary to suspend payments to a provider or supplier pending a fraud investigation.

Health Care Fraud and Abuse Control Account. Increases Health Care Fraud and Abuse Control (HCFAC) funding would by $10 million each year for fiscal years 2011 through 2020. The provision would also permanently apply the CPI-U adjustment to HCFAC and Medicare Integrity Program (MIP) funding.

Medicare and Medicaid Integrity Programs. Requires Medicare and Medicaid Integrity Program contractors to provide the Secretary and the HHS OIG with performance statistics, including the number and amount of overpayments recovered, the number of fraud referrals, and the return on investment for such activities.

**Sec. 6403. Elimination of duplication between the Healthcare Integrity and Protection Data Bank and the National Practitioner Data Bank.** Requires the Secretary to maintain a national health care fraud and abuse data collection program for reporting certain adverse actions taken against health care providers, suppliers, and practitioners, and submit information on the actions to the National Practitioner Data Bank (NPDB). The Secretary would also be required to establish a process to terminate the Healthcare Integrity and Protection Databank (HIPDB) and ensure that the information formerly collected in the HIPDB is transferred to the NPDB.

**Sec. 6404. Maximum period for submission of Medicare claims reduced to not more than 12 months.** Beginning January 2010, the maximum period for submission of Medicare claims would be reduced to not more than 12 months.

**Sec. 6405. Physicians who order items or services required to be Medicare enrolled physicians or eligible professionals.** Requires durable medical equipment (DME) or home health services to be ordered by a Medicare eligible professional or physician enrolled in the Medicare program. The Secretary would have the authority to extend these requirements to other Medicare items and services to reduce fraud, waste, and abuse.

**Sec. 6406. Requirement for physicians to provide documentation on referrals to programs at high risk of waste and abuse.** Beginning January 1, 2010, the Secretary would have the authority to disenroll, for no more than one year, a Medicare enrolled physician or supplier that fails to maintain and provide access to written orders or requests for payment for DME, certification for home health services, or referrals for other items and services. The provision would also extend the HHS OIG's permissive exclusion authority to include individuals or entities that order, refer, or certify the need for health care services that fail to provide adequate documentation to verify payment.

**Sec. 6407. Face-to-face encounter with patient required before physicians may certify eligibility for home health services or durable medical equipment under Medicare.** Requires physicians to have a face-to-face encounter with the individual prior to issuing a certification for home health services or DME. The Secretary would be authorized to apply the face-to-face encounter requirement to other items and services based upon a finding that doing so would reduce the risk of fraud, waste, and abuse.

**Sec. 6408. Enhanced penalties.** Subjects persons who fail to grant HHS OIG timely access to documents, for the purpose of audits, investigations, evaluations, or other statutory functions, to CMPs of $15,000 for each day of failure. Also, persons who knowingly make, use, or cause to be made or used any false statement to a Federal health care program would be subject to a CMP of $50,000 for each violation. The violations that could be subject to the imposition of sanctions and CMPs by the Secretary would include Medicare Advantage (MA) or Part D plans that: (1) enroll individuals in a MA or Part D plan without their consent, (2) transfer an individual from one plan to another for the purpose of earning a commission, (3) fail to comply with marketing requirements and CMS guidance, or (4) employ or contract with an individual or entity that commits a violation. Penalties for MA and Part D plans that misrepresent or falsify information

would be increased to up to three times the amount claimed by a plan or plan sponsor based on the misrepresentation or falsified information.

**Sec. 6409. Medicare self-referral disclosure protocol.** Within six months of enactment, the Secretary, in cooperation with the HHS OIG, would be required to establish a self-referral disclosure protocol to enable health care providers and suppliers to disclose actual or potential violations of the physician self-referral law.

**Sec. 6410. Adjustments to the Medicare durable medical equipment, prosthetics, orthotics, and supplies competitive acquisition program.** Requires the Secretary to expand the number of areas to be included in round two of the competitive bidding program from 79 of the largest metropolitan statistical areas (MSAs) to 100 of the largest MSAs, and to use competitively bid prices in all areas by 2016.

**Sec. 6411. Expansion of the Recovery Audit Contractor (RAC) program.** Requires States to establish contracts with one or more Recovery Audit Contractors (RACs). These State RAC contracts would be established to identify underpayments and overpayments and to recoup overpayments made for services provided under State Medicaid plans as well as State plan waivers. The Secretary would also be required to expand the RAC program to Medicare Parts C and D.

***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 individuals or entities from their Medicaid programs if the individuals or entities were terminated from Medicare or another State's Medicaid program.

**Sec. 6502. Medicaid exclusion from participation relating to certain ownership, control, and management affiliations.** Requires Medicaid agencies to exclude individuals or entities from participating in Medicaid for a specified period of time if the entity or individual owns, controls, or manages an entity that: (1) has failed to repay overpayments during the period as determined by the Secretary; (2) is suspended, excluded, or terminated from participation in any Medicaid program; or (3) is affiliated with an individual or entity that has been suspended, excluded, or terminated from Medicaid participation.

**Sec. 6503. Billing agents, clearinghouses, or other alternate payees required to register under Medicaid.** Requires any agents, clearinghouses, or other alternate payees that submit claims on behalf of health care providers to register with the State and the Secretary in a form and manner specified by the Secretary.

**Sec. 6504. Requirement to report expanded set of data elements under MMIS to detect fraud and abuse.** Requires States and Medicaid managed care entities to submit data elements from MMIS as determined necessary by the Secretary for program integrity, program oversight, and administration.

**Sec. 6505. Prohibition on payments to institutions or entities located outside of the United States.** Prohibits States from making any payments for items or services provided under a Medicaid State plan or waiver to any financial institution or entity located outside of the United States.

**Sec. 6506. Overpayments.** Extends the period for States to repay overpayments to one year when a final determination of the amount of the overpayment has not been determined due to an ongoing judicial or administrative process. When overpayments due to fraud are pending, State repayments of the Federal portion would not be due until 30 days after the date of the final judgment.

**Sec. 6507. Mandatory State use of national correct coding initiative.** Requires States to make their MMIS methodologies compatible with Medicare's national correct coding initiative (NCCI) that promotes correct coding and controls improper coding.

**Sec. 6508. General effective date.** Requires States to implement fraud, waste, and abuse programs before January 1, 2011.

***Subtitle G—Additional Program Integrity Provisions***

**Sec. 6601. Prohibition on false statements and representations.** Employees and agents of multiple employer welfare arrangements (MEWAs) will be subject to criminal penalties if they provide false statements in marketing materials regarding a plan's financial solvency, benefits, or regulatory status.

**Sec. 6602. Clarifying definition.**

**Sec. 6603. Development of model uniform report form.** To facilitate consistent reporting by private health plans of suspected cases of fraud and abuse, a model uniform reporting form will be developed by the National Association of Insurance Commissioners, under the direction of the HHS Secretary.

**Sec. 6604. Applicability of State law to combat fraud and abuse.** The Department of Labor will adopt regulatory standards and/or issue orders to prevent fraudulent MEWAs from escaping liability for their actions under State law by claiming that State law enforcement is preempted by Federal law.

**Sec. 6605. Enabling the Department of Labor to issue administrative summary cease and desist orders and summary seizures orders against plans in financially hazardous condition.** The Department of Labor is authorized to issue "cease and desist" orders to temporarily shut down operations of plans conducting fraudulent activities or posing a serious threat to the public, until hearings can be completed. If it appears that a plan is in a financially hazardous condition, the agency may seize the plan's assets.

**Sec. 6606. MEWA plan registration with the Department of Labor.** MEWAs will be required to file their Federal registration forms, and thereby be subject to government verification of their legitimacy, before enrolling anyone.

**Sec. 6607. Permitting evidentiary privilege and confidential communications.** Permits the Department of Labor to allow confidential communication among public officials relating to investigation of fraud and abuse.

### ***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 of HHS, 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.

### ***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 health reform presents an opportunity to address issues related to medical malpractice and medical liability insurance, states should be encouraged to develop and test alternative models to the existing civil litigation system, and Congress should consider state demonstration projects to evaluate such alternatives.

## Title VII – IMPROVING ACCESS TO INNOVATIVE MEDICAL THERAPIES

### ***Subtitle A—Biologics Price Competition and Innovation***

**Sec. 7001. Short Title.** The "Biologics Price Competition and Innovation Act of 2009."

**Sec. 7002. Approval pathway for biosimilar biological products.** Establishes a process under which the Secretary is required to license a biological product that is shown to be biosimilar to or interchangeable with a licensed biological product, commonly referred to as a reference product. Prohibits the approval of an application as either biosimilar or interchangeable until 12 years from the date on which the reference product is first approved. If FDA approves a biological product on the grounds that it is interchangeable to a reference product, HHS is prohibited from

making a determination that a second or subsequent biological product is interchangeable to that same reference product until 1 year after the first commercial marketing of the first interchangeable product.

Authorizes HHS to issue guidance with respect to the licensure of biological products under this new pathway, and it includes provisions governing patent infringement concerns such as the exchange of information, good faith negotiations, and initiation infringement actions. Applies certain provisions of the Food, Drug, and Cosmetic Act to this subtitle with respect to pediatric studies of biological products. Requires HHS to develop recommendations for Congress with respect to the goals for the process for the review of biosimilar biological product applications for the first five fiscal years after FY 2012.

**Sec. 7003. Savings.** The Secretary of the Treasury, in consultation with the HHS Secretary, shall for each fiscal year determine the amount of savings to the Federal Government as a result of the enactment of this subtitle. Notwithstanding any other provision of this subtitle, the savings to the Federal Government generated as a result of the enactment of this subtitle shall be used for deficit reduction.

### ***Subtitle B—More Affordable Medicines for Children and Underserved Communities***

**Sec. 7101. Expanded participation in 340B program.** Extends the 340B discounts to inpatient drugs and also extends participation to certain children's hospitals, cancer hospitals, critical access and sole community hospitals, and rural referral centers.

**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.

**Sec. 7103. GAO study to make recommendations on improving the 340B program.** Requires the GAO to make recommendations to Congress within 18 months on improvements to the 340B program.

## Title VIII – COMMUNITY LIVING ASSISTANCE SERVICES AND SUPPORTS

**Sec. 8002. Establishment of national voluntary insurance program for purchasing community living assistance services and support (CLASS program).** Establishes a new, voluntary, self-funded public long-term care insurance program, to be known as the CLASS Independence Benefit Plan, for the purchase of community living assistance services and supports by individuals with functional limitations. Requires the Secretary to develop an actuarially sound benefit plan that ensures solvency for 75 years; allows for a five-year vesting period for eligibility of benefits; creates benefit triggers that allow for the determination of functional limitation; and provides cash benefit that is not less than an average of $50 per day. No taxpayer funds will be used to pay benefits under this provision.

## TITLE IX – REVENUE PROVISIONS

### *Subtitle A – Revenue Offset Provisions*

**Sec. 9001. Excise tax on high cost employer-sponsored health coverage.** Levies an excise tax of 40 percent on insurance companies and plan administrators for any health coverage plan that is above the threshold of $8,500 for single coverage and $23,000 for family coverage. The tax would apply to self-insured plans and plans sold in the group market, but not to plans sold in the individual market (except for coverage eligible for the deduction for self-employed individuals). The tax would apply to the amount of the premium in excess of the threshold. The threshold would be indexed at CPI-U plus one percentage point, and a transition rule would increase the threshold for the 17 highest cost States for the first 3 years. An additional threshold amount of $1,350 for singles and $3,000 for families is available for retired individuals age 55 and older and for plans that cover employees engaged in high risk professions.

**Sec. 9002. Inclusion of cost of employer-sponsored health coverage on W-2**. Requires employers to disclose the value of the benefit provided by the employer for each employee's health insurance coverage on the employee's annual Form W-2.

**Sec. 9003. Distributions for medicine qualified only if for prescribed drug or insulin.** Conforms the definition of qualified medical expenses for HSAs, FSAs, and HRAs to the definition used for the medical expense itemized deduction. Over-the-counter medicine obtained with a prescription continues to qualify as a qualified medical expense.

**Sec. 9004. Increase in additional tax on distributions from HSAs and Archer MSAs not used for qualified medical expenses.** Increases the additional tax for HSA withdrawals prior to age 65 that are used for purposes other than qualified medical expenses from 10 percent to 20 percent. The additional tax for Archer MSA withdrawals not used for qualified medical expenses would increase from 15 percent to 20 percent.

**Sec. 9005. Limitation on health flexible spending arrangements under cafeteria plans.** Limits the amount of contributions to health FSAs to $2,500 per year.

**Sec. 9006. Expansion of information reporting requirements**. Requires businesses that pay any amount greater than $600 during the year to corporate and non-corporate providers of property and services to file an information report with each provider and with the IRS. Information reporting is already required on payments for services to non-corporate providers.

**Sec. 9007. Additional requirements for charitable hospitals.** Establishes new requirements applicable to nonprofit hospitals. The requirements would include a periodic community needs assessment.

**Sec. 9008. Imposition of annual fee on branded prescription pharmaceutical manufacturers and importers.** Imposes an annual flat fee of $2.3 billion on the pharmaceutical manufacturing sector beginning in 2010. This non-deductible fee would be allocated across the

industry according to market share and would not apply to companies with sales of branded pharmaceuticals of $5 million or less.

**Sec. 9009. Imposition of annual fee on medical device manufacturers and importers.** Imposes an annual flat fee of $2 billion on the medical device manufacturing sector beginning in 2010. This non-deductible fee would be allocated across the industry according to market share and would not apply to companies with sales of medical devices in the U.S. of $5 million or less. The fee does not apply to any sale of a Class I product or any sale of a Class II product that is primarily sold to consumers at retail for not more than $100 per unit (under the FDA product classification system).

**Sec. 9010. Imposition of annual fee on health insurance providers.** Imposes an annual flat fee of $6.7 billion on the health insurance sector beginning in 2010. This non-deductible fee would be allocated across the industry according to market share and would not apply to companies whose net premiums written are $25 million or less and whose fees from administration of employer self-insured plans are $5 million or less. The public option, as well coops and the national plan, will be subject to the insurance provider fee.

**Sec. 9011. Study and report of effect on veterans health care.** The Secretary of the U.S. Department of Veterans Affairs will review and report to Congress on the effect that the fees assessed on pharmaceutical and medical device manufacturers and health insurance providers have on the cost of medical care provided to veterans and veterans' access to medical devices and branded drugs.

**Sec. 9012. Eliminate deduction for expenses allocable to Medicare Part D.** Eliminates the deduction for the subsidy for employers who maintain prescription drug plans for their Medicare Part D eligible retirees.

**Sec. 9013. Modification of itemized deduction for medical expenses.** Increases the adjusted gross income threshold for claiming the itemized deduction for medical expenses from 7.5 percent to 10 percent. Individuals age 65 and older would be able to claim the itemized deduction for medical expenses at 7.5 percent of adjusted gross income through 2016.

**Sec. 9014. Limitation on excessive remuneration paid by certain health insurance providers.** Limits the deductibility of executive compensation under Section 162(m) for insurance providers if at least 25 percent of the insurance provider's gross premium income from health business is derived from health insurance plans that meet the minimum essential coverage requirements in the bill ("covered health insurance provider"). The deduction is limited to $500,000 per taxable year and applies to all officers, employees, directors, and other workers or service providers performing services for or on behalf of a covered health insurance provider.

**Sec. 9015. Additional hospital insurance tax on high-income taxpayers.** Increases the hospital insurance tax rate by 0.5 percentage points on an individual taxpayer earning over $200,000 ($250,000 for married couples filing jointly).

**Sec. 9016. Special deduction for Blue Cross Blue Shield (BCBS).** Requires that non-profit BCBS organizations have a medical loss ratio of 85 percent or higher in order to take advantage of the special tax benefits provided to them under IRC Section 833, including the deduction for 25 percent of claims and expenses and the 100 percent deduction for unearned premium reserves.

**Sec. 9017. Cosmetic Surgery Tax.** Imposes a five percent excise tax on voluntary cosmetic surgical and medical procedures performed by a licensed medical professional. The tax would be collected by the medical professional at the point of service. The definition of voluntary cosmetic procedures generally would be the same as the definition of cosmetic surgery or similar procedures that are not treated as included in medical care under the current Section 213(d)(9) definition.

***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 tribal health benefits.

**Sec. 9022. Establishment of simple cafeteria plans for small businesses.** Establishes Simple Cafeteria Plans that ease participation restrictions so that small businesses can provide tax-free benefits to their employees. Under this provision, self-employed individuals are included as qualified employees. The provision also exempts employers who make contributions for employees under a simple cafeteria plan from pension plan nondiscrimination requirements applicable to highly compensated and key employees.

**Sec. 9023. Qualifying therapeutic discovery project credit.** Creates a two year temporary tax credit subject to an overall cap of $1 billion to encourage investments in new therapies to prevent, diagnose, and treat acute and chronic diseases. The credit would be available for two years.