Summary of the Senate "Patient Protection and Affordable Care Act" and the "Health Care and Education Reconciliation Act of 2010"

March 24, 2010

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Guarantee Issue/Prohibition of Preexisting Condition Exclusions/ Rescissions	*Rescissions*: Prohibits group health plans (and issuers offering group coverage) or individual health insurance coverage from rescinding coverage once the plan has been issued. Allows for rescission when the covered individual commits fraud or an intentional misrepresentation of material fact as prohibited by the terms of coverage. Permits cancelations only with prior notice to the enrollee and only as permitted under section 2702(c) or 2742(b). [Sec. 1001 of the Act/Sec. 2712 of the PHSA] *Prohibition of Preexisting Condition Exclusions:* Prohibits group health plans (and issuers offering group coverage) or individual health insurance coverage from imposing any preexisting condition exclusion on coverage. [Sec. 1201 of the Act/Sec. 2704 of PHSA] Prohibits group health plans and issuers offering group or individual coverage from establishing any rules for eligibility based on any of the following health status-related factors in relation to the individual or a dependent of the individual: • Health status; • Medical condition (including both physical and mental); • Claims experience; • Receipt of medical care; • Genetic information; • Evidence of insurability; • Disability; and • Any other health status-related factor determined as appropriate by the Secretary. [Sec. 1201 of the Act/Sec. 2705 of PHSA] *Guaranteed Issue:* Requires group health plans (and issuers offering group coverage) or individual health insurance coverage to accept every employer and individual in the state that applies for coverage. Permits group health plans (and issuers offering group coverage) or individual health insurance coverage to have an open or special enrollment periods. Requires the establishment of special enrollment periods for "qualifying events" (under section 603 of ERISA) that conform to rules promulgated by the Secretary. [Sec. 1201 of the Act/Sec. 2702 of PHSA] *Renewability:* Requires health insurance issuers offering coverage in the individual or group market to renew or continue in force such coverage at the option of the plan sponsor or individual. [Sec. 1201 of the Act/Sec. 2703 of PHSA] *Waiting Periods:* Prohibits group health plans and health insurance issuers offering group health coverage from applying any waiting period that exceeds ninety days. [Sec. 1201 of the Act/Sec. 2708 of the PHSA]
Premium Variance/ Rating Provisions	Premium rates for group and individual health insurance may vary with respect to the particular plan or coverage involved only by: • family structure; • rating area;

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	• age (but not more than 3 to 1); and • tobacco use (but not more than 1.5 to 1). Prohibits premium rates from varying with respect to the particular plan or coverage involved by factors not listed above. [Sec. 1201 of the Act/Sec. 2701 of PHSA] Directs the state to define the rating areas and requires the Secretary to review for adequacy. Requires the Secretary, in consultation with the NAIC, to establish standard age bands. With respect to family coverage, rating variations for age and tobacco use shall be applied based on the portion of the premium that is attributable to each family member covered under the plan. [Sec. 1201 of the Act/Sec. 2701 of PHSA]
Oversight of Health Plans / Prior Approval of Rates	Requires the Secretary to establish a process for the annual review (beginning in 2010) of unreasonable premium increases. Carriers will be required to submit a justification for an unreasonable increase prior to implementation of the increase, and the information shall be posted on the issuer's website. Directs the Secretary to establish a program to award grants to states over a five-year period. Provides $250 million to fund grants designed to provide information and recommendations on rate reviews and establish centers to collect, analyze, and organize medical reimbursement information from health insurance issuers. Establishes functions of medical reimbursement data centers. As a condition of receiving a grant, a state must provide the Secretary with information regarding trends in rating and premium increases. Allows the state to make recommendations on excluding health plans from the exchanges. Beginning with plan year 2014, directs the Secretary and the states to monitor premium increases of health insurance coverage offered both in and out of the Exchange. [Sec. 1003 of the Act/Sec. 2794 of PHSA]
High Risk Pool	*Immediate Assistance for the Individual Market*: Within 90 days of enactment, requires the Secretary to establish or issue contracts to establish a temporary high risk pool (through 2013) to provide coverage for eligible individuals with no preexisting condition exclusions. Eligibility is limited to individuals who have been uninsured for at least six months prior to applying for pool coverage, and who have a preexisting condition. Establishes a minimum benefit with a 65 percent actuarial value and limits rating flexibility within the pool to the standards that will apply to the individual and small group markets (above), except that rates may impose a factor of not greater than 4 to 1 based on age based upon a standard rate for a given population. Appropriates $5 billion to subsidize premiums in the high risk pool. Establishes standards to protect against issuers and employers

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	discouraging individuals from purchasing coverage based on an individual's health status, and provides for sanctions for cases in which an issuer or employer has encouraged an individual to disenroll from existing health insurance coverage. [Sec. 1101 of the Act]
Simple Cafeteria Plans for Small Employers	Grants eligible small employers (100 or fewer workers) a safe harbor from nondiscrimination requirements for cafeteria plans if the employer satisfies minimum eligibility and participation requirements and minimum contribution requirements. • *Eligibility*: Allows all employees to participate (with exceptions) and allows each employee to elect any benefit available under the plan. • *Minimum Contribution*: Requires an employer to contribute an amount equal to 1) at least two percent of each employee's compensation for the year, or 2) an amount which is not less than the lesser of six percent of each employee's compensation for the year or twice the amount of the salary reduction contributions of each qualified employee. Applies to years beginning after December 31, 2010. [Sec. 9022 of the Act/Sec. 125(j) of the IRC]
Mental Health Parity	Requires the federal Mental Health Parity Act to apply to qualified health insurance plans in the same manner and to the same extent as it applies to health insurance issuers and group health plans. [Sec. 1311]
Provider Networks	Prohibits group health plans (and issuers offering group coverage) or individual health insurance coverage from discriminating with respect to participation under the plan against any health care provider who is acting within the scope of that provider's license or certification under applicable state law. Does not require the plan or issuer to contract with any provider willing to abide by the terms and conditions for participation as established by the plan or issuer. Does not prohibit the plan, issuer, or the Secretary from establishing varying reimbursement rates based on quality or performance measures. [Sec. 1201 of the Act/Sec. 2706 of PHSA]
Health Care Costs, Medical Loss Ratios, and Rebates	Requires health plans offering group or individual health insurance coverage (including grandfathered plans) to publicly report (in a manner to be established by the Secretary through regulation) on the ratio of the incurred loss (or incurred claims) plus the loss adjustment expense (or change in contract reserves) to earned premiums on: • reimbursement for clinical services; • activities that improve quality; and • all other non-claims costs, including an explanation of the nature of such costs (does not include federal and state taxes, license or regulatory fee costs). Requires health plans offering group or individual health insurance coverage (including grandfathered plans), beginning on January 11,

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	2011, to provide an annual rebate to each enrollee if the ratio of the amount of premium revenue spent on claims expenses (minus the exclusions listed above) is less than 85 percent (large group) or 80 percent (small group and individual market). Provides that the National Association of Insurance Commissioners (NAIC) – subject to the certification of the Secretary – establish uniform definitions and standardized methodologies for calculating the required information. [Sec. 1001 of the Act/Sec. 2718 of PHSA] [See also the **Additional Revenue Provisions and Other Tax Related Provisions** section below]
Consumer Assistance / Protection Initiatives	Requires group health plans and health insurance issuers offering group or individual coverage to implement an effective appeals process for coverage determinations and claims decisions in which the issuer, at a minimum, must: • Have an internal claims appeal process; • Provide notice to enrollees of available processes and the availability of consumer assistance or ombudsman programs; and • Allow enrollees to review files, evidence, and testimony, and to receive coverage pending the outcome of the appeals process. Requires a group health plan and health insurance issuer offering group or individual coverage to comply with applicable state external review laws, which, at a minimum, must include the consumer protections set forth in the Uniform External Review Model Act promulgated by the National Association of Insurance Commissioners (NAIC), or implement an effective external review process that meets minimum standards established by the Secretary consistent with the NAIC Model. [Sec. 1001 of the Act/Sec. 2719 of PHSA] A group health plan or health insurance issuer offering group or individual coverage requiring designation of a primary care provider must allow an enrollee to designate any participating primary care provider who is available to accept such individual. Requires a group or individual insurer to cover emergency services: • without the need for any prior authorization determination; • whether the health care provider furnishing such services is a participating provider with respect to such services: in a manner so that, if such services are provided to a participant, beneficiary, or enrollee by a nonparticipating health care provider with or without prior-authorization, or such services will be provided without imposing any requirement under the plan for prior authorization of services or any limitation on coverage where the provider of services does not have a contractual relationship with the plan for the providing of services that is more restrictive than the requirements or limitations that apply to emergency department services received from providers who do have such a contractual relationship with the plan; and if such services are provided out-of-network, the cost-sharing requirement (expressed as a copayment amount or coinsurance rate) is the same requirement that would apply if such services were provided in-network; and • without regard to any other term or condition of such coverage (other than exclusion or coordination of benefits).

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	[Sec. 1001 of the Act/Sec. 2719A of PHSA] Prohibits a group or individual insurer from requiring a preauthorization or referral for a female participant, beneficiary, or enrollee who seeks coverage for obstetrical or gynecological care provided by a participating health care professional who specializes in obstetrics or gynecology. [Sec. 1001 of the Act/Sec. 2719A of PHSA] *Health Insurance Consumer Assistance:* Authorizes $30 million for fiscal year 2014, with sums for additional years appropriated as necessary, for the Secretary to establish a grant program to eligible states to establish, expand or provide support for offices of health insurance consumer assistance or health insurance ombudsman programs. To be eligible, a state must designate an independent office or ombudsman that receives and responds to inquiries and complaints concerning health insurance coverage. The independent office shall: • Assist with filing of complaints and appeals; • Collect, track, and quantify problems and inquiries encountered by customers; • Educate consumers on rights and responsibilities in regards to health coverage; • Assist consumers with enrollment in health coverage; and • Resolve problems with obtaining premium tax credits. As a condition of receiving the grant, imposes reporting and data collection duties on state entities. [Sec. 1002 of the Act/Sec. 2703 of PHSA]
Prohibition on Discrimination Based on Health Status	Prohibits group health plans (and issuers offering group coverage) or individual health insurance coverage from establishing rules for eligibility (including continued eligibility) of any individual (or dependent) based on any of the following factors: • health status; • medical condition (including physical or mental illness); • claims experience; • receipt of health care; • medical history; • genetic information; • evidence of insurability (including arising from domestic violence); • disability; and • any other health status-related factor determined by the Secretary. [Sec. 1201 of the Act/Sec. 2705 of PHSA]

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Wellness Program	Defines a program of health promotion or disease prevention ("wellness program") as a program offered by an employer that is designed to promote health or prevent disease and that meets other qualifications. Establishes conditions for wellness programs: • When participation is not based on a health status factor, programs such as fitness center rebates and diagnostic testing are not subject to additional requirements. • If any of the conditions for obtaining a premium discount, rebate or reward is based on an individual satisfying a standard that is related to a health status factor, the reward for such programs may not exceed 30 percent of the cost of employee-only coverage under the plan (and if dependents participate, not more than 30 percent). • Allows the Secretary to increase this ceiling to 50 percent. Allows the reward to take the form of premium discounts or rebates, the absence of a surcharge, a waiver of cost-sharing mechanisms, or the value of a benefit that would not otherwise be covered under the plan. • Plan shall give individuals eligible for the program the opportunity to qualify for the award at least once a year. • The full reward under the wellness program shall be made available to all similarly situated individuals. • The plan or issuer shall disclose in all plan materials the availability of a reasonable alternative standard. [Sec. 1201 of the Act/Sec. 2705 of PHSA] Requires the wellness program to be reasonably designed to promote health or prevent disease and must not be a subterfuge for discriminating based on a health status factor. Requires the reward to be available to all similarly situated individuals and requires a reasonable alternative for obtaining the reward for an individual for whom it is unreasonably difficult due to a medical condition to satisfy the standard. Requires the plan or issuer to disclose in all plan materials describing the terms of the wellness program and the availability of a reasonable alternative standard. Grandfathers all existing wellness programs established prior to the date of enactment of this section and that applied with all applicable regulations. [Sec. 1201 of the Act/Sec. 2705 of PHSA] *Wellness Program Demonstration Project*: No later than July 1, 2014, directs the Secretaries of HHS and Treasury to establish a 10-state pilot program to apply the above provisions to programs of health promotion and disease prevention offered in the individual market. Does not prohibit a program of health promotion or disease prevention that was established or adopted by state law prior to the date of enactment of this section. Requires the Secretaries of HHS, Treasury, and Labor to evaluate and submit to the appropriate committees of Congress a report exploring issues relating to prevention and disease management. Allows the Secretaries of Labor, HHS, and Treasure to promulgate rules. [Sec. 1201 of the Act/Sec. 2705 of PHSA]
Preventive Health	Requires group health plans (and issuers offering group coverage) or individual health insurance coverage to provide coverage for:

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	• items or services that have an A or B rating in current recommendations of the U.S. Preventive Services Task Force (USPSTF); • immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention; • evidence-informed preventive care and screenings for infants, children, and adolescents as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA); and • additional preventing care and screening (with respect to women) provided for in guidelines supported by the Health Resources and Services Administration. Does not prohibit a plan or issuer from providing coverage for services in addition to those recommended by the USPSTF or from denying coverage for services that are not recommended by the USPSTF. Requires group health plans (and issuers offering group coverage) or individual health insurance coverage to abide by the minimum interval established by the Secretary between when a preventive service recommendation is issued and the plan year with respect to which the requirement for coverage is effective. The interval established is not less than one year. [Sec. 1001 of the Act, as amended by the Mikulski amendment (SA 2791)/Sec. 2713 of the PHSA]
Extension of Dependent Coverage	Requires group health plans (and issuers offering group coverage) or individual health insurance coverage providing coverage for dependent children to continue to make coverage available for an ~~unmarried~~ adult child until the child turns 26 years of age. Does not require a plan or issuer to make coverage available for a child of a child receiving dependent coverage (grandchildren). Requires the Secretary to establish regulations to define the dependents to which coverage shall be made available. [Sec. 1001 of the Act/Sec. 2714 of the PHSA]
Lifetime and Annual Limits	Prohibits group health plans (and issuers offering group coverage) or individual health insurance coverage from establishing lifetime limits on the dollar value of benefits for any participant or annual limits on the dollar value of benefits for any participant or beneficiary. With respect to plan years beginning prior to January 1, 2014, a group health plan and a health insurance issuer offering group or individual health insurance coverage may only establish a restricted annual limit (as determined by the Secretary) on the dollar value of benefits for any participant or beneficiary with respect to the scope of benefits that are essential health benefits. In defining restricted annual limit the Secretary is directed to balance access to needed services with a minimal impact on premiums. Prohibitions do not apply to placing annual or lifetime per beneficiary limits specific to covered benefits under an essential benefits package. [Sec. 1001 of the Act/Sec. 2711 of the PHSA]
Prohibition of	Requires a group health plan to satisfy the requirements of section 105(h)(2) of the IRC (which provides that a self-insured health plan

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Discrimination in Favor of Highly Compensated Individuals	cannot discriminate in favor of highly compensated individuals when pertaining to eligibility to participate and the benefits of the plan). Permits the establishment of contribution requirements that differ based on hourly or annual compensation for similarly situated individuals. [Sec. 1001 of the Act/Sec. 2716 of the PHSA]
No Changes to Existing Coverage / Grandfathering Existing Coverage	Nothing shall be construed to require that an individual terminate coverage under a group health plan or health insurance coverage in which such individual was enrolled prior to the date of enactment of this title. [Sec. 1251 of the Act] Except as specified below, does not apply such reforms including preexisting condition exclusions, guarantee issue, rating restrictions, lifetime and annual caps, and other provisions to individuals who were enrolled under a group health plan or an individual health insurance plan prior to the enactment of Title I regardless of whether the individual renews such coverage after the date of enactment. • Applies the uniform coverage documents and standard definitions requirements (found at section 2715) and the loss ratio reporting requirements and accompanying standards (found at section 2718) to grandfathered plans for plan years beginning on or after the date of enactment. [Sec. 1251 of the Act] Requires grandfathered plans (both individual and group) to comply, by six months after enactment, with certain insurance reform provisions including a prohibition on excessive waiting periods (longer than 90 days), a prohibition on lifetime benefit limits, a prohibition on rescissions, and extending dependent coverage to age 26. For group coverage only, the following provisions apply: • for renewals and new plan years beginning in 2014, prohibits pre-existing condition limits; • within six months of enactment, prohibits pre-existing condition limits for dependents who are under 19 years of age; • within six months after enactment, only allows "restricted" annual benefit limits for essential benefits; and • for renewals and new plan years beginning in 2014, the extension of dependent coverage to age 26 shall apply to an adult child only if that child is not eligible to enroll in an eligible employer-sponsored health plan other than such grandfathered plan. [Sec. 1251 of the Act/Sec. 2301 of the Reconciliation Bill] Group health plans providing coverage on the date of enactment of this act may allow new employees (and their families) to enroll in such grandfathered plans. Also allows for the addition of new family members to health insurance coverage in the individual market (for a consumer /primary insured who is enrolled on the date of enactment). [Sec. 1251 of the Act]
Interstate Sale of Insurance	*Interstate Sale of Insurance*: Directs the Secretary, in consultation with the NAIC, to issue regulations for the creation of health choice compacts by July 1, 2013. Allows two or more states to form compacts starting January 1, 2016 to allow for the purchase of individual health insurance plans across state lines.

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	Declares that insurers selling policies through the compact would only be subject to the laws and regulations of the state where the policy is written or issued. Requires the compacts to allow the insurance commissioner in the state where the consumer lives to enforce market conduct, unfair trade practices, network adequacy, and consumer protection standards. Requires insurers to either be licensed in both states or submit to the jurisdiction of each state with regard to these issues. Requires insurers to disclose that the health plan policy may not be subject to all the laws and regulations of the state where the consumer resides. Requires state legislative action before any state could enter into a compact for the sale of individual health insurance across state lines. *Effective Date:* A health care choice compact shall not take effect before January 1, 2016. [Sec. 1333]
Special Rule for Collective Bargaining Agreements	Does not apply provisions applicable to the individual and group markets (Subtitle A) to health insurance coverage maintained by a collective bargaining agreement until the date on which the last of the collective bargaining agreements relating to the coverage terminates. Any coverage amendment made pursuant to a collective bargaining agreement which amends the coverage solely to conform to any requirement added by Subtitle A must not be treated as a termination of such collective bargaining agreement. [Sec. 1251 of the Act]
Effective Dates	Effective dates vary by provision. To the extent an effective date is determined, it is highlighted under the appropriate issue area.
Whistleblower Protection	Prohibits employers from discriminating against any employee because the employee received specified subsidies under the PHSA, provided or plans to provide information relating to any violation of this Act, testified in a proceeding concerning such violation, or objected to or refused to participate in an activity that the employee reasonably believed to be in violation of this Act. Grants employees right of action against an employer who discriminates in violation of this subsection. [Sec. 1201 of the Act/Sec. 2706 of PHSA]
Reinsurance for Retirees	No later than 90 days after enactment, the Secretary shall establish a temporary reinsurance program to reimburse participating employment-based plans for the cost of providing health benefits to retirees for the cost of providing coverage to retirees (and to eligible spouses, surviving spouses, and dependants) during the period between when such program is established and ending on January 1, 2014. Reinsures only the claims for individuals between the ages 55 to 64 who are not active workers or dependents of active workers of an employer contributing to employment-based coverage and who are not Medicare eligible. Eligible employers are those offering

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	coverage that includes demonstrated programs to generate cost savings for those with chronic and high-cost conditions, and can show actual cost of medical claims. Participating employment-based plans shall submit reimbursement claims to the Secretary, who shall reimburse for 80 percent of that portion that exceed $15,000 (to be eligible for reimbursement, a claim shall be between $15,000 and $90,000, adjusted annually per CPI). Increases these thresholds annually based on the Medical Care Component of the CPI-U, rounded to the nearest multiple of $1,000. Appropriates not more than $5 billion to carry out this section. [Sec. 1102 of the Act]
Identifying Coverage Options	Not later than July 1, 2010, requires the Secretary in consultation with the states to establish a mechanism, including an Internet website, through which a resident or small business in any state may identify affordable health insurance coverage options in the state. Establishes criteria that must be included on such site and develop a standardized format to present such information. [Sec. 1103]
Study on Denials of Coverage	Requires the Comptroller General to conduct a study of the incidence of denials of coverage for medical services and denials of applications to enroll in health insurance plans by group health plans and health insurance issuers. In conducting the study, the Comptroller General shall consider samples of data concerning the following: • denials of coverage for medical services to plan enrollees, by the types of services for which such coverage was denied and the reasons such coverage was denied; • incidents in which group health plans and health insurance issuers deny the application of an individual to enroll in a health insurance plan offered by such group health plan or issuer; • the reasons such applications are denied; and • denials of coverage for medical services and denials of applications for enrollment in a plan by a group health plan or health insurance issuer, where such group health plan or health insurance issuer later approves such coverage or application. [Sec. 1562]
Establishment of American Health Benefit Gateways (Gateways) / Establishment of Health Insurance Exchange (Exchange)	*Assistance to States to Establish American Health Benefit Exchanges:* Not later than one year after the enactment of the Act, the Secretary shall appropriate amounts necessary to make awards to states to establish an Exchange. The Secretary will determine specific amounts on an annual basis. The Secretary may renew grants if recipients are making progress towards establishing an Exchange, implementing reforms outlined in this Act and meeting other benchmarks as determined by the Secretary. No grants shall be awarded after January 1, 2015. *Establishment of Exchanges:* By January 1, 2014, requires each state to establish: (1) an Exchange for the state that is designed to facilitate the purchase of qualified health plans; and

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	(2) a Small Business Health Options Program (SHOP Exchange) that is designed to assist qualified small employers in facilitating the enrollment of their employees in qualified health benefit plans offered in the small group market in the state. An Exchange shall be a governmental agency or nonprofit entity that is established by the state. *Merger of Individual and SHOP Exchanges:* A state may elect to provide only one Exchange in the state for providing both the Exchange and SHOP Exchange services to both qualified individuals and qualified small employers, but only if the Exchange has adequate resources to assist individuals and employers. *Criteria for Certification:* The Secretary shall, by regulation, establish criteria for the certification of health plans as QHBP. Criteria shall require that to be certified as a QHBP, a plan shall: • not employ marketing practices that have the effect of discouraging applicants with significant health needs; • ensure a wide choice of providers (consistent with network adequacy provisions under section 2702(c)); • include within provider networks certain essential community providers, where available, that serve predominately low-income, medically underserved individuals; • be accredited with respect to local performance on clinical quality measures such as the Healthcare Effectiveness Data and Information Set, patient experience ratings on a standardized Consumer Assessment of Healthcare Providers and Systems survey, consumer access, utilization management, quality assurance, provider credentialing, complaints and appeals, network adequacy and access, and patient information programs by any entity recognized by the Secretary for the accreditation of health insurance issuers or plans, and receive such accreditation within a period established by an Exchange; • implement a quality improvement strategy that incorporates a payment structure that provides increased reimbursement and other incentives; • utilize a uniform enrollment form that qualified individuals and qualified employers may use, either electronically or on paper, in enrolling in a QHBP offered through an Exchange and that takes into account criteria developed by the NAIC; • utilize the standard format for presenting health benefit plan options; • provide information to enrollees and to each Exchange in which the plan is offered, on any quality measures for health performance endorsed under section 399JJ of the Public Health Services Act; and • report to the Secretary at least annually on pediatric quality reporting measures established pursuant to the CHIP Reauthorization Act of 2009. Nothing shall require a QHBP to contract with a provider if the provider refuses to accept the generally applicable payment rates of the plan. *Rating System:* The Secretary shall develop a rating system that will rate QHBP offered through an Exchange in each benefits level on the basis of relative quality and price. The Exchange shall include the quality rating in the information provided to individuals and employers through the Internet portal.

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	Enrollee Satisfaction System: The Secretary shall develop an enrollee satisfaction survey system that would evaluate the level of enrollee satisfaction with qualified health plans offered through an Exchange, for each plan that had more than 500 enrollees in the previous year. Such information shall be available to consumers through the Exchange. *Internet Portals:* The Secretary shall operate and maintain an Internet portal as described in section 1103(a) of the Act and assist states in developing and maintaining their own such portals and shall make a model template available for Exchanges to use in order to direct qualified individuals and employers to QHBP, assisting such individuals and employers in determining whether they are eligible to participate in an Exchange or eligible for a premium tax credit or cost-sharing reduction and present standardized information regarding QHBP offered through an Exchange. The template shall include access to the uniform outline of coverage the plan is required to provide and a copy of plan's written policy. *Enrollment Periods:* The Secretary shall require an Exchange to provide: • an initial open enrollment as determined by the Secretary, with the determination having to be made no later than July 1, 2012; • annual open enrollment periods; • special enrollment periods under certain circumstances; and • special monthly enrollment periods for Indians. *Benefits:* Requires an Exchange to make available qualified health plans to qualified individuals and employers. An Exchange may make available a qualified health plan notwithstanding any provision of law that may require benefits other than the essential health benefits. Permits states to require that a qualified health plan offered in the state offer benefits in addition to the essential health benefits established. States requiring such additional benefits must assume the costs for such requirements. Requires a state to make payments to an individual enrolled in a qualified health plan offered in the state or on behalf of the individual directly to the qualified health plan in which the individual is enrolled to defray the cost of any additional benefits. *Stand-Alone Dental Benefits:* Requires each Exchange to allow an offeror of a health benefit plan that provides limited scope dental benefits to offer the plan through the Exchange either separately or in conjunction with a qualified health benefits plan if the plan provides pediatric dental benefits. *Exchange Functions:* An Exchange shall, at a minimum: • establish procedures for the certification and decertification of qualified health plans; • provide for a toll free telephone hotline to respond to requests for assistance; • maintain an Internet site through which enrollees and prospective enrollees of QHBP may obtain standardized comparative information on such plans; • assign a rating to each QHBP offered through the Exchange in accordance with criteria developed by the Secretary • utilize a standardized format for presenting health benefit plan options in the Exchange, including use of the uniform outline of coverage • inform individuals of eligibility requirements for Medicaid CHIP, or any applicable state or local public program and enroll individuals in such programs if the Exchange determines they are eligible;

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	• establishment and use of a calculator to determine the actual cost of coverage after application of any premium credit or cost-sharing subsidy; and • procedures for certification of exemption from the individual responsibility excise tax and transfer of those names and taxpayer identification numbers to the Secretary of individuals who are exempt from the tax. *Exchange Funding Limitations:* States shall ensure that Exchanges are self-sustaining beginning on January 1, 2015, including allowing Exchanges to charge assessments or user fees to participating health insurance issuers or to otherwise generate funding to support its operations. *Certification of QHBP by an Exchange:* An Exchange may certify a health plan as a QHBP if: • the plan meets the requirements for certification as set forth by the Secretary; • the Exchange determines that making the plan available is in the interests of the qualified individuals and employers in the state or states in which the Exchange operates; • Exchange may not exclude a health plan: o on the basis that the plan is a fee-for-service plan; o through the imposition of premium price controls; or o on the basis that the plan provides treatments necessary to prevent patients' deaths in circumstances the Exchange determines are inappropriate or too costly. *Premium Considerations in Certification:* An Exchange shall require health plans seeking certification as a QHBP to submit justification for any premium increase. Exchanges shall take this information into consideration, including patterns or practices of excessive or unjustified rate increases, when determining whether to certify a health plan and make it available through the Exchange. *Transparency in Coverage*: Requires the Exchange to make health plans seeking certification as qualified health plans to submit to the Exchange, the Secretary, and the state insurance commissioner, and make available to the public, accurate and timely disclosure of information with respect to claims payment, periodic financial disclosures, enrollment and disenrollment data, number of claims denied, information on cost-sharing, and information on enrollee and participant rights. Requires such information to be in "plain language" (as defined). Requires health plans seeking certification to learn the amount of cost-sharing under the individual's plan or coverage that the individual would be responsible for paying on a specific item or service by a participating provider in a timely manner upon the request of the individual. At a minimum, requires the information to be provided through a website or other means for individuals without internet access. *Regional Exchanges:* An Exchange may operate in more than one state if each state agrees to the operation of the exchange in that state and the Secretary approves the operation of the Exchange in all such states. Allows a state to establish one or more subsidiary Exchanges provided that it is for a geographically distinct area and the area served by the Gateway is at least as large as a rating area described in section 2701(a) of the PHSA. *Authority to Contract for Exchange Services:* Allows a state to contract with an eligible entity to carry out one or more responsibilities

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	of the Exchange. "Eligible entities" are defined as a state Medicaid agency or person incorporated under the laws of one or more states, has demonstrated experience on a state or regional basis in the individual and small group health insurance markets, and is not a health insurance issuer or a group of such issuers. *Rewarding Quality Through Market-based Initiatives*: Creates a payment structure that provides increased reimbursement or other incentives for improving health outcomes through the implementation of various initiatives, such as reporting, care/disease management, treatment compliance, preventing hospital readmissions, patient safety, reduction of medical errors, implementing wellness and health promotion activities, and implementing activities to reduce health care disparities. Requires the Secretary to develop guidelines based on these criteria. Requires health plans to report to the Exchange regarding the activities that a qualified health plan has conducted to implement these guidelines. *Enhancing Patient Safety*: Beginning January 1, 2015, allows qualified health plans to contract with hospitals with greater than 50 beds to the extent such hospitals use a patient safety evaluation system and implement a mechanism to ensure that each patient receives counseling and comprehensive discharge planning; or a health care provider if such provider implements such mechanisms to improve health care quality as required by the Secretary. Reasonable exceptions may be set by the Secretary. [Sec. 1311, as amended by the Pryor amendment (SA 2939)] *Qualified Health Benefit Plans:* Requires qualified health benefit plans to be: • certified by each Exchange through which the plan is offered; • provide the essential health benefits package; • be offered by a health insurance issuer that is: o licensed and in good standing to offer coverage in each state that issuer offers health insurance coverage; o agrees to offer at least one QHBP in the silver level and at least one plan in the gold level in each Exchange; o agrees to charge the same premium rate for each QHBP without regard to whether plan is offered through an Exchange or directly through an agent; and o complies with regulations developed by the Secretary. [Sec. 1301] *Treatment of Qualified Direct Primary Care Medical Home Plans:* Requires the Secretary to permit a qualified health benefits plan to provide coverage through a qualified direct primary medical home plan that meets the criteria established by the Secretary, so long as the qualified health plan meets all requirements that are otherwise applicable and the services covered by the medical home plan are coordinated with the entity offering the qualified health plans. [Sec. 1301]

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	Variation Based on Rating: A qualified health plan, including a multi-state plan, may as appropriate vary premiums by rating area. [Sec. 1301] *Navigators*: Requires the Secretary to award grants to establishing or participating states to enable such states (or the Exchanges operating them) to contract with private and public entities to: • conduct public education activities to raise awareness of the program; • distribute fair and impartial information concerning enrollment in qualified health plans and the availability of credits; • facilitate enrollment in a qualified health plan; • provide referrals to state agencies for any enrollee grievance, complaint or question regarding their health plan, coverage, or a coverage determination; and • provide information that is culturally and linguistically appropriate. To be eligible to enter into an agreement as stated above requires an entity to demonstrate that the entity has existing relationships with employers and employees, consumers, and self-employed individuals likely to be eligible to participate in the program. Entities may include trade, industry and professional associations, commercial fishing industry organizations, ranching and farming organizations, community and consumer focused nonprofit groups, chambers of commerce, unions, small business development centers, and other entities the Secretary determines capable. A navigator may not be a health insurance issuer or receive any consideration directly or indirectly from any health insurance issuer in connection with the participation of any employer in the program or the enrollment of any eligible employee in health insurance coverage. Grants awarded under this section must be made from the operational funds of the Exchange and not Federal funds received by the state to establish the Exchange. *Consumer Choice:* A qualified individual may enroll in any qualified health plan available to such individual. Employers may provide support for coverage of employees under a QHBP by selecting any level of coverage made available to employees through an Exchange and the employee may choose plan within that level. Qualified individuals may pay any applicable premium owed to the health insurance issuer issuing the plan. *Single Risk Pool:* Requires a health insurance issuer to create a single individual market risk pool for all enrollees in an individual plan, including individuals who purchase coverage outside of the Exchange. Requires a health insurance issuer to create a single risk pool for all enrollees in a small group health plan, other than self-insured group health plans, including individuals who purchase coverage outside of the Exchange. A state may require the individual and small group insurance markets within the state to be merged if the state determines it to be appropriate. *Empowering Consumer Choice*: Nothing shall be construed to prohibit a health insurance issuer from offering a health insurance policy

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	or providing coverage under such policy to a qualified individual where such policy is offered outside of an Exchange. Does not prohibit a qualified individual from enrolling in a health insurance plan where such plan is outside an Exchange. Nothing shall be construed as terminating, abridging, or limiting the operation of any requirement under state law with respect to any policy or plan that is offered outside of an Exchange. Qualified individuals are able to choose to enroll or not enroll in a qualified health plan or to participate in the Exchange. *Members of Congress in the Exchange:* After the effective date of this section, the only health plan the Federal Government may offer to members of Congress and congressional staff shall be health plans that are: • created under this Act; or • offered through and Exchange created under this Act. *Enrollment Through Agents/Brokers;* Requires the Secretary to establish procedures to allow agents and brokers to enroll individuals in any qualified health benefits plan in the individual or small group markets as soon as the plan is offered through an Exchange and to assist individuals in applying for premium credits and cost-sharing subsidies for plans sold through an Exchange. *Access Limited to Citizens and Lawful Residents:* Definitions: • The term "qualified individual" means, with respect to an Exchange, an individual who is seeking to enroll in a QHBP offered in the individual market through an Exchange; resides in the state that established the Exchange; is not incarcerated; and is a lawful resident of the United States. • The term "qualified employer" means a small employer that elects to make all full-time employees eligible for one or more QHBP in the small group market through an Exchange. Beginning in 2017, each state may allow issuers of health insurance in the large group market to offer QHBP in that market through an Exchange. Issuers will not be required to do so. If, after 2017, a state allows issuers to offer QHBP in the large group market through an Exchange, the term "qualified employer" shall include large employers. *Financial Integrity*: Requires Exchanges to annually report to the Secretary on Exchange expenditures. Permits the Secretary to conduct investigations and audits, and implement fraud and abuse reduction measures. If the Secretary determines that an Exchange or state has engaged in repeated acts of serious misconduct with respect to carrying out activities required or compliance, permits the Secretary to rescind payments by not more than 1 percent per year until adequate corrective actions are taken by the state. Requires the Secretary to provide for the efficient and non-discriminatory administration of Exchange activities and implement measures to reduce fraud and abuse. Directs the GAO to conduct an ongoing study of Exchange activities not later than five years after

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	enactment of this Act. [Sec. 1312] *Exchange Standards:* The Secretary shall, as soon as practicable after the date of enactment of the Act, issue regulations setting standards relating to: • establishment and operation of Exchanges (including SHOP Exchanges); • the offering of QHBP through Exchanges; • establishment of reinsurance and risk adjustment programs; and • any other requirements deemed necessary by the Secretary. In issuing regulations, the Secretary shall consult with the NAIC, health insurance issuers, consumer organizations and other individuals as deemed necessary to ensure balanced representation among interested parties. *State Action:* Each state that elects to apply requirements described above shall, not later than January 1, 2014, adopt and have in effect: • federal standards established by the Secretary; or • state laws or regulations that the Secretary determines will implement the standards within the state If a state is not an electing state as described above or if the Secretary determines on or before January 1, 2013 that an electing state will not have any required Exchange operational by January 1, 2014 or has not taken actions necessary to implement the Secretary's requirements, the Secretary shall, directly or through agreement with a not-for-profit entity, establish and operate an Exchange within the state. If a state is already operating an Exchange before January 1, 2010 and that Exchange already covers at least the percentage of the state's population as is projected to be covered nationally after the implementation of these reforms, the Secretary shall presume that such Exchange meets the standards of the Act, unless the Secretary determines otherwise. [Sec. 1321] *Waiver:* Allows a state to be granted a waiver if the state applies to the Secretary demonstrating coverage at least as comprehensive as required by the Act along with a 10-year budget plan that is budget neutral for the federal government. States may apply for plan years beginning after January 1, 2017. Permits the Secretary to grant a request for a waiver if the Secretary determines that the state plan: • will provide coverage at least as comprehensive as the essential health benefits plan offered through the Exchange; • will provide coverage and cost sharing protections against excessive out-of-pocket spending; • will provide coverage to at least a comparable number of its residents as respective provisions of the Act would provide; and • will not increase the federal deficit.

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	Establishes a regulatory process for the promulgation of governing regulations and public input regarding the waiver process. Waivers are prohibited from extending over a period of longer than 5 years unless a continuation of the waiver is granted. [Sec. 1332]
Risk-Adjustment	Beginning 2014 when the high risk pool is phased out, requires (as a condition of issuing commercial, major medical health insurance policies or administering benefit plans in years 2014-16) all health insurance plans to contribute to a reinsurance program for individual policies. Requires the Secretary, in consultation with the NAIC to establish a model regulation that enables states to establish and maintain a program that requires health insurance issuers, and third party administrators to make payments to an applicable reinsurance entity for any plan year beginning in the three year period beginning January 1, 2014. Requires the applicable reinsurance entity to collect payments and use amounts collected to make reinsurance payments to health insurance issuers that cover high risk individuals in the individual market for any plan year beginning in such 3-year period. Requires regulations to establish a method for determining high risk individuals including a list of at least 50 but not more than 100 high risk medical conditions. Requires the formula for determining payment amounts to issuers must provide for the equitable allocation of available funds through reconciliation and may be designed to provide a schedule of payments that specifies the amount paid or to use any other comparable method that is recommended by the American Academy of Actuaries. Requires health plans to contribute $25 billion over this three year period. [Sec. 1341] *Risk Corridors*: Requires the Secretary to establish and administer a program of risk corridors for 2014, 2015, and 2016 under which a QHBP will participate on the basis of the ratio of allowable costs of the plan to the plan's aggregate premiums. Requires the risk corridors to be modeled after that which applies to regional PPOs in Medicare Part D. Outlines the definition of *allowable costs* and the operations of the risk corridors. [Sec. 1342] *Risk-Adjustment Payment*: Requires states to assess a charge on plans and issuers whose enrollees' actuarial risk for one year is less than the average actuarial risk of all enrollees in all plans or coverage in the state for the same year that are not self-insured plans subject to ERISA. Requires states to provide payment to plans whose enrollees' actuarial risk for one year is greater than the average actuarial risk of all enrollees in all plans in the state for the same year that are not self-insured plans subject to ERISA. Requires the Secretary to establish criteria and methods for carrying out such risk-adjustment activities. Requires payments to be calculated retrospectively. Allows the Secretary to utilize criteria and methods similar to the criteria and

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	methods utilized under the Medicare Advantage Program and the Medicare Part D Prescription Drug Program. Risk adjustment provisions apply to a health plan or health insurance issuer providing coverage for an individual or an employer group that does not exceed state established criteria relating to the size of employers for participating or establishing states. [Sec. 1343]
Essential Benefits Package	*Essential Health Benefit Plan Requirements:* Defines "essential health benefits package" as any health plan, coverage that: • provides for essential health benefits as defined by the Secretary, which shall include at least the following general categories and the items and services covered within each category; o ambulatory patient services; o emergency services; o hospitalization; o maternity and newborn care; o mental health and substance use disorder services, including behavioral health treatment; o prescription drugs; o rehabilitative and habilitative services and devices; o laboratory services; o preventative and wellness services and chronic disease management; o pediatric services, including oral and vision care; • limits cost-sharing for such coverage; and • provides either the bronze, silver, gold or platinum level of coverage. The Secretary shall ensure that the scope of the essential health benefits coverage is equal to the typical coverage provided by an employer, which will be determined in conjunction with the Secretary of Labor, by having the Secretary of Labor conduct a survey of employer-sponsored coverage to determine typical benefits. The Secretary shall submit a report to the appropriate committees of Congress containing a certification from the Chief Actuary of CMS stating that the essential health benefits meet the limits on cost-sharing. In defining the essential health benefits, the Secretary shall provide notice and an opportunity for public comment. *Required Elements for Consideration by the Secretary:* In defining the essential health benefits, the Secretary shall: • ensure that essential health benefits reflect appropriate balance among all categories so that benefits are not unduly weighted toward any specific category; • not make coverage decisions, determine reimbursement rates, establish incentive programs or design benefits in any way that discriminates based on age, disability or life expectancy; • take into account health care needs of the population, including women, children, persons with disabilities and other minority

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	groups; • ensure that any health benefits established as essential are not subject to denial to individuals based on age or life expectancy, or an individual's present or future disability, degree of medical dependency or quality of life; • provide that a QHBP shall not be treated as providing essential health benefit coverage unless the QHBP provides: o coverage for emergency department services without any prior authorization requirements or any limitation on coverage where the provider does not have a contractual relationship with the plan that is more restrictive than the requirements or limitations that apply to emergency department services received from providers who do have a contractual relationship with the plan; and o if services are provided out-of-network, the cost-sharing requirement is same as if services were provided in-network; • provide that if a stand-alone dental benefits plan is offered through an Exchange, another health plan offered through the Exchange shall not fail to be treated as QHBP because the plan does not offer coverage of benefits offered through the stand-alone plan. The Secretary shall periodically review the essential health benefits and provide a report to Congress and the public that contains: • assessment of whether enrollees are having difficulty accessing needed services because of cost or coverage; • assessment of whether the essential health benefits need to be updated or modified to keep pace with medical or scientific advancement; • information on how essential health benefits will be modified to address any gaps in access or changes in the evidence base; • assessment of the potential of additional or expanded benefits to increase costs and the interaction between additional or expanded benefits and reductions in existing benefits to meet actuarial limitations; and based on survey findings, the Secretary shall periodically update the essential health benefits to address any gaps in access to coverage or changes in the evidence base as identified by the Secretary. *Limitations on Cost-sharing:* • In 2014, Prohibits cost-sharing incurred under a health plan with respect to self-only coverage or coverage other than self-only from exceeding the dollar amounts in effect under IRS requirements with respect to HSAs for self-only and family coverage respectively for taxable years beginning in 2014. • Beginning in 2015 and beyond, requires cost-sharing to be equal to self-only coverage amounts for 2014 plans, increased by an amount equal to the product of that amount and the premium adjustment percentage for the calendar year, which is defined as the percentage, if any, by which the average per capita premium for health insurance coverage in the United States for the preceding calendar year exceeds such average per capita premium for 2013. For coverage other than self-only, the limit is twice the amount in effect for self-only. Increases shall be rounded to the next lowest multiple of $50. *Limitations on Deductibles for Employer Sponsored Plans:* For plans offered in the small group market, the deductible shall not exceed $2,000 for individual coverage and $4,000 for any other plan. These amounts may be increased by the maximum amount of reimbursement reasonably available to a participant under a flexible spending arrangement. For self-only plans beginning in calendar year 2014, the limits shall be increased by equal to the product of that amount and the premium adjustment percentage for the calendar year, which is defined as the percentage, if any, by which the average per capita premium for health insurance coverage in the United

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	States for the preceding calendar year exceeds such average per capita premium for 2013. The dollar amount for all other plans shall be increased by an amount equal to double the amount in effect for self-only plans for plan years beginning after 2014. Increases shall be rounded to the next lowest multiple of $50. Limitations shall be applied in a manner so as not to affect the actuarial value of any health plan, including a plan in the bronze level. Nothing in this section shall allow a plan to have a deductible apply to benefits described in section 2713 of the PHSA. *Four Benefit Categories*: Defines four benefit categories: bronze, silver, gold and platinum. Requires all products issued in the individual and small group markets to meet the actuarial standards of one of these categories and requires all health insurance plans to offer, at a minimum, coverage in the silver and gold categories. *Definition of Levels*: Outlines the following benefit categories: • **Bronze**: represents minimum creditable coverage (MCC), equal to the actuarial equivalent to 60 percent of the full actuarial value of the benefits provided under the essential benefits package; • **Silver**: equal to the actuarial equivalent to 70 percent of the full actuarial value of the benefits provided under the essential benefits package; • **Gold**: equal **t**o the actuarial equivalent of 80 percent of the full actuarial value of the benefits provided under the essential benefits package; and • **Premium**: equal to the actuarial equivalent 90 percent of the full actuarial value of the benefits provided under the essential benefits package. • **Catastrophic-only**: Allows for a separate catastrophic-only policy which would provide the essential health benefits, except that the plan provides no benefits for any year until the individual has incurred cost-sharing expenses in an amount equal to the annual limitation in effect for the plan year. The plan must offer coverage for at least three primary care visits. Individuals eligible for enrollment must not have attained the age of 30 before the beginning of the plan year; or have a certification that the individual is exempt from the requirement under section 5000A of the IRS Code of 1986. The plan may only be offered in the individual market • **Child-only:** If a QHBP is offered through the Exchange at any level of coverage, the issuer shall also offer that plan through the Exchange at the same level, only open to individuals who have not attained the age of 21. The plan will be treated as a QHBP. *Actuarial Value:* Under regulations issued by the Secretary, the level of coverage of a plan shall be determined based on the essential health benefits provided to a standard population. The Secretary shall issue regulations permitting employer contributions to health savings accounts to be counted in determining the level of coverage for a plan offered by an employer. *Payments to Federally Qualified Health Centers:* If any item or service covered by a qualified health plan is provided by a Federally-qualified health center to an enrollee of the plan, the offeror of the plan must pay to the center for the item or service an amount that is not less than the amount of payment that would have been paid to the center otherwise. [Sec. 1302] *Abortion Services*: Permits a state to opt-out of providing abortion coverage through an Exchange if the state enacts a law prohibiting

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	such coverage. Nothing shall be construed to require abortion coverage as part of an essential benefits package. Prohibits a qualified health plan from providing abortion coverage if they receive federal funds. Nothing in the Act shall be construed to preempt or other have any effect on Federal or state laws regarding abortion. [Sec. 1303]
Transparency: Pharmacy Benefit Managers	Requires PBMs that contract with a PDP, an MA-PDP, or a QHBP to share basic information with the Secretary and, in the case of PBMs, with any plans with which the PBM contracts. Requires this information to be considered confidential and protected by the Secretary and the plans. Requires the disclosure of aggregate data on rebates, discounts, and price concessions along with price differentials between what the QHBP pays the PBM and the amount the PBM pays retail and mail order pharmacies. [Sec. 6005 of the Act/ Adds Sec. 1150A of the SSA]
Excise Tax on High-Cost Insurance/Annual Fee on Health Insurance Providers/ Deductibility of Executive Compensation	**Excise Tax on High-Cost Insurance** Imposes an excise tax on insurers equal to 40 percent of the aggregate value of applicable employer-sponsored coverage that exceeds the threshold amount of ~~$8,500~~ $10,200 for an individual policy and ~~$23,000~~ $27,500 for a family policy for ~~2013~~ 2018, multiplied by the health cost adjustment percentage (100 percent plus the excess, if any, of (1) the percentage by which the per employee cost for providing coverage under FEHBP for plan year 2018 exceeds such cost for plan year 2010, over (2) 55 percent). Also allows adjustments for employers whose workforce differs with respect to age and gender from the national risk pool. In years following ~~2013~~ 2018, the amount (after the health cost adjustment) shall be indexed by the cost of living adjustment determined for the year, increased by one percentage point in the case of determinations for calendar years beginning before 2020. In the case coverage under a group health plan which provides health insurance coverage, the tax is paid by the health insurance issuer. In the case of contributions to an HSA or MSA, the tax is paid by the employer. For other coverage, the person that administers the plan benefits is liable to pay the tax. Applies the excise tax to group health plans established primarily for federal employees, state employees, and employees of political subdivisions. For retired individuals over the age of 55 and a plan that covers employees engaged in "high risk professions" or employed to repair or install electrical or telecommunication lines, the threshold amount is increased by ~~$1,350~~ $1,650 for individual and ~~$3,000~~ $3,450 for family coverage. In calendar years after 2018, these threshold adjustments are indexed by the cost of living adjustment determined for the year, increased by one percentage point in the case of determinations for calendar years beginning before 2020. For purposes of this rule, employees considered to be engaged in a "high risk profession" are law enforcement officers, firefighters, members of a rescue squad or ambulance crew, longshore workers, and individuals engaged in the construction, mining, agriculture (but not food processing), forestry or fishing industries. ~~*Certain Transition Relief*: Under a transition rule for health insurance plans maintained in the 17 states in which health care was least affordable during 2012, as determined by the Secretary, the threshold amount is initially increased to 120 percent. The initial increase is~~

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	~~reduced each year thereafter (110 percent in 2014, and 105 percent in 2015) until the additional premium amount is eliminated entirely for taxable years beginning after December 31, 2015.~~ *Penalty for Under-Reporting Liability for Tax to Insurers*: If the employer reports to insurers and plan administrators (and the IRS) a lower amount of coverage costs subject to the excise tax than required, the employer is subject to a penalty equal to any additional excise tax that each insurer and administrator would have owed if the employer had reported correctly, increased for interest. Calculates the thresholds by taking into account the aggregate value of all employer-sponsored coverage, including coverage in the form of reimbursements under a FSA or HRA, employer contributions to an HSA, and coverage for dental, vision, and other supplementary health insurance coverage (excludes disability benefits and long-term care). Excludes from the high-cost insurance threshold all benefits listed under "excepted benefits" under Section 9832(c)(1)(A) of the IRC (except for coverage for on-site medical clinics) and fixed indemnity health coverage that is purchased by the employee with after-tax dollars, and dental and vision benefits. Effective for taxable years beginning after December 31, ~~2012~~ 2017. [Sec. 9001 of the Act/Sec. 4980I of the IRC] [Sec. 10901 of the Manager's Amendment/ Sec. 4980I of the IRC] [Sec. 1401 of the Reconciliation Bill] *Employer Health Insurance Reporting*: Requires an employer to disclose the value of the applicable employer-sponsored coverage on the employee's annual W-2. Effective in the first taxable year after December 31, 2010. [Sec. 9002 of the Act/Sec. 6051(a) of the IRC] **Annual Fee on Health Insurance Providers** Imposes an annual fee on the health insurance sector beginning in calendar year ~~2011~~2014, allocated by market share. The covered entity's tax liability is the ratio of 1) the entity's net premiums written with respect to health insurance for any U.S. health risk; to 2) the aggregate net premiums written with respect to health insurance. Exempts the first $25 million of net premiums written from the tax, and makes a health plan liable for 50 percent of the net premiums written between $25-50 million and 100 percent of premiums over $50 million. In the case of certain tax-exempt entities, only 50 percent of premiums (over $50 million) are considered in calculating the tax. Establishes the annual fee (the "applicable amount") accordingly: • ~~2011~~ 2014: ~~$2~~ $8 billion; • ~~2012~~ 2015: ~~$4~~ $11.3 billion; • ~~2013~~ 2016: ~~$7~~ $11.3 billion; • ~~2014, 2015, and 2016~~ 2017: ~~$9~~ $13.9 billion; and • ~~2017~~ 2018 and thereafter: ~~$10~~ $14.3 billion. In the case of any calendar year beginning after 2018, the annual fee is the applicable amount for the preceding calendar year increased by the rate of premium growth. ~~Creates a limited exemption from the fee for certain non-profit insurers that abide by medical loss ratio standards and other requirements.~~ Creates a limited exemption from the fee for certain non-profit insurers that 1) have no part of net earnings directed to shareholders, direct no substantial resources to propaganda or lobbying, and do not participate in any political campaign for public office; and 2) receive more than 80 percent of income from government programs targeting certain populations.

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	Exempts from the fee voluntary employee benefit associations (VEBAs) that are established by an entity (other than an employer or employers) for the purpose of providing health care benefits. Exempts from the fee any insurance coverage described in paragraph (1)(A) or (3) of section 9832(c) of the IRC, any insurance for long-term care, or any Medicare supplemental health insurance. The fees assessed would not be deductible for U.S. income tax purposes. Adds a penalty to insurers that underreport the net premiums written for any calendar year. [Sec. 9010 of the Act, as amended by Sec. 10905 of the Manager's Amendment/Sec. 1406 of the Reconciliation Bill] **Deductibility of Executive Compensation** Limits deductibility of remuneration in excess of $500,000 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 creditable coverage requirements. Effective for remuneration paid in taxable years beginning after December 31, 2012, and includes deferred remuneration paid after December 31, 2012, attributable to services performed after December 31, 2009. [Sec. 9014 of the Act/Sec. 162(m) of the IRC]
Additional Revenue Provisions and Other Tax Related Provisions	*Distributions for Medicine Qualified Only if for Prescribed Drug or Insulin*: Eliminates the eligibility of over-the-counter drugs as a tax-free expense under a Health Savings Account, an Archer Medical Savings Account, a flexible spending arrangement, or a health reimbursement arrangement. Limits the definition of a "qualified medical expense" to include drugs and medicine only if such drug or medicine is a prescribed drug or insulin. Effective after December 31, 2010. [Sec. 9003 of the Act/ Secs. 223(d)(2), 220(d)(2), 106, and 105of the IRC] *Health Savings Accounts*: The additional tax on distributions from an HSA that are not used for qualified medical expenses is increased from 10 to 20 percent (and from 15 to 20 percent for MSAs) of the disbursed amount. Effective for disbursements made during tax years starting after December 31, 2010. [Sec. 9004 of the Act/Sec. 223(f)(4)(A) of the IRC] *Limiting Flexible Spending Arrangements Under Cafeteria Plans*: Salary reductions by an employee for a taxable year for purposes of coverage under an FSA under a cafeteria plan are limited to $2,500. For taxable years beginning after December 31, ~~2011~~ 2013, the dollar amount shall be increased by a cost-of-living adjustment. Effective for taxable years beginning after December 31, ~~2010~~ 2012. [Sec. 9005 of the Act, as amended by Sec. 10902 of the Manager's Amendment/Sec. 125 of the IRC/Sec. 1403 of the Reconciliation Bill] *Corporate Information Reporting*: Modifies the general information reporting requirement by eliminating the exception for payments to corporations. Effective for payments made in taxable years after December 31, 2011. [Sec. 9006 of the Act/Sec. 6041 of the IRC] *Non-profit Hospital Information*: Establishes a national requirement for 501(c)(3) charity hospitals to conduct a community health needs assessment, establish a financial assistance policy, limit charges for those in financial need, and other requirements. A civil monetary penalty of $50,000 would be assessed for noncompliance. [Sec. 9007 of the Act/Secs. 501 and 4959 of the IRC] *Annual Fee on Manufacturers and Importers of Branded Drugs*: Imposes an annual fee on any person that manufacturers or imports

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	prescription drugs for sale in the U.S. Fees collected would be paid to the Treasury. The fee on the sector would be ~~$2.3 billion payable annually beginning in 2010, apportioned among covered entities based on each entity's relative market share of covered domestic sales for the prior year.~~ : • 2011: $2.5 billion • 2012: $3 billion • 2013: $3 billion • 2014: $3 billion • 2015: $3 billion • 2016: $3 billion • 2017: $3.5 billion • 2018: $4.2 billion • 2019 and thereafter: $2.8 billion A "covered entity" is any manufacturer or importer of certain drugs or biologics offered for sale under prescription in the U.S, and would include both domestic and foreign manufacturers and importers. A "branded prescription drug sale" would include sales of branded prescription drugs made to or funded by "specified government programs" (Medicare, Medicaid, VA, and TRICARE). The fees assessed would not be deductible for U.S. income tax purposes. Firms with sales of branded pharmaceuticals of $5 million or less would be exempt from the fee. ~~Effective for calendar year 2010 and thereafter, with respect to domestic covered sales in calendar year 2009 and thereafter.~~ This section shall apply to calendar years beginning after December 31, 2010. [Sec. 9008/Sec. 1404 of the Reconciliation Bill] ~~*Annual Fee on Manufacturers and Importers of Medical Devices*: Imposes a fee on any person that manufacturers or imports medical devices offered for sale in the U.S. The aggregate fee on the sector would be a $2 billion payable annually beginning in 2011 ($3 billion after 2017), apportioned among covered entities based on each entity's relative market share of covered domestic sales for the prior year. A "covered entity" is any manufacturer or importer of medical devices offered for sale in the U.S., and would include both domestic and foreign manufacturers and importers. The fees assessed would not be deductible for U.S. income tax purposes. Firms with sales of medical devices of $5 million or less would be exempt from the fee. Effective with respect to domestic covered sales in calendar year 2010 and thereafter after December 31, 2012. [Sec. 9009 of the Act, as amended by Sec. 10904 of the Manager's Amendment/ Sec. 1841(a) of the SSA/Sec. 1405 of the Reconciliation Bill]~~ *Sales Tax on the Manufacturer, Producer, or Importer of Medical Devices*: Repeals the annual fee on manufacturers and importers of medical devices and imposes a 2.3 percent sales tax on any taxable medical devices. Exempts eyeglasses, contact lenses, hearing aids, and other devices designated by the Secretary. Applies the tax to sales after December 31, 2012. [Adds Sec. 4191 of the IRC/ Sec. 1405 of the Reconciliation Bill] *Repeal Business Deduction for Federal Subsidies for Certain Retiree Prescription Drug Plans*: Removes an employer tax exclusion for retiree prescription drug plans. Effective for taxable years beginning after December 31, ~~2010~~ 2012. [Sec. 9012 of the Act/Sec. 139A of the IRC/Sec. 1407 of the Reconciliation Bill]

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	Modify the Itemized Deduction for Medical Expenses: Increases the threshold for the deduction from 7.5 percent of AGI to 10 percent for regular income tax purposes. Individuals age 65 and older (and their spouses) are exempt from the increased threshold and would continue to be eligible to claim the Section 213 deduction through 2016 if their medical expenses exceed 7.5 percent of AGI. Effective for taxable years beginning after December 31, 2012. [Sec. 9013 of the Act/Sec. 213 of the IRC] *Additional Hospital Insurance Tax on High-income Taxpayers*: Increases the Medicare hospital insurance payroll tax rate by 0.9 percentage points on an individual taxpayer earning in excess of $200,000 or $250,000 for married couples filing jointly. A 3.8 percent tax on income from interest, dividends, annuities, royalties and rents for taxpayers above certain thresholds ($200,000, singles/$250,000, couples) shall be assessed. Effective for taxable years beginning after December 31, 2012. [Sec. 9015 of the Act, as amended by Sec. 10906 of the Manager's Amendment/ Sec. 3101(b) of the IRC] *Treatment of Certain Health Organizations (Medical Loss Ratio)*: Blues Cross and Blue Shield organizations and other tax-exempt plans that are taxed under section 833 would maintain their tax-preferred status only if their premium revenue expended on clinical services is not less than 85 percent. This provision is effective for taxable years beginning after December 31, 2009. [Sec. 9016 of the Act/ Sec.833 of the IRC] *Tax on Indoor Tanning Services*: Imposes a 10 percent tax on indoor tanning services. Excludes from the tax phototherapy services performed by a licensed medical professional. Applies to services performed on or after July 1, 2010. [Sec. 10907 of the Manager's Amendment/ Sec. 5000B of the IRC] *Exclusion for Assistance Provided to Participants*: Excludes from gross income any amount received under any state loan repayment or loan forgiveness program that is intended to provide for the increased availability of health care services in underserved or health professional shortage areas. Applies to amounts received by an individual in taxable years beginning after December 31, 2008. [Sec. 10908 of the Manager's Amendment/ Sec. 108(f) of the IRC] *Expansion of Adoption Credit*: Expands the adoption credit and aid through adoption assistance programs from $10,000 to $13,170. Applies to taxable years beginning after December 31, 2009. [Sec. 10908 of the Manager's Amendment/ Sec. 23(b) of the IRC]
Individual Affordability Credits	*Payment of Credits/Subsidies*: Allows a tax credit for a qualified health plan, for any taxable year in an amount equal to the premium assistance credit amount of the taxpayer for the taxable year. The premium assistance amount is the amount equal to the lesser of: (A) the monthly premiums for such month for 1 or more qualified health plans offered in the individual market within a State which cover the taxpayer, the taxpayer's spouse, or any dependent (as defined in section 152) of the taxpayer and which were enrolled in through an Exchange established by the State under Section 1311 of the Patient Protection and Affordable Care Act, or (B) the excess of the adjusted monthly premium for such month for the applicable second lowest cost silver plan with respect to the taxpayer, over an amount equal to 1/12 of the product of the applicable percentage and the taxpayer's household income for the taxable year.

	Summary of the "Patient Protection and Affordable Care Act," (as passed by the Senate on December 24, 2009, and by the House on March 21, 2010) and the "Health Care and Education Reconciliation Act of 2010" (highlighted, as passed by the House on March 21, 2010)
	Requires the applicable tax credit percentage for any taxable year to be equal to ~~2.8 percent, increased by the number of percentage points (not greater than 7) which bears the same ratio to 7 percentage points as the taxpayer's income between 100 and 200 percent FPL.~~ the percentage corresponding to the taxpayer's income as follows: • Up to 133 percent FPL – initial premium percentage of 2 percent; final premium percentage of 2 percent • 133 percent to 150 percent FPL – initial premium percentage of 3 percent; final premium percentage of 4 percent • 150 percent to 200 percent FPL – initial premium percentage of 4 percent; final premium percentage of 6.3 percent • 200 to 250 percent FPL – initial premium percentage of 6.3 percent; final premium percentage of 8.05 percent • 250 to 300 percent FPL – initial premium percentage of 8.05 percent; final premium percentage of 9.5 percent • 300 to 400 percent FPL – initial premium percentage of 9.5 percent; final premium percentage of 9.5 percent ~~The taxpayer's applicable percentage is 2 percent for household incomes that equal or exceed between 100 and 133 percent FPL.~~ The tax credits do not extend beyond 400 percent FPL. Taxpayers with incomes below 100 percent FPL and lawful aliens not eligible for Medicaid will be treated the same as those who make 100 percent FPL. Married couples must file jointly to receive the credit. Those individuals who are dependents to another taxpayer will not receive the tax credit. Links the premium credits to the second lowest-cost Silver plan in the area where the individual resides which is offered through the same Exchange through which the qualified health plan is offered and provides self-only and family coverage in the case of an applicable tax payer. ~~Beginning with calendar years after 2014, the specified reference premiums shall be annually adjusted by either the applicable percentage for any taxpayer for any taxable year equal to 2.8 percent or by 2 percent if a taxpayer's income is between 100 percent and 133 percent FPL.~~ Beginning with calendar years after 2014, the initial and final applicable percentages shall be adjusted to reflect excess of the rate of premium growth for the preceding calendar year over the rate of income growth for the preceding calendar year. For calendar years after 2018, the applicable percentages shall be adjusted in the same manner, so long as the aggregate amount of premium tax credits and cost-sharing reductions for the preceding year exceeds .504 percent GDP for that year. Employees offered minimum essential 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~~ 9.5 percent of the employee's income are eligible for the premium assistance credit. *Reconciliation of Credit:* Requires tax credits to be reduced by the amount of any advance payment of such credit under Section 1412 of the Patient Protection and Affordable Care Act. If advance payment to a taxpayer exceeds the applicable tax credit, the tax for the taxable year shall be increased by the amount of such excess. For taxpayers whose income is less than 400 percent FPL, the increase shall not exceed $400. *Study on Affordable Coverage:* Requires the Comptroller General to conduct a study, not later than 5 years after the date of the enactment of this Act, on the affordability of health insurance coverage, including: • the impact of the tax credit for qualified health insurance coverage of individuals under section 36B of the Internal Revenue

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	Code of 1986 and the tax credit for employee health insurance expenses of small employers under section 45R of such code on maintaining and expanding the health insurance coverage of individuals; • the availability of affordable health benefits plans, including a study of whether the percentage of household income used for purposes of section 36B(c)(2)(C) of the Internal Revenue Code of 1986 is the appropriate level for determining whether employer-provided coverage is affordable for an employee and whether such level may be lowered without significantly increasing the costs to the Federal Government and reducing employer-provided coverage; and • the ability of individuals to maintain essential health benefits coverage (as defined in section 5000A(f) of the Internal Revenue Code of 1986). [Sec. 1401 of the Act/Sec. 1001 of the Reconciliation Bill] *Reduced Cost Sharing:* The standard out-of-pocket maximum limits would be reduced by two-thirds for those between 100-200 percent FPL; reduced by one-half for those between 200-300 percent FPL, and reduced by one-third for those between 300-400 percent FPL. The plan's share of total allowed costs of benefits would be increased to ~~90~~ 94 percent for those between 100-150 percent FPL and to ~~80~~ 87 percent for those between 150-200 percent FPL. The plan's share of total allowed costs of benefits would be increased to ~~70~~ 73 percent for those between 200-250 ~~300~~ percent FPL, and to 70 percent for those between ~~300~~ 250-400 percent FPL. The cost-sharing assistance does not take into account benefits mandated by States. Provides that American Indians with household incomes below 300 percent of FPL are treated as an eligible insured and requires the plan offeror to eliminate any cost-sharing under the plan. If an Indian enrolled in a qualified health plan is furnished an item or service directly by the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization or through referral under contract health services no cost-sharing under the plan shall be imposed under the plan for such item or service; and the issuer of the plan shall not reduce the payment to any such entity for such item or service by the amount of any cost-sharing that would be due. [Sec. 1402/Sec. 1001 of the Reconciliation Bill] *Eligibility Determinations*: Requires the Secretary to establish a program for determining income and coverage requirements, tax credits and reduced cost sharing, coverage under an employer-sponsored benefit plan and exemptions from the individual responsibility requirement for individuals who enroll in a qualified health plan offered through an Exchange. Requires applicants in a qualified health plan offered through an Exchange to provide: • the name, address and date of birth of each individual to be covered by the plan; • social security number and other pertinent immigration information (in the case of an enrollee whose eligibility is based on attestation of citizenship); • information regarding income and family size (in the case of an enrollee who is claiming a premium tax credit or reduced cost sharing); • changes in marital status, family size or income; • regarding employer-sponsored coverage, the name and address of the employer, the enrollee's employment information and if

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	the employer provides minimum essential coverage; and • information from enrollees seeking exemptions based on status as a member of an exempt religious sect, member of a health care sharing ministry, an Indian, or for a hardship. The Secretary, in consultation with the Secretary of the Treasury, the Secretary of Homeland Security, and the Commissioner of Social Security, shall provide that verifications and determinations for eligibility shall be done electronically and by determining the consistency of the information submitted with the information maintained in the records of the Secretary of the Treasury, the Secretary of Homeland Security, or the Commissioner of Social Security through such other method as is approved by the Secretary. If the information provided by an applicant is inconsistent with information in the records maintained by the Exchange or is not verified by the Secretary, the Secretary shall notify the Exchange and the Exchange shall take, among others, the following actions: • make a reasonable effort to identify and address the causes of such inconsistency, by contacting the applicant to confirm the accuracy of the information; • in the case the inconsistency is not resolved, the Exchange shall notify the applicant of such fact; • provide the applicant an opportunity to either present satisfactory documentary evidence or resolve the inconsistency for a 90-day period; and • charge a fine of not more than $25,000 if the correct information is not provided. Any person who knowingly provides false information is subject to a fine of not more than $250,000. [Sec. 1411] *Advance Determination:* Requires the Secretary, upon request of the Exchange, to establish a program to allow for the advanced determination with respect to the income eligibility of individuals enrolling in a qualified health plan in the individual market through the Exchange. Advance determination of eligibility shall be made during open enrollment and on the basis of the individual's household income for the most recent taxable year. Prohibits any Federal payments to individuals who are not lawfully present in the United States. Allows states to make payments to or on behalf of an individual for coverage under a qualified health plan offered through an Exchange that are in addition to any credits or cost-sharing reductions allowable to the individual under this Act. The Secretary of the Treasury shall make the advance payment of any premium tax credit allowed under section 36B of the IRC to the issuer of a qualified health plan on a monthly basis. An issuer of a qualified health plan receiving an advance payment with respect to an individual enrolled in the plan shall: • reduce the premium charged the insured for any period by the amount of the advance payment for the period; • notify the Exchange and the Secretary of such reduction; • include with each billing statement the amount by which the premium for the plan has been reduced by reason of the advance payment; and • in the case of any nonpayment of premiums by the insured, notify the Secretary of such nonpayment; and allow a 3-month grace period for nonpayment of premiums before discontinuing coverage.

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	[Sec. 1412] *Streamlining Enrollment Procedures:* 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 CHIP, the individual is enrolled for assistance under such plan or program. Requires the Secretary to develop a single streamlined form that may be used to apply for all applicable state health subsidy programs. It may be filed online, in person, by mail or over the phone. It may be filed with the Exchange or state officials and is structured to maximize an applicant's ability to complete the form satisfactorily. Allows states to develop their own streamlined form as an alternative to this form as long as it is consistent with standards promulgated by the Secretary. *Eligibility Based on Data Exchanges*: Requires states to develop for all applicable health subsidy programs, a secure, electronic interface allowing an exchange of data that allows a determination of eligibility for all such programs based on a single application. [Sec. 1413] *Disclosures to carry out eligibility requirements:* Allows for limited disclosure of tax return information to Exchanges or State agencies to carry out eligibility requirements for premium tax credits or any cost-sharing reduction under Medicaid, CHIP, or a program under the Patient Protection and Affordable Health Care Act. [Sec. 1414] 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. [Sec. 1415] *Study of Geographic Variation in Application of FPL:* Requires the Secretary to conduct a study to examine the feasibility and implication of adjusting the application of the federal poverty level for different geographic areas of the U.S, and its territories, to reflect the variations in cost-of-living among different areas within the United States. If the Secretary determines that an adjustment is feasible, the study should include a methodology to make such an adjustment. Requires, not later than January 1, 2013, the Secretary to submit to Congress a report on such study and include any appropriate recommendations determined by the Secretary. [Sec. 1416]
Small Business Tax Credit	Qualified small employers shall receive a health coverage credit equal to 50 percent (35 percent in the case of a tax-exempt eligible small employer) of the lesser of the aggregate amount of nonelective contributions the employer made on behalf of its employees during the taxable year under the arrangement for premiums for qualified health plans offered by the employer to its employees through an Exchange, or the aggregate amount of nonelective contributions which the employer would have made during the taxable year under the arrangement if each employee had enrolled in a qualified health plan which had a premium equal to the average premium (as determined by the Secretary of Health and Human Services) for the small group market in the rating area in which the employee enrolls for coverage.

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	The term "eligible small employer" means an employer who employs 25 or less qualified employees during the taxable year, and the average annual employee compensation of such employer does not exceed $40,000. The term "full-time equivalent employees" means a number of employees equal to the number determined by dividing the total number of hours of service for which wages were paid by the employer to the employees during the taxable year by 2080. Excess hours worked above 2080 hours are not included in this figure. This figure also does not include the hours worked by seasonal employees unless they work for an employer more than 120 days during the year. Tax exempt small employers can also receive a tax credit and receive the lesser of the amount of the credit determined with respect to such employer or the amount of the payroll taxes of the employer during the calendar year in which the taxable year begins. In the case of any taxable year beginning in 2010, 2011, 2012, or 2013, on dollar amounts equal to $25,000, the following modifications shall apply in determining the amount of the credit: • the credit shall be determined without regard to whether the taxable year is in a credit period and for purposes of applying this section to taxable years beginning after 2013, no credit period shall be treated as beginning with a taxable year beginning before 2014; and • the amount of the credit shall be determined by: o substituting 35 percent (25 percent in the case of a tax-exempt eligible small employer)' for 50 percent (35 percent in the case of a tax-exempt eligible small employer); o by reference to an eligible small employer's nonelective contributions for premiums paid for health insurance coverage of an employee; and o by substituting for the average premium the Secretary of Health and Human Services determines is the average premium for the small group market in the State in which the employer is offering health insurance coverage (or for such area within the State as is specified by the Secretary). This section is effective to taxable years beginning after December 31, 2010. [Sec. 1421 of the Act/Sec. 45R of the IRC]
Individual Responsibility	Beginning after 2013, an applicable individual shall ensure that the individual and any dependent of the individual who is an applicable individual is covered under minimum essential coverage for each month. Imposes "shared responsibility payments" on individuals without qualifying coverage for any month during the taxable year. Payment shall be levied on the parent or guardian of a child who does not have qualifying coverage. The term "applicable individual" does not include those incarcerated, not lawfully present in the United States, or claiming religious conscience. An individual failing to meet this requirement for 1 or more months will receive a penalty in an amount equal to the lesser of the sum of

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	the monthly penalty amounts (discussed below) determined for months in the taxable year during which 1 or more such failures occurred or an amount equal to the national average premium for qualified health plans which have a bronze level of coverage, provide coverage for the applicable family size involved, and are offered through Exchanges for plan years beginning in the calendar year with or within which the taxable year ends. The monthly penalty amount with respect to any taxpayer for any month during which any failure occurred is an amount equal to 1/12 of the greater of the following amounts: • an amount equal to the lesser of the sum of the applicable dollar amounts for all individuals with respect to whom such failure occurred during such month, or 300 percent of the applicable dollar amount for the calendar year with or within which the taxable year ends; or • an amount equal to the following percentage of the taxpayer's household income for the taxable year: o ~~0.5~~ 1.0 percent for taxable years beginning in 2014; o ~~1.0~~ 2.0 percent for taxable years beginning in 2015; and o ~~2.0~~ 2.5 percent for taxable years beginning after 2015. The amount of the penalty for any month with respect to an individual is an amount equal to 1/12 of the applicable dollar amount for the calendar year. The amount of penalty for any taxable year with respect to all individuals for whom a taxpayer is liable shall not exceed an amount equal to 300 percent of the applicable dollar amount within which the taxable year ends. The "applicable dollar amount" is, in general, ~~$750~~ $695. This amount will be phased in beginning at $95 for 2014 and ~~$425~~ $325 for 2015. In the case of any calendar year beginning after 2016, the applicable dollar amount shall be equal to ~~$750~~ $695 increased by an amount equal to ~~$750~~ $695 multiplied by the cost of living adjustment. In the event that an increase is not a multiple of $50, the increase shall be rounded to the next lowest multiple of $50. If an applicable individual is under age 18 at the beginning of a month, the applicable dollar amount for that individual shall be equal to one-half the applicable dollar amount for the calendar year in which the month occurs. Does not impose a tax penalty when an applicable individual: • was not covered for a period of less than three months; • has a contribution for a calendar year that exceeds 8% of the individual's household income; • has a taxable income of less than 100% FPL; • is a Native American; or • has a hardship with respect to the ability to obtain coverage under a qualified health plan as determined by the Secretary. Requires individuals to obtain essential health benefits coverage through: • a qualified health benefits plan within or outside of the Exchange; • grandfathered health benefits; • an employer;

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	• Medicare, Medicaid, SCHIP; • TRICARE or the VA: or • FEHBP. Waives criminal and civil penalties for failure to pay a tax imposed by this section. [Sec. 1501 of the Act/Sec. 5000A of IRC/Sec. 1002 of the Reconciliation Bill]
Reporting Health Insurance Coverage	*Individuals:* Beginning January 1, 2013, requires every person who provides essential health benefits coverage to an individual during a calendar year to submit a "return" in a form prescribed by the Secretary that contains: • the name, address and TIN of the primary insured and the name of each other individual obtaining coverage under the policy; • the dates during which an individual was covered • the amount (if any) of any advance payment under section 2248 of the Social Security Act of any cost-sharing subsidy or premium credit; and • any other information required by the Secretary. If essential health benefits coverage consists of health insurance coverage provided through a group plan of an employer, a "return" shall include: • the name, address and employer identification number of the employer maintaining the plan; • the portion of the premium (if any) required to be paid by the employer; and • if the coverage is a QHBP in the small group market, offered through an exchange, any other information the Secretary may require for administration of the credit for employee health insurance expenses of small employers. [Sec. 1502 of the Act/Sec. 6055 of IRC] *Large Employers:* Beginning June 30, 2013, requires every applicable large employer to submit a "return" to the Secretary. The "return" shall contain: • name, date and employer ID number • a certification as to whether the employer offered its full-time employees (and dependents) opportunity to enroll in a health benefits plan or grandfathered health benefits plan, including months for which coverage was available and the monthly premium for the lowest cost option for each enrollment category; • name, address and TIN of each full-time employee; and • any other information determined by the Secretary. [Sec. 1514 of the Act/Sec. 6056 of the IRC]

	Summary of the "Patient Protection and Affordable Care Act," (as passed by the Senate on December 24, 2009, and by the House on March 21, 2010) and the "Health Care and Education Reconciliation Act of 2010" (highlighted, as passed by the House on March 21, 2010)
Notification of Nonenrollment	Not later than June 30 of each year, requires the IRS to send a notification to each individual who files an individual income tax return and who is not enrolled in qualifying coverage. Requires such notification to include information on the services available through the Exchange operating in the state in which the individual resides. [Sec. 1502 of the Act/Sec. 6055 of IRC]
Employer Responsibility / Health Coverage Participation Requirements	*Automatic Enrollment:* Requires employers with more than 200 full-time employees that offer enrollment in 1 or more health benefit plans to automatically enroll new full-time employees in one of the plans and to continue the enrollment of current employees in a health benefit plan provided by the employer. The automatic enrollment program must include adequate notice and opportunity to opt-out. [Sec. 1511 of the Act/Sec. 18A of FLSA] *Notice to Employees:* Requires employers to provide to each employee at the time of hiring (or with respect to current employees, not later than March 1, 2013) written notice informing them of the existence of the Exchange, including a description of the services provided by such Exchange and the manner in which the employee may contact the Exchange to request assistance. The notice must also inform employees that 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 tax credit and that if the employee purchases a QHBP through the Exchange, the employee will lose the employer contribution. [Sec. 1512 of the Act/Sec. 18B of FLSA] *Large Employers:* Requires large employers (50 or more employees) that do not offer coverage to pay a fee for each employee who receives a tax credit for health insurance through an Exchange. Employers with more than 50 full-time workers that do not offer coverage and have at least one worker who receives the premium assistance tax credit to pay a fee of ~~$750~~ $2,000 for each full-time employee. For larger employers offering coverage that have at least one employee receiving a premium tax credit, the amount that must be paid to offset those subsidies is equal to the product of the number of full-time employees and ~~400 percent of the applicable payment amount~~ 1/12 of $3,000. *Application of Employer Size to Assessable Penalties*: The number of individuals employed by a large employer as full-time during any month shall be reduced by 30 for purposes of calculating the assessable penalty or the overall limitation. ~~Large employers requiring an extended waiting period to enroll in any minimum essential coverage under an employer-sponsored plan must pay $600 for each fulltime employee. Extended waiting period means any waiting period exceeding 60 days.~~ *Counting Part-Time Workers in Setting the Threshold for Employer Responsibility:* In determining whether an employer qualifies as a "large employer," the total number of hours worked in a month by part-time employees, divided by 120, shall be added to the number of full time employees. Requires the Secretary of Labor to review and report to Congress the effects of fees and assessments on workers' wages, using the National Compensation Survey from the Bureau of Labor and Statistics. The Secretary shall report the results to the House Ways and Means Committee and the Senate Finance Committee. *Effective Date:* January 1, 2014

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	[Sec. 1513 of the Act/Sec. 1003 of the Reconciliation Bill]
Implementation Funding	Establishes a Health Insurance Reform Implementation Fund ("the Fund") within HHS to carry out these provisions. Appropriates out of any Treasury funds not otherwise appropriated $1,000,000,000 for federal administrative expenses. [Sec. 1005 of the Reconciliation Bill]
Multi-State Plans	*Multi-State Plans:* Requires the Director of the Office of Personnel Management (OPM) to enter into contracts with health insurance issuers to offer at least 2 multi-state qualified health plans through each Exchange in the State. Requires such plans to provide individual, or in the case of small employers, group coverage. Requires each contract to be for at least 1 year, but may be autorenewable from term to term in the absence of notice of termination by either party. Requires coverage to be consistent with the essential benefits package established. Requires that at least one contracted entity be with a non-profit entity. Requires the Director to administer these multi-state plans in a manner consistent with the Federal Employees Health Benefits Program (FEHBP), including loss ratios, profit margins, and premiums charged. Requires that at least one multi-state plan offered in an Exchange does not cover abortion services for which public funding is prohibited. *Eligibility:* A health insurance issuer is eligible to enter into a contract with the Director if the issuer: • agrees to offer a multi-state qualified health plan that meets the requirements of the Exchange in each state; • is licensed in each state ; and • complies with minimum benefit standards. *Requirements for Multi-State Plans:* Requires a multi-state qualified health plan to: • offer a uniform benefits package in each state that consists of the essential benefits; • meet all requirements of a qualified health benefit plan relating to the offering of the bronze, silver, and gold levels of coverage and catastrophic coverage; • provide determinations of premiums; • offer in all geographic regions and in all states that have adopted community rating for the date of enactment of this Act. *Additional Benefits:* Permits states to require additional benefits in addition to the essential health benefits. States adding benefits must be absorbed by the state and not affect the amount of premium credits. *Credits:* An individual enrolled in a multi-state qualified health plan is eligible for premium credits and cost-sharing assistance in the

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	same manner as an individual enrolled in a qualified health plan. *State Rating Requirements:* To the extent a multi-state qualified health plans are required to follow rating requirements less than 3:1 pursuant to state law, permits Exchanges to only permit the offering of such multi-state plan. *Multi-state Plan Phase In:* Requires the Director to contract with a health insurance issuer for the offering of a multi-state qualified health plan if: • in Y1 for which the issuer offers a plan, such issuer offers the plan in at least 60 percent of states; • in Y2 such issuer offers the plan in at least 70 percent of states; • in Y3 such issuer offers the plan in at least 85 percent of states; and • in subsequent years, such issuer offers the plan in all states. [Sec. 1334]
Health Care Cooperatives	Establishes the nonprofit Consumer Operated and Oriented Plan (CO-OP) program to foster the creation of qualified nonprofit health insurers to offer qualified health benefit plans in the individual and small group markets in states in which the issuers are licensed to offer such plans. Requires the Secretary to provide through the CO-OP loans and grants to provide assistance with start-up costs and solvency requirements as required by states. Establishes criteria for awarding loans and grants including: • taking into account any recommendations by the Advisory Board established under the Act; • giving priority to applicants that will offer QHBP on statewide basis with private support; and • ensuring sufficient funding for at least one qualified nonprofit health insurance issuer in each state. Prohibits loans or grants from being used for carrying on propaganda or otherwise attempting to influence legislation or for marketing purposes. If the Secretary determines that a person failed to meet any requirements of the loan and grant money, requires such person to repay the amount equal to the sum of 110% of the amount of the loans and grants received plus interest on the aggregate amount of the loans and grants for the period the loans or grants were outstanding. No later than January 1, 2013 the Secretary shall begin distribution of loans and grants under the CO-OP program. Defines "qualified nonprofit health insurance issuer", for purposes of the CO-OP. Requires CO-OP participants to: • be organized as a nonprofit, member corporation under state law;

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	• not be an existing organization that provides insurance as of July 16, 2009, and must not be an affiliate or successor of any such organization; • have governing documents that incorporate ethics and conflict of interest standards protecting against insurance industry involvement and influence; • not be sponsored by a state or sub-state government; • have substantially all of its activities involve providing health coverage; • have a strong consumer focus; • meet solvency and licensure requirements, follow rules on payments to providers, and comply with network adequacy rules, rate and form filing rules and any state premium assessments; • only offer a health plan after the state has in effect, or the Secretary has implemented, the market reforms described by the Act; and • use profits to lower premiums, improve benefits, or improve quality of health care. Qualified nonprofit health insurance issuers participating in CO-OP may establish a private purchasing council to enter into collective purchasing arrangements for services that increase administrative and other cost efficiencies. Allows a purchasing council to be established to execute these collective purchasing agreements, but explicitly prohibits these purchasing councils from setting payment rates. Prohibits the Secretary from participating in any negotiations between one or more qualified nonprofit health insurance issuers; and establish or maintain a price structure for reimbursement of any health benefits covered by such issuers. Appropriates $6 billion to carry out this section. Grants an exemption from federal income tax under section 501(a) of the IRC to organizations receiving a grant or loan under the CO-OP program. Such tax status is conditional to the CO-OP grantee abiding by the grant agreement. *GAO Study:* The GAO shall conduct an ongoing study (beginning in 2014) on competition and market concentration in the health insurance market in the US after the implementation of the reforms. The report shall be submitted no later than December 31st of each even-numbered year to the appropriate Congressional committees. [Sec. 1322]
Free Choice Vouchers	Requires an offering employer to provide free choice vouchers to each qualified employee of such employer. The amount of any free choice voucher shall be equal to the monthly portion of the cost of the eligible employer-sponsored plan which would have been paid by the employer if the employee were covered under the plan with respect to which the employer pays the largest portion of the cost of the plan. Such amount shall be equal to the amount the employer would pay for an employee with self-only coverage unless such employee elects family coverage (in which case such amount shall be the amount the employer would pay for family coverage).

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	Requires an Exchange to credit the amount of any free choice voucher to the monthly premium of any qualified health plan in the Exchange in which the qualified employee is enrolled and the offering employer shall pay any amounts so credited to the Exchange. Defines "offering employer" as one who offers minimum essential coverage to its employees consisting of coverage through an eligible employer-sponsored plan; and who pays any portion of the costs of such plan. Defines "qualified employee" as any employee: • whose required contribution for minimum essential coverage through an eligible employer-sponsored plan exceeds 8 percent of such employee's household income for the taxable year which ends with or within in the plan year; and does not exceed 9.8 percent of such employee's household income for such taxable year; • whose household income for such taxable year is not greater than 400 percent FPL for a family of the size involved; and who does not participate in a health plan offered by the offering employer. These requirements shall apply to vouchers provided after December 31, 2013. [Sec. 10108 of the Manager's Amendment]
State Health Programs for Low-Income Individuals Not Eligible for Medicaid	Requires the Secretary to establish a basic health program under which the state enters into contracts with health plans to provide essential benefits packages to eligible individuals through the Exchange. Individuals are eligible for the programs if they are a resident of the state and have a household income that exceeds 133 percent FPL but does not exceed 200 percent FPL. Individuals 65 years of age and older are not eligible, nor are those with access to an employer-sponsored plan that constitutes affordable coverage. Before establishing a program, the Secretary must certify that the plan offered through the program provides that the monthly premium does not exceed the amount of the monthly premium had the individual enrolled in the second lowest cost silver plan and that appropriate cost-sharing measures are met. Requires the benefits provided under the program to cover at least the benefits required under the essential benefits package. State basic health programs are required to have a competitive bidding process with emphasis placed on innovation, care coordination, preventive care, and incentives for appropriate utilization of physician services. Permits states to provide multiple standard health plans to low income individuals through the program, and allows regional compacts to be formed between states to include coverage of eligible individuals in all of the states. Approved programs are eligible to receive federal funding in the amount equal to 95 percent of tax credits and cost-sharing subsidies that would have been provided for eligible individuals had they enrolled in traditional qualified health plans through the exchange. Funding determinations are to be made on a per enrollee basis and shall take into account all relevant factors necessary to determine the

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	value of the premium tax credits and cost-sharing deductions that would have been provided to eligible individuals. [Sec. 1331]
Improving Access to Health Care Services	*Spending for Federally-Qualified Health Centers (FQHCs)*: Appropriates – • $2,988,821,592 for FY 2010 • $3,862,107,440 for FY 2011 • $4,990,553,440 for FY 2012 • $6,448,713,307 for FY 2013 • $7,332,924,155 for FY 2014 • $8,332,924,155 for FY 2015 • for FY 2016 and beyond, the amount appropriated for the preceding year, adjusted by the product of 1) one + the average percentage increase in the costs incurred per patient served, and 2) one + the average percentage increase in the total number of patients served. [Sec. 5201 of the Act/Sec. 330 of the PHSA] Directs the Secretary to establish, through a negotiated rulemaking process, a comprehensive methodology and criteria for the designation of medically underserved populations and health professions shortage areas. [Sec. 5602] Reauthorizes the Wakefield Emergency Medical Services for Children Program. [Sec. 5603 of the Act/Sec. 1910 of the PHSA] *Co-Locating Primary and Specialty Care in Community-Based Mental Health Settings*: The Secretary, acting through the Administrator, shall award grants and cooperative agreements to eligible entities to establish demonstration projects for the provision of coordinated and integrated services to special populations through the co-location of primary and specialty care services in community-based mental and behavioral health settings. Funds received must be used to provide onsite primary care services, for reasonable costs associated with medically-necessary referrals to qualified specialty care professionals, IT, or facility modifications. No later than 90 days after an award is made, an entity shall submit an evaluation to the Secretary concerning the effectiveness of the activities carried out with the grant money. Appropriates $50,000,000 for FY 2010 and sums necessary for each of FYs 2011-2014. [Sec. 5604 of the Act/Sec. 520K of the PHSA]
Access to Therapies	Restricts the Secretary from promulgating regulations that: • creates any unreasonable barriers to the ability of individuals to obtain appropriate medical care; • impedes timely access to health care services; • interferes with communications regarding a full range of treatment options between the patient and the provider; • restricts the ability of health care providers to provide full disclosure of all relevant information to patients making health care decisions;

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	• violates the principles of informed consent and the ethical standards of health care professionals; or • limits the availability of health care treatment for the full duration of a patient's medical needs. [Sec. 1554]
HIT Enrollment Standards and Protocol	No later than 180 days after enactment, requires the Secretary, in consultation with the HIT Policy Committee and the HIT Standards Committee to develop interoperable and secure standards and protocols that facilitate the electronic enrollment of individuals in Federal and State health and human services programs. Requires such standards and protocols to include: • electronic matching against federal and state data to serve as evidence for eligibility; • simplification and submission of electronic documentation; • reuse of stored eligibility information; • capability for individuals to apply, recertify, and manage their eligibility information online; • ability to expand enrollment systems to integrate new programs, rules, and functionalities; • notification of eligibility, recertification and other needed communication; and • other functionalities necessary to provide eligibles with streamlined enrollment process. [Sec. 1561 of the Act/Sec. 3021 of the PHSA]
Grants for Implementation of Appropriate Enrollment of HIT	The Secretary shall award grants (amount not specified) to eligible entities (defined as state and local governments) that apply for such grants to develop new and adopt existing technology systems to implement HIT enrollment standards. Also allows the Secretary to determine other qualified entities and requires the Secretary to ensure that the entity will share such appropriate enrollment technology. [Sec. 3021]
Key National Indicators	Establishes a "Commission on Key National Indicators," composed of 8 members to be appointed equally between the majority and minority leaders of the Senate and the Speaker and minority leader of the House, to conduct comprehensive oversight of a newly-established key indicators system, make recommendations on improvements to the system (including annual reports to Congress and to the National Academy of Sciences ("the Academy"), coordinate with federal government users and information providers to assure access to quality data, and contract with the Academy. The Academy shall determine how best to establish a key national indicator system by creating its own institutional capability or by partnering with an independent nonprofit organization as an Institute to implement the system. The Academy shall create an appropriate governance mechanism and, no later than 270 days after enactment and annually thereafter, shall submit to the Co-Chairpersons of the Commission a report that contains its findings and recommendations.

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	The Comptroller General shall conduct a study of previous work conducted by all public agencies, private organizations, or foreign countries with respect to best practices for a key national indicator system. The GAO shall also conduct annual audits of the Institute's financial statements and programmatic assessments of the Institute. Appropriates $10,000,000 for FY 2010 and $7,500,000 for each of FYs 2011 through 2018. [Sec. 5605]
National Strategy to Improve Health Care Quality	*National Strategy and Priorities*: Requires the Secretary to establish a national strategy by January 1, 2011 to improve the delivery of health care services, patient health outcomes, and population health. Requires the Secretary to identify national priorities for improvement in developing the national strategy. Priorities shall include: • addressing the health care provided to patients with high-cost chronic diseases; • improving research and dissemination of strategies and best practices to improve patient safety and reduce medical errors, preventable admissions and readmissions, and health care-associated infections; • having the greatest potential for improving the health outcomes, efficiency, and patient-centeredness of heath care; • reducing health disparities; • addressing gaps in quality and health outcomes measures, comparative effectiveness information (taking into consideration limitations established by Sec. 1182 of the SSA), and data aggregation techniques; • identifying areas in the delivery of health care services that have the potential for rapid improvement in the quality of patient care; • improving Federal payment policy to emphasize quality and efficiency; • enhancing the use of health care data to improve quality, efficiency, transparency, and outcomes; and • addressing other areas as determined by the Secretary. The strategic plan shall include provisions for addressing: • agency coordination within the Department, including steps to minimize duplication of efforts and utilization of common quality measures; • agency-specific strategic plans to achieve national priorities; • establishment of annual benchmarks for each relevant agency to achieve national priorities; • a process for regular reporting by the agencies to the Secretary on the plan implementation; • strategies to align public and private payers with regard to quality and patient safety efforts; and • incorporating quality improvement and measurement in the strategic plan for HIT as required by the American Recovery and Reinvestment Act of 2009. Requires the Secretary to update the national strategy annually which includes: 1) a review of short- and long-term goals and any gaps in the strategy; and 2) an analysis of the progress or lack of progress in meeting such goals and any barriers to such process. Requires the Secretary to, not later than January 1, 2011, create an Internet website to make public information regarding the national quality

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	improvement priorities, the agency-specific strategic plans for health care quality described in subsection (b)(2)(B), and other information the Secretary deems appropriate. [Sec. 3011 of the Act/Sec. 399HH of the PHSA] *Interagency Working Group on Health Care Quality*: Requires the President to convene the "Interagency Working Group on Health Care Quality" whose goals include: • achieving collaboration, cooperation, and consultation between federal department and agencies with respect to developing and disseminating strategies, goals, models, and timetables that are consistent with national priorities; • avoiding inefficient duplication of quality improvement efforts and resources; • streamlining a process for quality reporting and compliance requirements; and • assessing alignment of quality efforts in the public sector with private sector initiatives. The group must include senior-level staff members of various departments and other federal agencies with activities relating to quality and safety. Requires the group to, not later than December 31, 2010, and annually thereafter, submit a progress report to Congress and make it public on an internet website. [Sec. 3012] *Quality Measure Development*: Defines "quality measure" as a standard for measuring the performance and improvement of population health or of health plans, providers of services, and other clinicians in the delivery of health care services. Requires the Secretary, no less than triennially, to identify gaps in, improvements, updates, or expansions needed in existing quality measures taking into consideration gaps identified by a qualified consensus-based entity and other stakeholders and quality measures identified by the pediatric quality measures program. Requires the Secretary to make available to the public a report on any gaps identified and the process used to make such identification. The Secretary shall award grants, contracts, or intergovernmental agreements to eligible entities for purposes of developing, improving, updating, or expanding quality measures. Requires the Secretary to coordinate grants with other grants under the SSA. Defines eligibility requirements. Entities receiving a grant, contract, or agreement shall use such award to develop quality measures that meet certain criteria. Permits the Secretary, in awarding grants, contracts, or agreements, to give priority to quality development measures that allow for the assessment of: • health outcomes and functional status of patients; • the continuity, management, and coordination of health care and care transitions, including episodes of care, for patients across the continuum of providers, health care settings, and health plans; • the experience, quality and use of information provided to and used by patients, caregivers, and authorized representatives to inform decisionmaking about treatment options; • the meaningful use of health information technology; • the safety and effectiveness, patient centeredness, appropriateness, and timeliness of care; • the efficiency of care; • health disparities across health disparity populations and geographic areas;

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	• patient experience and satisfaction; and • the use of innovative strategies and methodologies. Permits the Secretary to use funds to update and test quality measures endorsed by consensus-based entities or adopted by the Secretary. Requires the Administrator of CMS to develop quality measures for use under this Act. Requires the Secretary to develop and periodically update at least every three years provider-level outcome measures for hospitals, physicians, and other providers including the following categories: • outcome measurement for acute and chronic diseases including the five most prevalent and resource-intensive conditions; and • outcome measurement for primary and preventive care including measurements for care provided to distinct patient populations. The goal of the measures are to address issues regarding risk adjustment, accountability, and sample size, include the full scope of services comprising a cycle of care, and include multiple dimensions. Requires the Secretary to publicly report on the measures for hospital-acquired conditions. Appropriates $75,000,000 for each of FYs 2010-2014. [Sec. 3013 of the Act/Sec. 931 of the PHSA] *Quality and Efficiency Measure Endorsement*: Consensus-based entities must provide a report which identifies gaps in endorsed quality and efficiency measures and areas in which evidence is insufficient to support endorsement of quality and efficiency measures and where targeted research may address such gaps. Requires a consensus-based entity to convene multi-stakeholder groups to provide input on the selection of quality and efficiency measures, for use in reporting performance information to the public or for use in health care programs other than for use under this Act, from among measures it has endorsed and interim measures that are used or proposed to be used by the Secretary and on national priorities for performance improvement. Establishes transparency requirements regarding the activities of the multi-stakeholder group. Requires the consensus-based entity to report the input of the multi-stakeholder groups to the Secretary annually beginning February 1, 2012. The Secretary shall determine to use recommended quality and efficiency measures only after taking into account the guidance of multi-stakeholder groups. This subsection shall apply with respect to determinations or requirements by the Secretary for the use of quality and efficiency measures made on or after the date of enactment of this Act. Requires the Secretary, not less than once every 3 years, to review quality and efficiency measures used by the Secretary. Requires the Secretary to make available to the public a list of quality and efficiency measures that the Secretary is considering. Requires the Secretary, at least every three years beginning March 1, 2012, to conduct an assessment on the quality and efficiency impact of the use of endorsed measures and make such assessment available to the public. Requires the Secretary to establish a process for dissemination of measures used. Appropriates $20 million for each of FYs 2010 through 2014.

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	[Sec. 3014 of the Act/Sec. 1890(b) of the SSA] *Quality Measures Data Collection and Public Reporting:* Requires the Secretary to establish and implement an overall strategic framework to carry out the public reporting of performance information. Requires the Secretary to collect data on quality and resource use measures from information systems used to support health care delivery to implement the public reporting of performance information. Such efforts must be aligned with the requirements and assistance regarding the expansion of health information technology systems, the interoperability of such systems, and related standards. Permits the Secretary to award grants to eligible entities for such purpose. [Sec. 3015 of the Act/Sec. 399II of the PHSA] Requires the Secretary, in consultation with a qualified consensus-based entity and other entities as appropriate, to develop websites that make performance information publicly available. Requires a consensus-based entity to convene a multi-stakeholder group to provide input on the design and format of the website. Appropriates funds as necessary for FYs 2010 through 2014. [Sec. 3015 of the Act/Sec. 399JJ of the PHSA]
Coverage for Individuals Participating in Approved Clinical Trials	Prohibits a group or individual insurer from: • denying an individual from participating in a clinical trial, including an approved clinical trial conducted out of state from where the qualified individual lives; • denying (or limiting or imposing additional conditions on) the coverage of routine patient costs for items and services furnished in connection with participation in the trial; and • discriminating against the individual on the basis of the individual's participation in such trial. Defines "routine patient care costs" to include all items and services consistent with the coverage provided in the plan (or coverage) that is typically covered for a qualified individual who is not enrolled in a clinical trial. The term does not include investigational items, devices, or services itself; items and services provided solely to satisfy data collection and analysis needs not used for direct clinical management of the patient; or a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis. If one or more participating providers is participating in a clinical trial, nothing shall be construed as preventing a plan or issuer from requiring that a qualified individual participate in the trial through such a participating provider if the provider will accept the individual as a participant in the trial. Applies to a qualified individual participating in an approved clinical trial conducted outside the state in which the individual resides. Defines "qualified individual" as an individual who is a participant or beneficiary in a health plan who: • is eligible to participate in an approved clinical trial according to the trial protocol with respect to treatment of cancer or other life-threatening disease or condition; and • has a referring health care professional that is a participating health care provider and has concluded that the individual's participation would be appropriate, or the participant or beneficiary provides medical and scientific information establishing

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	their participation in such trial would be appropriate. Does not require coverage of benefits for routine patient care services provided outside of the plan's health care provider network unless out-of-network benefits are otherwise provided by the plan. Defines "approved clinical trial" as a phase I, II, III, or IV clinical trial conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is a federally funded trial as defined; a study conducted under an investigational new drug application reviewed by the FDA; or the study is a drug trial that is exempt from having such an investigational new drug application. [Sec.2709]
Health Care Delivery System Research: Quality Improvement Technical Assistance / Comparative Effectiveness	Establishes the Patient Safety Research Center within AHRQ to identify, develop, evaluate, disseminate, and provide training in innovative methodologies and strategies for quality improvement practices in the delivery of health care services that represent best practices in health care quality, safety, and value. General functions of the Center include: • implementing its functions using research from a variety of disciplines; • conducting support activities for best practices for quality improvement practices in the delivery of health care services, health outcomes, patient safety, and medical errors; • identifying providers that deliver consistently high-quality, efficient health care services and employ best practices that are adaptable and scalable to diverse health care settings; • assessing research, evidence, and knowledge about effective strategies and methodologies; • finding ways to translate information rapidly and effectively into practice, and document the sustainability of those improvements; • creating strategies for quality improvement through the development of tools, methodologies, and interventions that can reduce variations in the delivery of health care; • identifying, measuring, and improving organizational, human, or other causative factors; • providing for the development of best practices in the delivery of health care services which have a high likelihood of success, are specified with sufficient detail, are readily adaptable, address continuum of care issues, and engage patients; • providing for funding of the activities of organizations with recognized expertise and excellence in improving delivery; and • building capacity at the state and community level to lead quality and safety efforts [Sec. 3501] The Center shall support, through a contract or other mechanism, research on health care delivery system improvement and development of tools to facilitate adoption of best practices that improve the quality, safety, and efficiency of health care delivery services. Suggests establishing a Quality Improvement Network Research Program in order to test, scale, and disseminate interventions to improve quality and efficiency in health care. Recipients of program funding may include national, state, multi-state, or multi-site quality improvement networks. Research requirements include:

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	• addressing priorities of the national strategic plan; • addressing concerns of health care institutions and providers, reducing preventable morbidity and mortality; • supporting development of reliable and efficient delivery processes; • translating research findings from clinical research and comparative effectiveness research into recommendations; • expanding demonstration projects for improving children's health care quality; • identifying and mitigating hazards; • including the conduct of systematic reviews to improve quality safety and efficiency; and • including examination of how to measure and evaluate progress of patient safety activities. [Sec. 3501 of the Act/Sec. 399V-1 of the PHSA] Such research findings shall be made publicly available and shared with the National Coordinator of HIT to inform the activities of the HIT extension program, relevant standards, certification criteria or implementation specifications. Requires the Director to identify a list of processes or systems on which to focus research, taking into account cost, consumer assessments, and provider assessments. Requires the Director to award technical assistance grants or contracts to eligible entities (e.g., provider, provider association, professional society, health care worker organization, etc.) to provide support to institutions that deliver health care and health care providers. Eligible entities for an implementation award may be a hospital or other provider or consortium of providers and should have demonstrated quality improvement expertise. Requires an entity to agree to make available non-federal contributions toward the activities to be carried out under the grant in an amount equal to $1 for each $5 of Federal funds provided under the grant. Requires the Director to evaluate entity performance. [Sec. 3501 of the Act/Sec. 399V-1 of the PHSA] Authorizes the establishment of a non-profit corporation, the "Patient-Centered Outcomes Research Institute," to assist patients, clinicians, purchasers, and policy makers in making informed health decisions by advancing the quality and relevance of clinical evidence through research and evidence synthesis. Creates a 19-member Board of Governors comprised of: • the Director of the Agency for Healthcare Research and Quality; • the Director of the National Institutes of Health; and • 17 experts and stakeholder representatives appointed by the Comptroller General, including: o three representatives of consumers; o seven representatives of physicians and providers; o three representatives of private payers of which one must represent health insurers and one employers who self-insure; o three representatives of pharmaceutical, device, and diagnostic manufacturers or developers; o one representing quality improvement or independent health service researchers; and o two members representing the federal government or the states of which one must represent a federal health program or agency. Directs the Board to oversee the Institute's operations. Members of the Board would serve a six-year term and be limited to two terms. The Institute would work to identify priorities for comparative clinical effectiveness research and establish a research project agenda, coordinating its activities and resources with those of other public and private agencies to ensure the most efficient use of resources and that research is not duplicated.

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	The Institute would design research to take into account potential differences in outcomes among different subpopulations. Directs the Institute to enter into contracts with federal agencies, as well as with appropriate academic research, private sector research, or study-conducting entities, for the management and conduct of research in accordance with the research agenda. Contracting entities would be required to abide by the same transparency and conflict of interest requirements that apply to the Institute, comply with the methodological standards adopted by the Board, consult with the rare disease advisory panel for the relevant study as appropriate, and allow for researchers who conduct original research to publish their research in a peer-reviewed journal or other publication. Requires the Institute, as appropriate, to appoint expert advisory panels to assist in identifying research priorities and establishing the research agenda. Requires the establishment of an expert advisory panel in carrying out randomized clinical trials and a panel for the study of rare disease. Establishes a standing methodology committee to serve the Institute and determine a process to establish and maintain detailed methodological standards for comparative clinical effectiveness studies, as well as establish and maintain standards regarding clinical outcomes measures, risk-adjustment, and other aspects of research and assessment. Ensures a process for peer review of the research. Requires the Institute to disseminate findings of research to clinicians, patients, and the public in a comprehensible manner and form, and to submit an annual report to Congress, the president, and the public on research activities, the research project agenda and budget, and any other relevant information. The Comptroller General would review the results of annual financial audits of the Institute and report to Congress annually. [Sec. 6301 of the Act, as amended by Sec. 10602 of the Manager's Amendment/ Adds Part D to Title XI of the SSA] *Dissemination and Building Capacity for Research*: Directs the Office of Communication and Knowledge Transfer (Office) at AHRQ, in consultation with the NIH, to broadly disseminate the research findings that are published by the Institute and other government-funded research relevant to comparative clinical effectiveness research. Requires the Office to create informational tools that organize and disseminate research findings for physicians, health care providers, patients, payers, and policy makers. Requires the Secretary to coordinate with federal health programs to build capacity for comparative clinical effectiveness research to physicians, health care providers, patients, vendors of health information technology focused on clinical decision support, appropriate professional associations, and federal and private health plans. [Sec. 6301 of the Act/ Adds Sec. 937 to Title XI of the SSA] *Limitations on Certain Uses of Comparative Clinical Effectiveness Research*: Allows the Secretary to use the research published by the Institute to make coverage decisions under Medicare only if such determinations are made through an iterative and transparent process which includes public comment and considers the effect on subpopulations. Restricts the Secretary's ability to use research or findings from the Institute in determining coverage, reimbursement, or incentive programs or otherwise places value on patient life years. [Sec. 6301 of the Act/ Adds subsection (a) to Part D to Title XI of the SSA] Creates the Patient-Centered Outcomes Research Trust Fund ("PCORTF") in the Treasury to fund the Institute and its activities, and

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	authorizes: • $10 million in FY 2010; • $50 million in FY 2011; • $150 million in FY 2012; and • $150 million in each of FY 2013-2019 from the Treasury into the PCORTF and amounts collected from fees on health insurance and self-insured plans. Requires the Secretary to transfer from the Medicare Federal Hospital Insurance and the Federal Supplemental Medical Trust Funds $1 for every enrollee under Part A or B (FY 2013) and $2 for every enrollee under Part A or B (FY 2014-2019). For FY 2015-2019, increases the fee by the rate of growth in National Health Expenditures. [Sec. 3501 of the Act/ Adds Sec. 9511 to the IRC] Imposes a fee of $1 in FY 2013, and $2, updated per inflation (increase in National Health Expenditures) in FY 2014-2019 on each health insurance policy and for each self-insured health plan in the U.S., multiplied by the number of lives covered under that policy. Defines health insurance policy as any accident or health insurance policy, including under a group plan, with respect to individuals residing in the U.S. Excludes policies where substantially all of its coverage is of excepted benefits. These per enrollee fees are to be treated as if they were taxes. [Sec. 3501 of the Act/ Adds Secs. 4375, 4376, and 4377 to the IRC] Terminates the Federal Coordinating Council for Comparative Effectiveness Research on the effective date of this Act. [Sec. 6302 of the Act/ Sec. 804 of Division A of the ARRA of 2009] *Clinical Effectiveness Review Protocols:* Requires the Secretary to contract with the Institute to employ the results of the systematic reviews of clinical effectiveness research study and the best methods identified by the Institute for the purpose of identifying existing and new clinical practice guidelines that were developed using such best methods. [Sec. 10303 of the Manager's Amendment/Sec. 304(b) of MIPPA]
Studies of Self-Insured and Large Group Market	Requires the Department of Labor to prepare an aggregate annual report, using data collected from the Annual Return/Report of Employee Benefit that shall include general information on self-insured group health plans (including plan type, number of participants, benefits offered, funding arrangements, and benefit arrangements) as well as data from the financial filings of self-insured employers (including information on assets, liabilities, contributions, investments, and expenses). [Sec. 1253] Requires the Department of Health and Human Services to conduct a study of the fully-insured and self-insured group health plan markets to compare the characteristics of employers and determine the extent to which new insurance market reforms are likely to cause

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	adverse selection in the large group market or to encourage small and midsize employers to self-insure. The information collected shall include: • the extent to which self-insured group health plans can offer less costly coverage; • claim denial rates, plan benefit fluctuations and the impact of the limited recourse options on consumers; and • any potential conflict of interest as it relates to the health care needs of self-insured enrollees and self-insured employers' financial contribution or profit margin, and the impact of such conflict on administration of the health plan. [Sec. 1254]
Grants to Support Interdisciplinary Care	Requires the Secretary to establish a program to provide grants to eligible entities to establish community-based multidisciplinary, interprofessional teams to support primary care practices within the hospital services areas served by eligible entities. Requires grants to be used to establish health teams to provide support services to primary care providers; and provide capitated payments to primary care providers as determined by the Secretary. Eligibility requirements include being a state or state-designed entity, submitting a plan for achieving long-term financial sustainability within 3 years, incorporating prevention initiatives and care management resources, ensuring a multidisciplinary team approach, and submitting an application. Requirements for health teams include: • establishment of contractual agreements with primary care providers; • supporting patient-centered medical homes (defined as a mode of care that includes personal or other primary care physicians, whole person orientation, coordinated and integrated care, safe and high quality care through evidence-based medicine, appropriate use of HIT, and continuous quality improvements, expanded access to care and payment recognizing added value to patient in a patient-centered care model); • collaboration with local primary care providers and existing state and community based resources to coordinate disease prevention, chronic disease management, transitioning between health care providers and settings and case management; • collaboration with local providers; • incorporation of providers, patients, caregivers and authorized representatives in program design and oversight; • support to local primary care providers in coordinating access and providing quality-driven, cost-effective patient- and family-centered health care; • provide coordination of the appropriate use of complementary and alternative (CAM) services to those who request them; • collection and reporting of data that permits evaluation of the success of the collaborative effort on patient outcomes; • establishment of a coordinated system of early identification and referral of children at risk; • provide 24-hour care management and support during transition in care settings; • serving as a liaison to community prevention and treatment programs; • demonstration of a capacity to implement and maintain HIT that meets the requirements of certified electronic health record (EHR) technology to facilitate coordination; and • reports to the Secretary on quality measures. Includes requirements for primary care providers contracting with a care team.

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	[Sec. 3502]
Grants to Implement Medication Management Services in Treatment of Chronic Disease	Requires the Secretary to award grants to implement medication management services (MTM services) provided by licensed pharmacists for the collaborative, multidisciplinary, and interprofessional approach to the treatment of chronic diseases. To be eligible for a grant an entity must: • provide a setting appropriate for MTM services; • submit a plan for achieving long term financial sustainability; • submit a plan, where applicable, for coordinating MTM services with other local providers or through the Medicare Medical Home Pilot program; • submit a plan for providing MTM services to targeted individuals; and • submit any other information requested by the Secretary. Requires the MTM services to include: • assessments of health and functional status; • medication treatment plans and medication therapy; • monitoring and evaluating the response of a patient to therapy; • initial comprehensive medication review, quarterly targeted medication reviews, and additional follow-up interventions; • documentation and communication regarding care delivered; • education and training regarding appropriate use of medication; • information, support services, and resources and strategies to enhance patient adherence with therapeutic regimens; • coordination and integration of MTM services within the broader health care management services provided to the patient; and • other services allowed under the scope of the practice of pharmacists. Requires an entity to focus MTM services towards individuals who take four or more medications, take high-risk medications, have two or more chronic diseases, or have undergone a transition of care or other factors that might create a high-risk of medication-related problems. Requires an entity that receives a grant to consult with experts and report to the Secretary regarding MTM services provided. Requires the Secretary to report to Congress an assessment of the MTM services program and recommend modifications to the program. Permits the Secretary to award grants for the development of performance measures that assess the use and effectiveness of medication therapy management services. [Sec. 3503 of the Act/Sec. 935 of the PHSA]

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National Diabetes Prevention Program	The Secretary, acting through the Director of the CDC, shall establish a national diabetes prevention program targeted at adults at high risk for diabetes. Appropriates sums necessary for each of FYs 2010-2014. [Sec. 10501 of the Manager's Amendment]
Medical Liability Alternatives	*State Demonstration Programs to Evaluate Alternatives to Current Medical Tort Litigation*: Authorizes the Secretary to award demonstration grants to states for development, implementation, and evaluation of alternatives to current tort litigation for resolving disputes over injuries allegedly caused by health care providers or health care organizations. Grants are awarded for not more than five years. Requires such demonstrations to allow for a resolution of disputes over health care injuries and to promote a reduction of health care errors. Prohibits a demonstration from limiting or curtailing a patient's existing legal rights, ability to file a claim in or access a state's legal system, or otherwise abrogate a patient's ability to file a medical malpractice claim. Requires the GAO to appoint a panel to review state applications for grants, which would be comprised of representatives of patient advocates, health care providers and health care organizations, medical malpractice attorneys and insurers, state officials, and patient safety experts. Requires the Secretary to consult with this review panel before awarding grants. Requires the Secretary to contract with a research organization to evaluate the efficacy of the state demonstration programs. Requires MedPAC and MACPAC to each conduct an independent evaluation of the demonstration programs' impact on their respective health care programs and beneficiaries. Defines "health care organization" as any individual or entity which is obligated to provide, pay for, or administer health benefits under any health plan; "health care provider" as any individual or entity that is 1) licensed, registered, or certified under federal or state laws or regulations to provide health care services; or required to be so licensed, registered, or 2) certified but that is exempted by other statute or regulation. Authorizes $50 million to carry out this section. [Sec. 10607 of the Manager's Amendment/ Adds sec. 399V-4 of the PHSA] *Extension of Medical Malpractice Coverage to Free Clinics*: Extends medical liability protection to an entity governing a free clinic in providing services for the free clinic. Effective on the date of enactment. [Sec. 10608 of the Manager's Amendment/ Amends sec. 224(o)(l) of the PHSA]
Design and Implementation of Regionalized Systems for Emergency Care / Pilot Program	*Regionalized Communication Systems for Emergency Care Response:* Requires the Secretary to award at least four multiyear contracts or grants to eligible entities to support demonstration programs that design, implement, and evaluate innovative models of regionalized, comprehensive, and accountable emergency care and trauma systems that: • coordinate with public safety services, public health services, emergency medical services, medical facilities, and other entities within a region including 911 and emergency medical dispatch services; • include a mechanism that operates throughout the region to ensure that the correct patient is taken to the medically appropriate facility in a timely fashion;

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	• allow for the tracking of pre-hospital and hospital resources; and • include a consistent region-wide pre-hospital, hospital, and interfacility data management system. Establishes application requirements for entities seeking a contract or grant. Requires an entity that receives a grant to match at least $1 for every $3 of Federal funds. Gives priority to an applicant that serves a medically underserved population. Requires the Secretary to submit a report to Congress containing the results of an evaluation of the program. Requires the Secretary to contract with an academic institution or other entity to conduct an independent evaluation of the demonstration programs to be disseminated to the public and Congress. Authorizes $24 million for each of FY 2010 through 2014. [Sec. 3504] *Support for Emergency Medicine Research:* Requires the Secretary to support Federal programs administered by NIH, AHRQ, HRSA, and CDC, and others involved in improving the emergency care system to expand and accelerate research in emergency medical care systems and emergency medicine. Requires similar support of such agencies to coordinate and expand research in pediatric emergency medicine. [Sec. 3504 of the Act/Secs. 1204 and 498D of the PHSA]
Trauma Care Centers and Service Availability	Requires the Secretary to establish 3 programs to award grants to qualified public, nonprofit, Indian Health Service, Indian tribal, and urban Indian trauma centers in order to assist in defraying uncompensated care costs. Includes minimum qualifications of trauma centers such as the existence of policies for patients who are unable to pay for part or all of their received care. Includes qualifications for substantial uncompensated care grants and an award basis for each eligible trauma center according to certain percentages (e.g., category A trauma centers, 100 percent of the uncompensated care costs). Emergency awards shall be granted to trauma centers in limited geographic areas. Requires the Secretary to enforce a trauma care data registry which would include trauma centers receiving a grant. Grants shall be for 3 FYs, except the Secretary would be able to increase payments for one additional fiscal year. Beginning 2 years after the date of enactment of this Act, and every 2 years thereafter, the Secretary shall biennially report to Congress regarding grants status. Appropriates $100 million for FY 2009, and such sums as may be necessary for FYs 2010 through 2015. Allows the Secretary to provide funding ($100 million for each of FYs 2010-2015) to states to enable such states to award grants to eligible entities to support physician compensation in trauma-related physician specialties where shortages exist and to provide for individual safety net trauma center fiscal stability. [Sec. 3505]

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Physician Payment Sunshine Provisions	*Physician Payment Sunshine*: Provides for transparency between physicians and applicable manufacturers with respect to payments and other transfers of value and physician ownership or investment interests in manufacturers. Calls for manufacturers to provide annual transparency reports (on March 31, starting in 2013), penalties for noncompliance, procedures for the submission of information, and public availability of this information. [Sec. 6002 of the Act/ Adds sec. 1128G to the SSA] *Imaging Self-Referral Sunshine*: The in-office ancillary exception would include a requirement that, with respect to magnetic resonance imaging, computed tomography, positron emission tomography, and other services designated by the Secretary, the referring physician must inform the individual at the time of referral that the individual may obtain the services from a person other than that physician, a physician who is a member of the same practice as that physician, or an individual who is directly supervised by that physician or another physician in the practice. [Sec. 6003 of the Act/ Sec. 1877(b)(2) of the SSA] *Prescription Drug Samples*: Requires drug manufacturers and authorized distributors to annually report (starting in 2012) the information required under the Prescription Drug Marketing Act of 1987 to the Secretary. [Sec. 6004 of the Act/ Adds sec. 1128G to the SSA]
Program to Facilitate Shared Decision-Making	Attempts to facilitate collaborative processes between patients, caregivers, or authorized representatives, and clinicians that engage the patient, caregiver or authorized representative in decision making. Includes definitions of patient decision aid, and preference sensitive care. Requires the Secretary to enter into an 18-month contract with a qualified consensus-based entity to develop, identify and endorse standards for patient decision aids. Requires the Secretary to establish a program to award grants or contracts to develop, update, and produce patient decision aids for preference sensitive care. Includes requirements for patient decision aids including presentation of up-to-date clinical evidence about treatment risks and benefits. Materials developed shall be disseminated to the public via the internet. Requires the Secretary to establish a program to provide for the phased-in development, implementation, and evaluation of shared decision making using patient decision aids and provide grants to establish Shared Decision Making Resource Centers (SDMRCs) to: 1) develop and implement best practices and support the effective use of shared decision making techniques by providers who participate in training by the SDMRCs, and 2) fund development of performance measures. Providers receiving grants shall report data on quality measures to the Secretary. [Sec. 3506 of the Act/Sec. 936 of PHSA]
Drug Benefit and Risk Information	Requires the Secretary to determine whether the addition of quantitative summaries of the benefits and risks of drugs in a standardized format (such as a table or drug facts box) to the promotional labeling or print advertising of such drugs would improve health care

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Formatting	decision making by clinicians and patients. Requires review of all scientific evidence and research on decision making and social and cognitive psychology and consult with drug manufacturers, clinicians, patients, and consumers, experts in health literacy, representatives of racial and ethnic minorities, and experts in women's and pediatric health. Requires that, not later than one year after the date of enactment of this Act, the Secretary shall submit a report to Congress and not later than three years after the date of submission of the report, shall promulgate regulations to implement such drug information formatting. [Sec. 3507]
Prescription Drug Labeling Changes	Outlines how a proposed labeling of an abbreviated new drug application would be approved, in particular if • the application is otherwise eligible for approval but for expiration of patent, an exclusivity period, or of a delay in approval described in paragraph (5)(B)(iii), and a revision to the labeling of the listed drug has been approved by the Secretary within 60 days of such expiration; • the labeling revision does not include a change to the "Warnings" section; • the application's sponsor agrees to submit revised labeling of the drug not later than 60 days after the notification of any changes to such labeling required by the Secretary; and • such application otherwise meets the applicable requirements for approval under this subsection. [Sec. 10609 of the Manager's Amendment/ Sec. 505(j) of the Federal Food, Drug, and Cosmetic Act]
Demonstration Program to Integrate Quality Improvement and Patient Safety Training into Clinical Education of Health Professionals	Permits the Secretary to award grants to eligible entities or consortia to implement demonstration projects to develop and implement academic curricula that integrate quality improvement and patient safety in the clinical education of health professionals. Such awards shall be made on a competitive basis and pursuant to peer review. Discusses grant eligibility requirements. Matching funds requirements (not less than $1 for each $5 of federal funds) apply. Not later than 2 years after the date of enactment, and annually thereafter, the Secretary shall submit a report to various Congressional committees. [Sec. 3508]
Office of Women's Health	Establishes within the Office of the Secretary an Office of Women's Health to address various health concerns of women. Establishes a National Women's Health Information Center to facilitate the exchange of information relating to various preventative health matters and to coordinate efforts to promote women's health programs and policies with the private sector. Permits the Secretary to make grants to, and enter into cooperative agreements, and contracts with public and private entities, agencies, and organizations.

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	Not later than one year after the date of enactment, and every second year thereafter, the Secretary shall prepare and submit to appropriate committees of Congress a report describing these activities. Establishes within the Centers for Disease Control and Prevention, an Office of Women's Health, within the Office of the Director, an Office of Women's Health and Gender-Based Research, within the Office of the Administrator of the Health Resources and Services Administration an Office of Women's Health, within the Office of the Commissioner, an Office of Women's Health. Lists similar duties of each Office. [Sec. 3509 of the Act/Sec. 229 of the PHSA]
Administrative Simplification	*Standardization of Coverage Documents*: Directs the Secretary to, not later than 12 months after enactment, develop standards for use by group health plans (and issuers offering group or individual coverage) in compiling and providing enrollees with a summary of benefits and coverage explanation. Requires the Secretary to consult with the NAIC and a working group of stakeholders. Requires that the outline of coverage: • must not exceed four pages and does not have print smaller than 12-point font; • has language that is presented in a culturally and linguistically appropriate manner and that uses terminology understandable by the average enrollee; • includes uniform definitions of standard insurance terms; • has a description of coverage, including the dollar amount for the following benefits: daily hospital room and board, miscellaneous hospital services, surgical services, anesthesia services, physician services, prevention and wellness services, prescription drugs, other benefits as identified by the Secretary; and • includes the exceptions, reductions and limitations on coverage, the cost-sharing provision, the renewability and continuation of coverage provisions, a statement whether the plan provides minimum essential coverage, a statement that the outline is a summary of the policy and that the coverage document itself should be consulted to determine the governing contractual provisions, a contact number for the consumer to call with additional questions, and a web link where a copy of the actual individual coverage policy or group certificate of coverage can be reviewed and obtained. [Sec. 1001 of the Act/Sec. 2715 of the PHSA] Not later than 24 months after enactment, requires each entity (a health insurance issuer (including a group health plan) offering health insurance coverage (including carriers under the FEHB Program) and the Secretary with respect to coverage under Medicare, Medicaid, and CHIP) to deliver an outline of coverage to each applicant at the time of application, an enrollee at the time of enrollment, or a policyholder at the time of issuance of the policy. [Sec. 1001 of the Act/Sec. 2715 of the PHSA] Requires the standards for the outline of coverage summary to preempt any related state standards that require an outline of coverage. Fines an entity up to $1000 for each willful failure to provide this information. [Sec. 1001 of the Act/Sec. 2715 of the PHSA] *Standardization of Medical Terms:* Requires Secretary of HHS to promulgate regulations for the development of standard definitions of

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	terms used in health insurance coverage and medical terms, including: premium, co-insurance, co-payment, out-of-pocket limit, preferred provider, non-preferred provider, out-of-network co-payments, UCR fees, excluded services, grievance and appeals, hospitalization, hospital outpatient care, emergency room care, physician services, prescription drug coverage, durable medical equipment, home health care, skilled nursing care, rehabilitation services, hospice services, emergency medical transportation, and any other terms determined by the Secretary. [Sec. 1001 of the Act/Sec. 2715 of the PHSA] Requires the uniform outline of coverage document to be provided to: • applicants at the time of application; • enrollees at the time of enrollment; • policyholder or certificate holders at the time the policy is issued or the certificate is delivered. [Sec. 1001 of the Act/Sec. 2715 of the PHSA] Requires the Secretary to adopt and regularly update standards, implementation specifications, and operating rules for the electronic exchange and use of health information for the purposes of financial and administrative transactions. Requirements for standards, implementation specifications, and operating rules include: • Requiring minimal augmentation by paper transactions or clarifications by phone calls; • Enabling the real time determination of a patient's financial responsibility at the point of service and, prior to service, including whether a patient is eligible for a specific service with a specific physician at a specific facility which may include a machine-readable health plan identification card; • Providing for timely acknowledgement; and • Ensuring that all data elements within a standard, specification, or criteria be described in unambiguous terms. [Sec. 1104 of the Act] Allows the Secretary to use interim final rule-making to adopt operating standards. Requires the Secretary to consider recommendations for operating rules developed by a qualified nonprofit entity that meets specified requirements. Requires the National Committee for Vital and Health Statistics to review the operating rules developed by the nonprofit entity, determine if the operating rules represent a consensus view of the health care industry, and recommend to the Secretary rules to be adopted. [Sec. 1104 of the Act] Requires the following rule adoption and implementation deadlines: • Eligibility verification and claims status operating rules must be adopted by July 1, 2011, and effective by January 1, 2013; • Claims remittance/payment, and electronic funds transfer operating rules must be adopted by July 1, 2012, and effective by January 1, 2014; and • Other operating rules (including health claims or equivalent encounter information, enrollment and disenrollment in a health plan, health plan premium payments, and referral certification and authorization) must be adopted by July 1, 2014, and effective by January 1, 2016. Requires a health plan to file a statement with the Secretary confirming compliance with these operating rules. [Sec. 1104 of the Act] Requires health insurance plans to comply with HIPAA operating rules adopted by the Secretary by April 1, 2014, or face a penalty ($1

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	per covered life until certification is complete not to exceed $20 per covered life (or not to exceed $40 per covered life if the plan knowingly provided inaccurate or incomplete information)). Requires the Secretary to establish a process with a reasonable notice and dispute resolution mechanism before penalties could be assessed. Creates a process for periodic review and updates to all HIPAA standards. [Sec. 1104 of the Act] Requires the Secretary to promulgate a final rule to establish a unique health plan identifier based on the input of the National Committee of Vital and Health Statistics. Requires the rule to be effective by October 1, 2012. Requires the Secretary to promulgate a final rule to establish a standard for electronic funds transfer, which must be adopted not later than January 1, 2012, and effective not later than January 1, 2014. Requires the Secretary to adopt a final rule establishing a transaction standard for health claims attachments, which must be final not later than January 1, 2014, and effective not later than January 1, 2016. [Sec. 1104 of the Act] Requires that a plan or coverage that is not offered through an Exchange shall only be required to submit the information required to the Secretary and the State insurance commissioner, and make such information available to the public. [Sec. 1001 of the Act/Sec. 2715A of the PHSA]
Patient Navigator Program	Prohibits the Secretary from awarding grants to an eligible entity (including public or nonprofit private health centers, hospitals, cancer centers, rural health clinics, or academic health centers) under the Patient Navigator Outreach and Chronic Disease Prevention program unless such entity provides assurances that patient navigators recruited, assigned, trained, or employed using grant funds meet minimum core proficiencies (as defined by the entity submitting the application) that are tailored for the main focus or intervention of the navigator involved. Authorizes appropriations of $3.5 million for FY 2010 and as may be necessary for fiscal years 2011 through 2015. [Sec. 3510]
National Prevention, Health Promotion and Public Health Council	Requires the President to establish the National Prevention, Health Promotion and Public Health Council ("the Council"), to be comprised of representatives from designated federal agencies, to: • provide coordination and leadership with respect to prevention, wellness, health promotion practices, and the public health system; • after obtaining input from relevant stakeholders, develop a strategy to improve the health status of Americans and reduce the incidence of preventable illness; • make recommendations to the President and Congress concerning the country's most pressing health challenges; and • consider and propose evidence-based models, policies, and innovative approaches for the promotion of transformative models of prevention, integrative health, and public health on individual and community levels. The President shall establish the Advisory Group on Prevention, Health Promotion, and Integrative and Public Health ("Advisory

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	Group"), comprised of 25 licensed health professionals, to operate within HHS and report to the Surgeon General. The Advisory Group shall develop policy and program recommendations, and advise the Council. [Sec. 4001(a)-(f)]
National Prevention, Health Promotion and Public Health Council Strategy	No later than one year after enactment, the Chairperson of the Council, in consultation with the Council, shall develop and make public a national prevention, health promotion, and public health strategy, to be revised periodically. The strategy shall set specific goals for improving health in the United States, establish specific and measureable actions and timelines to carry out the strategy, and make recommendations to improve federal efforts. No later than July 1, 2010 (and annually thereafter through January 1, 2015), the Council shall report to the President and Congress on prevention and health promotion efforts, national progress, priorities, and plans. No less than every five years, the Secretary of HHS and Comptroller General of the U.S. shall conduct periodic reviews and evaluations of the programs and post the analyses on agencies' websites. [Sec. 4001(g)/(h)]
Public and Private Health Investment Fund / Prevention and Wellness Trust	Establishes the Prevention and Public Health Investment Fund ("Investment Fund"), to be administered through the Office of the Secretary, to provide for expanded and sustained national investment in prevention and public health programs to improve health and help restrain the rate of cost growth in the private and public sectors. Investment Fund amounts are to be appropriated out of moneys in the Treasury as follows: • $500,000,000 for FY 2010 • $750,000,000 for FY 2011 • $1,000,000,000 for FY 2012 • $1,250,000,000 for FY 2013 • $1,500,000,000 for FY 2014 • $2,000,000,000 for FY 2015 and beyond The Secretary shall transfer amounts in the Fund to accounts within HHS to increase funding, over the fiscal year 2008 level, for programs authorized by the PHSA for prevention, wellness and public health activities. [Sec. 4002]
Clinical Preventive Services and Community Preventive Services Task Forces	Requires the Directors of AHRQ and the CDC to convene an independent Prevention Services Task Force and Community Preventive Services Task Force, respectively, comprised of individuals with appropriate expertise. The former shall focus its attention on the review of clinical preventive services measures; the latter shall focus its attention on the review of population-based services. The duties of the Task Forces shall include:

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	• development of additional topic areas for recommendation; • review of interventions and updating recommendations (at least once every 5 years); • improvement of integration with federal health objectives and related target setting for health improvement; • enhanced dissemination of recommendations; and • annual reports to Congress and related agencies identifying gaps in research and recommending areas deserving further examination. AHRQ shall provide ongoing support for Prevention Services Task Force operations, and the CDC for Community Preventive Services Task Force operations. The Task Forces shall coordinate their work. Authorizes sums necessary to carry out the Task Forces' activities. [Sec. 4003]
Education and Outreach Campaign Regarding Preventive Benefits	The Secretary shall provide for the planning and implementation of a national public-private partnership for a prevention and health promotion outreach and education campaign to raise public awareness of health improvement across the life-span. Requires the Campaign to: • describe the importance of utilizing preventive services to promote wellness, reduce health disparities, and mitigate chronic disease; • promote the use of preventive services recommended by the USPSTF and the Community Preventive Services Task Force; • encourage healthy behaviors linked to the prevention of chronic diseases; • explain the preventive services covered under health plans offered through an Exchange; • describe additional preventive care supported by the CDC and other appropriate agencies; and • provide general health promotion information. Requires HHS to consult with IOM to provide ongoing advice on evidence-based scientific information for policy, program development, and evaluation. No later than one year after enactment, the Secretary, acting through the Director of CDC, shall establish and implement a national science-based media campaign on health promotion and disease prevention, to be evaluated every two years. The Secretary, acting through the Director, shall implement a plan for dissemination of information through providers, and shall contract with a qualified entity for the development and operation of a federal internet website personalized prevention plan tool. The Secretary shall provide guidance and relevant information to states and providers regarding preventive and obesity-related services available to Medicaid enrollees and, no later than January 1, 2011 and every three years thereafter though January 1, 2017, shall report to Congress on these efforts.

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	Authorizes sums necessary to carry out this section. [Sec. 4004]
Increasing Access to Clinical Preventive Services: School Based Health Clinics	The Secretary shall award grants to support the operation of school-based health centers. To be eligible for a grant an entity shall: • be a SBHC (as defined in the SSA; providing, at a minimum, comprehensive primary health services during school hours in accordance with standards; and not performing abortions) or sponsoring facility; and • submit an application. In awarding grants, the Secretary shall give preference to those entities serving large populations of Medicaid-eligible children, and may waive application requirements if good cause is shown. Funds may be used for acquiring and leasing equipment, providing training related to the provision of health services, management and operation of clinic programs, and payment of salaries for physicians, nurses, and other personnel of the clinic. Funds may not be used to provide abortions. Each eligible entity that receives a grant shall provide, from nonfederal sources, an amount equal to 20 percent of the grant to carry out its activities. This requirement may be waived should it result in serious hardship. The Secretary shall develop and implement a plan for evaluating SBHCs and monitoring their performance. [Sec. 4101 of the Act/Sec. 399Z-1 of the PHSA]
Increasing Access to Clinical Preventive Services: Oral Health Prevention	The Secretary, acting through the Director of the CDC and in consultation with professional oral health organizations, shall establish a five-year national, public education campaign ("the campaign") that focuses on oral healthcare prevention and education. The Secretary shall ensure that campaign activities are targeted toward specific populations (such as children, pregnant women and the elderly) and utilize science-based strategies to convey oral health prevention messages. In addition, the Secretary, acting through the Director of the CDC, shall award demonstration grants to eligible entities to demonstrate the effectiveness of research-based disease management activities. The Secretary shall use the results of these demonstrations in implementing a public education campaign. Authorizes sums necessary for FYs 2010-2014.

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	The Secretary shall update specified national oral healthcare surveillance activities. [Sec. 4102 of the Act/Secs. 399LL, 399LL-1, and 399LL-2 of the PHSA]
Community-based Overweight and Obesity Prevention Program	Appropriates $25,000,000 for the Secretary to carry out this function for the period of FYs 2010-2014. [Sec. 4306 of this Act/Sec. 1139A(e)(8) of the SSA]
Community Transformation Grants	The Secretary, acting through the Director of the CDC, shall award competitive grants to state and local government agencies and community-based organizations to implement, evaluate, and disseminate evidence-based community preventive health activities to reduce chronic disease rates, address health disparities, and develop a stronger evidence-base of effective prevention programming. No less than 20 percent of the grants shall go to rural and frontier areas. To be eligible to receive such grants, entities must: • be a state or local government agency, a national network of community-based organizations, a state or local nonprofit, or an Indian tribe; • submit an application to the Director; and • demonstrate a history or capacity to develop relationships necessary to engage key stakeholders from multiple sectors across a community. Entities receiving grants shall use funds to: • create a healthier school environment (e.g., healthy food options and physical activity); • create an infrastructure to support active living and access to nutritious foods; • develop and promote programs targeting a variety of age levels to increase nutrition, physical activity, smoking cessation, and safety; • address special population needs; • work to highlight healthy food options; • assess and implement worksite wellness programs; and • prioritize strategies to reduce racial and ethnic disparities. Eligible entities shall use amounts awarded to conduct activities to measure progress, and shall report annually to the Director on such evaluations. Requires the Director to develop programs to provide training on effective strategies for prevention and chronic disease control, and to provide feedback and technical assistance to grantees.

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	Authorizes appropriated sums as may be necessary to carry out this section for each of FYs 2010-2014. [Sec. 4201]
Healthy Aging	The Secretary, acting through the Director of the CDC, shall award grants to state or local health departments and Indian tribes to carry out 5-year pilot programs to provide public health community interventions, screenings, and clinical referrals for individuals between 55 and 64 years of age. To be eligible to receive a grant, an entity shall: • be a state or local health department or Indian tribe; • submit an application to the Secretary; • design a strategy to improve the health of the designated population through community-based public health intervention; and • demonstrate a capacity to develop necessary relationships with relevant agencies, providers, community-based organizations, and insurers to carry out required activities. Entities awarded grant money shall use the funds to: • develop and implement public health intervention activities (e.g., improving nutrition, reducing tobacco use); • conduct ongoing health screenings to identify risk factors for disease; • ensure that individuals with risk factors receive clinical referral/treatment (including assistance in determining insurance status); and • measure changes in the prevalence of risk factors among participants. Requires the Secretary to conduct an annual evaluation of the effectiveness of the pilot project and assess possible changes to such program. Authorizes sums necessary to carry out these requirements for FYs 2010-2014. *Evaluation and Plan for Community-Based Prevention and Wellness Programs for Medicare Beneficiaries*: The Secretary shall conduct an evaluation of community-based prevention and wellness programs and develop a plan for promoting healthy lifestyles and chronic disease self-management for Medicare beneficiaries. No later than September 30, 2013, the Secretary shall report to Congress on recommendations for legislative and administrative action to promote healthy lifestyles and disease management, any relevant findings, and the results of the evaluation. Appropriates $50,000,000 to CMS from the federal Hospital Insurance Trust and Federal Supplemental Medical Insurance Trust Funds for these purposes. [Sec. 4202]

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Standards for Accessing Medical Diagnostic Equipment	No later than 24 months after enactment, the Architectural and Transportation Barriers Compliance Board, in consultation with the Commissioner of the FDA, shall promulgate, and periodically review, standards for medical diagnostic equipment used in physicians' offices, clinics, emergency rooms, hospitals, and other medical settings, ensuring usability by individuals with accessibility needs. [Sec. 4203 of the Act/Sec. 510 of the Rehabilitation Act of 1973]
Immunizations	Allows the Secretary to negotiate and enter into contracts with vaccine manufacturers to purchase and deliver vaccines for adults provided vaccines under specified grants. A state may obtain additional quantities of such vaccines through manufacturers at a price negotiated by the Secretary. The Secretary, acting through the Director of the CDC, shall establish a demonstration program to award grants to states to improve the provision of recommended immunizations for children, adolescents, and adults through the use of evidence-based, population-based interventions for high-risk populations. States must submit an application to the Secretary to receive funds, and, upon receipts, shall use the money to, among other activities: • provide immunization reminders to target populations; • educate target populations concerning immunizations; • reduce out-of-pocket costs for families for vaccines; and • carry out immunization promoting activities. No later than 3 years after receiving a grant, a state shall submit an evaluation of its progress to the Secretary. No later than 4 years after enactment, the Secretary shall report to Congress on the effectiveness of the program. Authorizes sums necessary to carry out this section for FYs 2010-2014. *GAO Study and Report on Beneficiary Access to Vaccines*: Requires GAO to study and report to Congress, no later than June 1, 2011, on the impact of coverage of adult immunizations under Part D on access to those immunizations by Medicare beneficiaries. Appropriates $1,000,000 from the Treasury for FY 2010 to carry out this provision. [Sec. 4204 of the Act/Sec. 317 of the PHSA]
Nutrition Labeling	Requires a restaurant or similar food establishment that is part of a chain with 20 or more locations to disclose specified information on its food offerings, including a nutrient content disclosure statement with the number of calories contained in the food item, and a succinct statement concerning suggested daily caloric intake as specified by the FDA. Includes exceptions to such requirements. Establishes similar requirements for packaging on vending machine items.

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	[Sec. 4205 of the Act/Sec. 403 of the Federal Food, Drug, and Cosmetic Act]
Individualized Wellness Plan Demonstration Project	The Secretary shall establish a pilot program to test the impact of providing at-risk populations who utilize community health centers an individualized wellness plan designed to reduce risk factors for preventable conditions as identified by a comprehensive risk-factor assessment. The Secretary shall enter into agreements with no more than 10 community health centers to conduct activities under the pilot program. Wellness plan risk factors shall include weight, tobacco and alcohol use, exercise rates, nutritional status, and blood pressure. Individualized wellness plans shall make comparisons between the individual involved and a control group of individuals with respect to the risk factors described. Authorizes sums necessary to carry out this section. [Sec. 4206 of the Act/Sec. 330 of the PHSA]
Reasonable Break Time for Nursing Mothers	Employers shall provide a reasonable break time for an employee to express breast milk for one year after the employee's child's birth, and shall provide a private place for such purpose. Does not apply to employers with less than 50 employees, if such requirements would impose an undue hardship. [Sec. 4207 of the Act/Sec. 7 of the Fair Labor Standards Act]
Support for Prevention and Public Health	The Secretary, acting through the Director of the CDC, shall fund research in the areas of public health services and systems, including: • examining evidence-based practices relating to prevention, and comparing community-based public health interventions in terms of effectiveness and cost; • analyzing the translation of interventions from academic settings to real world settings; and • identifying effective strategies for organizing, financing, or delivering public health services. Requires the Secretary to submit an annual report to Congress on these activities and findings. [Sec. 4301]

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Data Collection, Analysis, and Quality	Requires the Secretary, no later than 2 years after enactment, to develop reporting requirements for use by group health plans and issuers offering group and individual health insurance coverage with respect to plan or coverage benefits and health care provider reimbursement structures that: • Improve health outcomes through activities such as quality reporting, case management, care coordination, chronic disease management, and medication and care compliance initiatives; • Implement activities to prevent hospital readmissions through a comprehensive program for hospital discharge; • Implement activities to improve patient safety and reduce medical errors through the use of best clinical practices; and • Implement wellness and health promotion activities. Requires group health plans and health insurance issuers offering group or individual coverage to annually submit a report on whether the benefits satisfy the elements above. Reports will be published on a public website. For the purposes of subsection, wellness and health programs may include the following wellness and prevention efforts: • Smoking cessation; • Weight management; • Stress management; • Physical fitness; • Nutrition; • Heart disease prevention; • Healthy lifestyle support; and • Diabetes prevention. [Sec. 1001 of the Act/Sec. 2717 of PHSA] No later than 2 years after enactment, the Secretary shall ensure that federally-supported health care or public programs collect data on race, ethnicity, gender, geographic location, socioeconomic status, primary language, disability status, and any other demographic data deemed appropriate by the Secretary. In collecting data, the Secretary shall use OMB standards for race and ethnicity measures, and develop other standards for other data measures. The Secretary, acting through the National Coordinator for HIT, shall develop national standards for management of data collected and develop interoperability and security systems for data management. Requires the Secretary to report its analysis to various federal agencies, publish the analysis on the HHS website, and make data available for research. The Secretary shall ensure that data is protected by privacy protections that are at least as stringent as those promulgated under HIPAA, and that all appropriate safeguards are in place. The Secretary shall establish procedures for sharing data with other federal and state

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	agencies. Requires the Secretary to ensure that any data collected regarding racial and ethnic minority groups are also collected regarding underserved rural and frontier populations. Authorizes sums necessary to carry out this section for FYs 2010-2014. Data may not be collected unless funds are directly appropriated for such purpose. *Addressing Health Care Disparities in Medicaid and CHIP*: The Secretary shall evaluate approaches for the collection of data on disparities in services and performance on the basis of race, ethnicity, sex, primary language, and disability status, ensuring patient privacy and minimizing administrative burdens. No later than 18 months after enactment, the Secretary shall report to Congress on the evaluation. No later than 24 months after enactment, the Secretary shall implement approaches identified in the report. [Sec. 4302 of the Act/Sec. 3101 of the PHSA/Sec. 1946 of the SSA]
CDC and Employer-based Wellness Programs	*Technical Assistance for Employer-Based Wellness Programs*: Requires the Director of the CDC to provide employers with technical assistance, consultation, and other resources in evaluating employer-based wellness programs, including measuring employee participation and methods to increase participation, developing standardized measures that assess policy changes necessary to have a positive health impact on employees' health behaviors, and evaluating programs as they relate to employee health status, absenteeism and productivity of employees. *National Worksite Health Policies and Programs Study*: No later than 2 years after enactment and at regular intervals thereafter, the Director of the CDC shall conduct a national worksite health policies and programs survey to assess employer-based wellness programs. The Director shall report to Congress with recommendations for implementing effective employer-based wellness programs. *Prioritization of Evaluation by the Secretary:* Requires the Secretary to evaluate all programs funded through the CDC before conducting such an evaluation of privately funded programs, unless an entity with a privately funded wellness program requests such an evaluation. *Prohibition of Federal Workplace Wellness Requirements:* Prohibits any mandate requirements for workplace wellness programs. [Sec. 4303 of the Act/Secs. 399MM, 399MM-1, 399MM-2, and 399MM-3 of the PHSA]
Grants for Small Businesses to Provide Comprehensive Workplace Wellness	The Secretary shall provide 5-year grants to eligible employers to provide their employees with access to comprehensive workplace wellness programs. "Eligible employer" means an employer who employs less than 100 employees who work 25 hours or more each week, and does not provide such a program as of the date of enactment. To receive funding, eligible employers must submit an application, which shall include a proposal for a wellness program that meets designated requirements and criteria.

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Programs	Appropriates $200,000,000 for the period of FYs 2011-2015, to be available until expended. [Sec. 10408 of the Manager's Amendment]
Cures Acceleration Network	Establishes a Cures Acceleration Network (CAN) within the Office of the Director of NIH to conduct and support advances in basic research; award competitive grants and contracts to eligible entities to accelerate the development of high-need cures; provide the resources necessary for government agencies, research organization, biotech companies, and other entities to develop high-need cures; reduce barriers between laboratory discoveries and clinical trials for new therapies; and facilitate FDA review of the high-need cures funded by CAN. "Eligible entity" means a public or private entity (may include a research institution, an institution of higher education, a medical center, a biotech company, a disease advocacy or patient advocacy organization, or an academic research institution) which submits the appropriate application and provides any additional information required by the Director of NIH. CAN shall be administered by a 24-member Board, appointed by and serving at the pleasure of the Secretary, with expertise in research, medicine, biopharm, discovery and delivery of medical products, bioinformatics, medical instrumentation, and regulatory review and approval of medical products (at least 1 individual who is imminent in each of these fields). In addition, at least 4 individuals shall be recognized leaders in venture capital or private equity, and at least 8 shall represent disease advocacy organizations. The Board shall advise and provide recommendations to the Director of NIH. Appropriates $500,000,000 for FY 2010, and sums necessary for succeeding FYs, to fund the grant programs established in this section. [Sec. 10409 of the Manager's Amendment/Sec. 402C of the PHSA]
Epidemiology-Laboratory Capacity Grants	The Secretary, acting through the Director of the CDC, shall establish an Epidemiology and Laboratory Capacity Grant Program to award grants to eligible entities to assist public health agencies in improving surveillance for, and response to, infectious disease and other conditions of public health importance by: • strengthening epidemiological capacity; • enhancing laboratory practice; • improving information systems; and • developing and implementing prevention and control strategies. Authorizes appropriations of $190,000,000 for each of FYs 2010-2013. [Sec. 4304 of the Act/Sec. 2821 of the PHSA]

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Pain Research at NIH	Encourages the Director of NIH to continue and expand, through the Pain Consortium, an aggressive program of basic and clinical research on the causes of and potential treatments for pain. Requires the Pain Consortium to make annual recommendations on appropriate pain research activities. No later than one year after enactment, the Secretary shall establish the Interagency Pain Research Coordinating Committee to coordinate all efforts within HHS and other federal agencies relating to pain research. [Sec. 4305 of the Act/Sec. 409J of the PHSA]
Pain Care Education and Training	*IOM Conference on Pain*: No later than one year after appropriation of funds for this provision, the Secretary shall seek to enter into an agreement with the IOM (or other appropriate entity) to convene a Conference on Pain to, among other activities, increase the recognition of pain as a significant public health concern; evaluate the adequacy of assessment, diagnosis, treatment, and management of pain across various demographic groups; and identify various barriers to appropriate pain care. A summary report shall be submitted to Congress no later than June 30, 2011. Appropriates sums necessary for each of FYs 2010 and 2011. [Sec. 4305]
Public Awareness Campaign on Pain Management	*Program for Education and Training in Pain Care*: The Secretary may provide grants, agreements, and contracts to health professions schools, hospices, and other public and private entities for the development and implementation of programs to provide education and training to health care professionals in pain care. Establishes guidelines with respect to prioritizing grants, contracts, and agreements including approved topics and program sites. Authorizes sums necessary for each of FYs 2010-2012. [Sec. 4305 of the Act/Sec. 759 of the PHSA]
Effectiveness of Federal Health and Wellness Initiatives	To determine whether existing federal health and wellness initiatives are effective in achieving their stated goals, the Secretary shall conduct an evaluation of such programs as they relate to changes in health status of the public and on the federal workforce; and submit a report to Congress concerning such evaluation. [Sec. 4402]
National Health Care Workforce Evaluation and Assessment	Establishes a National Health Care Workforce Commission ("the Commission") to review health care workforce supply and demand and make recommendations of priorities and goals to Congress and to the Administration; oversee and report to Congress on the operation of the State Health Care Workforce Development Grants established in the Act; study effective mechanisms for financing education and training for careers in health care; submit recommendations to Congress and to the Departments of HHS and Labor on improving workplace safety; and assess reports from the National Center for Health Care Workforce Analysis. Requires the Comptroller General to appoint the Commission's 15 members, representing a cross-section of stakeholders, including employers, third-party payers, the health care workforce, consumers, and labor unions. The Comptroller General shall establish a system for public disclosure by members of the Commission of financial or other potential conflicts of interest. Members would serve for 3 years, and would be compensated. The Comptroller General shall make initial appointments of members no later than September 30, 2010. The Commission would meet at least on a quarterly basis.

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	The Commission shall consult with federal, state, and local agencies, Congress, and other organizations (e.g., MEDPAC and other public-private health care partnerships). It may, consistent with applicable privacy rules, secure necessary information from any department or agency, and may detail federal government employees without reimbursement. The GAO shall have unrestricted access to all of the Commission's data, and the Commission shall be subject to periodic audit. Appropriates sums necessary to carry out these provisions. In addition, the Commission may accept gifts to this end. [Sec. 5101]
State Health Care Workforce Development Grants	Establishes a competitive health care workforce development grant program ("the Program") to enable state partnerships to complete comprehensive planning and to facilitate workforce strategies at the state and local levels. The Health Resources and Services Administration ("the Administration") would oversee operation of the Program, in consultation with the Commission, and would serve as the Program's fiscal and administrative agent. *Planning Grants*: Planning grants shall be awarded for a period of no more than one year and for an amount not exceeding $150,000. Eligible partnerships shall apply for and receive planning grants. (Defines an "eligible partnership" as a state workforce investment board that includes representatives from specified stakeholder groups, including health care employers, labor organizations, and the recognized state federation of labor.) The governor of a recipient state has the authority to appoint a fiscal and administrative agency for the partnership. Partnerships receiving a grant shall carry out a number of required activities relating to workforce development, and shall provide a match (in an amount no less than 15 percent of the amount of the grant) to carry out its work. No later than one year after receiving a grant, a partnership shall report to the Administration on the state's performance; the Administration, in turn, shall submit an analysis to Congress on each state's activity. *Implementation Grants*: The Administration shall recommend recipients of implementation grants, awarded for a period of no more than 2 years, to the fiscal and administrative agent. These competitive grants would enable partnerships that have received a planning grant and completed all its requirements to implement activities that would address workforce demands within the state. A partnership seeking grant money must provide specified information, including a budget proposal and planned activities, in its application. Partnerships receiving a grant shall carry out a number of required activities relating to workforce development, and shall provide a match (in an amount no less than 25 percent of the amount of the grant) to carry out its work. For each year of the grant, a partnership shall report to the Administration on the state's performance; the Administration, in turn, shall submit an analysis to Congress on each state's activity. Appropriates $8,000,000 for FY 2010 and sums necessary for each subsequent fiscal year to award planning grants. Authorizes $150,000,000 for FY 2010 and sums necessary for each subsequent fiscal year to award implementation grants.

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	[Sec. 5102]
Health Care Workforce Program Assessment	*National Center for Health Workforce Analysis*: The Secretary shall establish the National Center for Health Workforce Analysis ("the National Center") which shall, in collaboration with the Commission: • provide for the development of information describing and analyzing the health care workforce and related issues; • evaluate the effectiveness of programs on an annual basis; • develop and publish performance benchmarks; • establish, maintain, and make public on the internet a national health workforce database; and • establish and maintain a registry of each grant awarded. The Center shall collaborate with federal agencies and professional and educational organizations for purposes of linking data, and may contract with such organizations to carry out these activities. *State and Regional Centers for Health Workforce Analysis*: The Secretary shall award grants to, or enter into contracts with, eligible entities to collect, analyze, and report program data, and provide technical assistance to local and regional entities on the collection, analysis, and reporting of data. (Defines an "eligible entity" as a state, a state workforce investment board, a public health or health professions school, an academic health center, or appropriate public or private nonprofit entity that submits an appropriate application to the Secretary.) The Secretary shall increase the amount of a grant or contract for the longitudinal evaluation of individuals who have received education, training, or financial assistance from programs. Appropriates $7,500,000 for each of FYs 2010-2014 to the National Center, $4,500,000 for each of FYs 2010-2014 to the State and Regional Centers, and sums necessary for FYs 2010-2014 to grants for longitudinal evaluations. No later than 180 days after enactment, all of the operations of the National Center for Health Workforce Analysis of the Health Resources and Services Administration shall be transferred to the National Center. [Sec. 5103]
Increasing the Supply of the Health Care Workforce	*Federally Supported Student Loan Funds; Nursing Student Loan Program*: Provides that students failing to comply with the terms of medical school and primary care federally-supported loans shall be assessed an interest rate of 2 percent greater than if they had complied. Also amends loan agreements under the Nursing Student Loan Program. [Secs. 5201-5202 of the Act/Secs. 723 and 836 of the PHSA] *Health Care Workforce Loan Repayment Programs*: Requires the Secretary to establish and carry out a pediatric specialty loan repayment program under which the eligible individual agrees to be employed full-time for a specified period (no less than 2 years) in providing pediatric medical sub-specialty, pediatric surgical specialty, or child and adolescent mental and behavioral health care.

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	[Defines an "eligible individual" as a qualified health professional (as defined in the Act) who agrees to work in, or for a provider serving, a health professional shortage area or medically-underserved area, or to serve a medically-underserved population; is a U.S. citizen or permanent resident enrolled in an accredited program; and who has acceptable academic standing.] Appropriates $30,000,000 for each of FYs 2010-2014 to carry out provisions relating to pediatric medical and surgical specialists, and $20,000,000 for each of FYs 2010-2014 for child and adolescent mental health professionals. [Sec. 5203 of the Act/Sec. 775 of the PHSA] *Public Health Workforce Recruitment and Retention Programs*: The Secretary shall establish the Public Health Workforce Loan Repayment Program ("the Program") to assure an adequate supply of public health professionals to eliminate critical shortages in federal, state, local, and tribal public health agencies. To be eligible to participate, an individual must: • be accepted for enrollment (or be enrolled) as a student in an accredited academic institution in a final year of a course of study leading to a public health or health professions degree, and have accepted employment with a federal, state, local, or tribal public health agency or related training fellowship to commence upon graduation; • have graduated, during the preceding 10-year period, from an accredited educational institution and received a public health or health professions degree / be employed by (or have accepted employment with) a federal, state, local, or tribal public health agency or related training fellowship; • be a U.S. citizen; • submit an application to the Secretary and execute the required written contract with the Secretary; and • have not received, for the same service, a reduction of loan obligations under section 455(m), 428J, 428K, 428L, or 460 of the Higher Education Act of 1965. (The written contract specifies that the Secretary will repay the loan, that the individual will serve as a full-time employee for a period of either 3 years or such longer time specified by the Secretary, that the individual shall relocate to a priority service area in exchange for an additional loan repayment incentive, and that any financial obligation is contingent on funds being appropriated. It also specifies damages to which the U.S. is entitled in the event of a breach.) For each year of an individual's service, the Secretary may pay up to $35,000 on behalf of the individual. Appropriates $195,000,000 for FY 2010 and sums necessary for each of FYs 2011-2015. [Sec. 5204 of the Act/Sec. 776 of the PHSA] *Grants for State and Local Programs*: The Secretary may make grants to, or contract with, any eligible entity to award scholarships to eligible individuals to enroll in degree or professional training programs for purposes of enabling mid-career professionals in the public health and allied health workforce to receive additional training. Appropriates $60,000,000 for FY 2010 and sums necessary for each of FYs 2011-2015, with half going to each of the public health and allied health mid-career professionals. (Defines an "eligible entity" as an accredited institution that offers a course of study, certificate program, or professional training program in public or allied health or a related discipline. Defines an "eligible individual" to include those employed in public health positions who are interested in advancing their education.) [Sec. 5206 of the Act/Secs. 765 and 777 of the PHSA] *Funding for National Health Service Corps*: Appropriates the following amounts for funding the National Health Service Corps: • $320,461,632 for FY 2010

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	• $414,095,394 for FY 2011 • $535,087,442 for FY 2012 • $691,431,432 for FY 2013 • $893,456,433 for FY 2014 • $1,154,510,336 for FY 2015 • for FY 2016 and beyond, the amount appropriated for the preceding year, adjusted by the product of 1) one + the average percentage increase in the costs of health professions education during the prior FY, and 2) one + the average percentage change in the number of individuals residing in health professions shortage areas during the prior fiscal year relative to the number during the previous fiscal year. [Sec. 5207] *Establishing a Ready Reserve Corps*: Establishes a commissioned Regular Corps and a Ready Reserve Corps for service in time of national emergency. Appropriates $5,000,000 for each of FYs 2010-2014 for recruitment and training and $12,500,000 for each of FYs 2010-2014 for the Ready Reserve Corps. [Sec. 5210 of the Act/Sec. 203 of the PHSA]
Community Health Centers and the National Health Service Corps Fund	Establishes a Community Health Center Fund ("CHC Fund"), administered through the Office of the Secretary, to provide for expanded and sustained national investment in community health centers under the National Health Services Corps and section 330 of the PHSA. Authorizes the transfer to the Secretary of: • $290,000,000 for FY 2011, • $295,000,000 for FY 2012, • $300,000,000 for FY 2013, • $305,000,000 for FY 2014, and • $310,000,000 for FY 2015 to provide enhanced funding for the National Health Service Corps; and • ~~$700,000,000~~ $1,000,000,000 for FY 2011, • ~~$800,000,000~~ $1,200,000,000 for FY 2012, • ~~$1,000,000,000~~ $1,500,000,000 for FY 2013, • ~~$1,600,000,000~~ $2,200,000,000 for FY 2014, and • ~~$2,900,000,000~~ $3,600,000,000 for FY 2015 to provide enhanced funding for the community health center program under section 303 of the PHSA. In addition, appropriates out of any monies in the Treasury not otherwise appropriated, $1,500,000,000 to be available for FYs 2011-2015 for use by the Secretary for construction and renovation of community health centers. These appropriations shall be available until expended.

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	[Sec. 10503 of the Manager's Amendment/Sec. 2303 of the Reconciliation Bill]
Demonstration Project to Provide Access to Affordable Care	No later than 6 months after enactment, the Secretary, acting through the Health Resources Administration, shall establish a 3-year demonstration project in up to 10 states to provide access to comprehensive health care services to the uninsured at a reduced rate. Each state in which a participant is selected shall receive $2,000,000 to establish and carry out the program. The Secretary shall assess the feasibility of expanding the project to other states. To be eligible to participate, an entity shall be a state-based, nonprofit, public-private partnership that provides access to comprehensive health care services to the uninsured at a reduced rate. Appropriates sums necessary. [Sec. 10504 of the Manager's Amendment]
Enhancing Health Care Workforce Education and Training	*Training in Family Medicine, General Internal Medicine, General Pediatrics, and Physician Assistantship*: The Secretary may make grants to, or contract with, an accredited public or nonprofit hospital, medical school, affiliated PA program, or public or private nonprofit entity to support and develop primary care training programs. The duration of awards shall be 5 years. Appropriates $125,000,000 for FY 2010 and sums necessary for FYs 2011-2014, with 15 percent allocated to PA training programs. Appropriates $750,000 for each of FYs 2010-2014 for programs that integrate academic administrative units. [Sec. 5301 of the Act/Sec. 747 of the PHSA] *Training Opportunities for Direct Care Workers*: Requires the Secretary to award grants to eligible entities to enable new training opportunities for direct care workers who are employed in long-term care settings (e.g., nursing homes, assisted living facilities, and home and community-based settings). (Defines an "eligible entity" as an accredited institute of higher education that has established a public-private educational partnership with a long-term care provider and submits an appropriate application.) Entities receiving funds shall use the awarded amounts to provide assistance to eligible individuals to offset the cost of tuition for enrollment in the entity's academic programs. As a condition of receiving assistance, the individual must agree to work in the field for a minimum of 2 years. (An "eligible individual" is enrolled in courses offered by the entity and maintains satisfactory academic progress.) Appropriates $10,000,000 for the period of FYs 2011-2013. [Sec. 5302 of the Act/Sec. 747A of the PHSA] *Training in General, Pediatric, and Public Health Dentistry*: The Secretary may make grants to, or contract with, a school of dentistry, public or nonprofit private hospital, or public or private nonprofit entity to support and develop dental training programs. Grants may be awarded to operate faculty loan repayment programs. The duration of awards shall be 5 years. Appropriates $30,000,000 for FY 2010 and sums necessary for each of FYs 2011-2015. Entities may carry over funds, but for no more than 3 years. [Sec. 5303 of the Act/Sec. 748 of the PHSA] *Alternative Dental Health Care Providers Demonstration Project*: Authorizes the Secretary to award grants to 15 eligible entities to

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	establish a demonstration program to establish training programs to train or employ alternative dental health care providers to increase access to dental services in rural and underserved communities. (Defines an "eligible entity" as: 1) an institute of higher education, public-private partnership, federally-qualified health center, Indian Health Service facility, state or county public health clinic, or public hospital; 2) is within an accredited program; and 3) submits an appropriate application to the Secretary.) Each grant shall be no less than $4 million for the 5-year period of the demonstration. The Director of IOM shall conduct a study of the demonstration projects, and gather and compare data from each. Authorizes the appropriation of sums necessary to carry out this section. [Sec. 5304 of the Act/Sec. 340G-1 of the PHSA] *Geriatric Education and Training; Career Awards:* • *Geriatric Education*: Requires the Secretary to award grants or contracts to entities that operate geriatric education centers to be used to carry out fellowship programs **and** either family caregiver training **or** incorporation of best practices concerning mental disorders common among older adults. An award shall be for $150,000, with no more than 24 geriatric education centers receiving awards. Appropriates $10,800,000 for the period of FYs 2011-2014. • *Geriatric Career Incentive Awards*: Requires the Secretary to award grants or contracts to health care professionals to foster greater interest in entering the fields of geriatrics, long-term care, and chronic care management. An individual must submit an appropriate application and, if awarded a grant, must agree to teach or practice in one of these fields for a minimum of 5 years. Appropriates $10,000,000 for the period of FYs 2011-2013. Expands eligibility for geriatric academic career awards, and authorizes the Secretary to transfer funds awarded to an individual to the institution where the individual will carry out the award. [Sec. 5305 of the Act/Sec. 753 of the PHSA] *Mental and Behavioral Health Education and Training Grants*: The Secretary may award grants to eligible institutions of higher education to support the recruitment of students for, and education and clinical experience of the students in, behavioral and mental health education programs, as well as state-licensed mental health nonprofit and for-profit organizations. An institution must demonstrate: • participation in its programs by a diverse group of individuals; • understanding of these individuals' concerns; • any program assisted by grant money will prioritize cultural and linguistic competency; • the institution will provide information required by the Secretary; and • the institution would pay any liquidated damages incurred by violation of the agreement. For FYs 2010-2013, appropriates $8,000,000 for training in social work, $12,000,000 for training in graduate psychology, $10,000,000 for training for professional child and adolescent mental health, and $5 million in training for paraprofessional child and adolescent work. [Sec. 5306 of the Act/Sec. 756 of the PHSA] *Cultural Competency, Prevention and Public Health, and Individuals with Disabilities Training*: The Secretary shall support the development, evaluation, and dissemination of model curricula for cultural competency, prevention, and public health proficiency and

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	aptitude for working with individuals with disabilities training for use in health professions schools and continuing education programs, and shall evaluate the adoption and facilitate the inclusion of these measures as appropriate. Authorizes sums necessary for each of FYs 2010-2015. [Sec. 5307 of the Act/Sec. 741 of the PHSA] *United States Public Health Sciences Track*: Establishes a United States Public Health Sciences Track ("the Track"), at sites to be selected by the Secretary, with authority to grant appropriate advanced degrees in a manner emphasizing team-based service, public health, epidemiology, and emergency preparedness and response. Each year, it shall graduate no less than 150 medical students (10 of whom shall be awarded studentships to the Uniformed Services University of Health Sciences), 100 dental students, 250 nursing students, 100 public health students, 100 behavioral/mental health students, 100 physician assistant or nurse practitioner students, and 50 pharmacy students. The Surgeon General shall conduct the business of the Track, including faculty appointments, developing a longitudinal plan and educational programs, and entering into contracts with designated entities for purposes of facilitating cooperative enterprises and enhancing the Track's educational initiatives. Students shall be selected under procedures prescribed by the Surgeon General and shall enter into a written contract with the Surgeon General under which the student accepts tuition and a stipend in exchange for maintaining enrollment and completing a period of obligated service upon graduation. Appropriates funds necessary beginning with FY 2010. [Sec. 5315 of the Act/Secs. 271-274 of the PHSA] *Preventive Medicine and Public Health Training Grant Program*: The Secretary, acting through the Administrator of the Health Resources and Services Administration and in consultation with the Director of the CDC, shall award grants to, or enter into contracts with, eligible entities to provide training to graduate medical residents in preventive medicine specialties. "Eligible entity" means an accredited school of public health or school of medicine or osteopathic medicine; an accredited public or private nonprofit hospital; a state, local, or tribal health department; or a consortium of 2 or more of these entities. The Secretary shall report annually to Congress on the program. Appropriates $43,000,000 for FY 2011 and sums necessary for each of FYs 2012-2015. [Sec. 10501 of the Manager's Amendment/Sec. 768 of the PHSA]
Provisions Relating to the Nursing Workforce	*Nurse-Managed Health Clinics*: Requires the Secretary to award grants for the cost of operation of nurse-managed health clinics that apply for such funding and meet certain eligibility requirements. Grant amounts shall be determined based on need. Appropriates $50,000,000 for FY 2010 and sums necessary for each of FYs 2011-2014. [Sec. 5208 of the Act/Sec. 330A-1 of the PHSA] Authorizes support for accredited nurse-midwifery programs. [Sec. 5308 of the Act/Sec. 811 of the PHSA] *Nurse Education, Practice, and Retention Grants*: The Secretary may award grants to, and contract with, eligible entities to enhance the nursing workforce by initiating and maintaining nurse retention programs. (Defines an "eligible entity" as including an accredited school of nursing, a health care facility, or a partnership of such school or facility.) Appropriates sums necessary for each of FYs 2010-2012. [Sec. 5309 of the Act/Sec. 831A of the PHSA] *Nurse Faculty Loan Program*: The Secretary, acting through the Administrator of the Health Resources and Services Administration, may enter into an agreement with "eligible individuals" for the repayment of education loans to increase the number of qualified nursing faculty. (Defines an "eligible individual" as a U.S. citizen, national, or permanent resident who holds a license as a registered nurse and

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	has either completed a masters or doctorate program at an accredited school or is currently enrolled in such a program.) The recipient shall serve as a full-time member of the faculty of an accredited school of nursing for a total period of at least 4 years during the 6 year period beginning on the date of receipt of a degree or the date of agreement, whichever is later. [Sec. 5311 of the Act/Secs. 846-847 of the PHSA] Appropriates $338,000,000 for FY 2010 and sums necessary for each of FYs 2011-2016 for purposes of carrying out parts B, C, and D of Title VIII of the PHSA. (the Nurse Faculty Loan Program exists within this Title.) [Sec. 5312 of the Act/Sec. 871 of the PHSA] *Demonstration Grants for Family Nurse Practitioner Training Programs*: The Secretary shall establish a training demonstration program for family nurse practitioners to employ and provide a 1-year training for practitioners who have graduated from a nurse practitioner program for careers as primary care providers in FQHCs and nurse-managed health clinics. Appropriates sums necessary for each of FYs 2011-2014. [Sec. 10501 of the Manager's Amendment, adding Sec. 5316 to the Act]
Skilled Nursing Facilities, Nursing Workforce, and Additional Grant Programs	*Nursing Home Transparency and Accountability*: Improves transparency of information about skilled nursing facilities (SNF) and nursing homes, enforcement of SNF and nursing home standards and rules, and training SNF and nursing home staff. Such reforms include disclosure requirements regarding the ownership of a facility and accountability requirements for SNFs to develop a compliance and ethics program. [Sec. 6101 and 6102 of the Act/ Sec. 1124 of the SSA; Adds Sec. 1128I to the SSA] *Nursing Home Compare Medicare Website*: Requires the Secretary to create a 'Nursing Home Compare' Medicare website with information for consumers. [Sec. 6103 of the Act/ Sec. 1819 of the SSA] *SNF Reporting of Expenditures*: Within two years of enactment, requires SNFs to report expenditures for wages and benefits for direct care staff, breaking out data for RNs, LPNs, CNAs, and other medical and therapy staff. Requires the Secretary to use the expenditure report data to categorize the expenditures by: • spending on direct care services (including nursing, therapy, and medical services); • spending on indirect care (including housekeeping and dietary services); • capital assets (including building and land costs); and • administrative services costs. [Sec. 6104 of the Act/ Sec. 1888 of the SSA] *Standardized Complaint Form*: Requires the Secretary to develop a standardized complaint form for use by a resident in filing a complaint with a state survey and certification agency and a state long-term care ombudsman program with respect to a SNF. Requires the state to establish a complaint resolution process. [Sec. 6105 of the Act/ Adds Sec. 1128I to the SSA] *Ensuring Staffing Accountability:* Requires the Secretary, beginning two years after enactment of this section, to require a SNF to submit staffing information based on payroll data. [Sec. 6106 of the Act/ Sec. 1128I to the SSA]

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	GAO Study and Report on Five-star Quality Rating System: Requires the GAO to study the Five-star Quality Rating System for nursing homes. Requires the study to examine how the system is being implemented, any problems with the system or its implementation, and how the system may be improved. [Sec. 6107] *Civil Money Penalty Regarding Skilled and other Nursing Facilities:* Requires the Secretary to impose a civil money penalty in the applicable per instance or per day amount for each day or instance of noncompliance. Includes reductions of civil money penalties in certain circumstances and collection processes. [Sec. 6111 of the Act/ Sec. 1819(h)(2)(B)(ii) of the SSA] *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 program to identify efficient, effective, and economical procedures for long-term care facilities or providers to conduct background checks on prospective employees. The program shall be conducted in a manner similar to the pilot program conducted under section 307 of the MMA of 2003 – including the prohibition on hiring abusive workers and the authorization of the imposition of penalties by a participating state, with certain modifications. Appropriates for FY 2010-2012 no more than $160,000,000. Provides up to $3,000,000 to the Secretary to conduct and evaluate the program. No later than 180 days after completion of the program, the Inspector General of HHS shall report to Congress on the results of the evaluation conducted under the program. [Sec. 6201] *National Independent Monitor Pilot Program:* Authorizes the Secretary, not later than 1 year after the date of the enactment of this Act, to establish a 2 year pilot program to develop, test, and implement use of an independent monitor to oversee interstate and large intrastate chains of skilled nursing facilities and nursing facilities. Responsibilities of the independent monitor include: • Conducting periodic reviews and preparing root-cause quality and deficiency analyses of a chain to assess if facilities are in compliance with state and federal laws and regulations; • Undertaking sustained oversight of the chain; • Analyzing the management structure, distribution of expenditures, and nursing staffing levels of facilities of the chain; • Reporting findings and recommendations; and • Publishing the results of such reviews, analyses, and oversight. Requires a participating chain in the pilot program to submit to the independent monitor a report regarding implementation of recommendations not later than 10 days after receipt of a finding of an independent monitor. Not later than 10 days after the date of receipt of such report, the independent monitor shall finalize its recommendations and submit a report to the Secretary and the chain. Requires the Inspector General to evaluate the pilot program and, not later than 180 days after the completion of the pilot program, submit a report to Congress. [Sec. 6112] *Notification of Facility Closure*: Mandates that any individual who is an administrator of a SNF or nursing facility submit to the

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	Secretary, the state long-term care ombudsman, residents of the facility, and the legal representatives of such residents a written notification not later than 60 days prior to an impending closure. Ensures for the relocation of residents and continuation of payments until residents are relocated. This amendment shall take effect 1 year after the date of the enactment of this Act. [Sec. 6113 of the Act/Sec. 1128I of the SSA].
Infrastructure to Expand Access to Care	Appropriates to HHS $100,000,000 for FY 2010, to remain available for obligation until September 30, 2011 for use for debt service on, or direct construction or renovation of, a health care facility, affiliated with an academic health center at a public research university that contains a state's sole public academic medical and dental school, that provides research, inpatient tertiary care, or outpatient clinical services. [Sec. 10502 of the Manager's Amendment]
Addressing the Needs of Underserved Communities	*Allied Health Workforce Recruitment and Retention Programs*: Assures an adequate supply of allied health professionals to eliminate shortages in federal, state, local, and tribal public health agencies or in settings where patients might require health care services. [Sec. 5205 of the Act/Sec. 428K of the Higher Education Act of 1965] *Grants to Promote the Community Health Workforce*: Requires the Director of the CDC, in collaboration with the Secretary, to award grants to eligible entities to promote positive health behaviors for populations in medically-underserved areas through the use of community health workers. Each entity seeking funding must submit an appropriate application. The Secretary shall encourage community health workers who receive grants to collaborate with academic institutions and one-stop delivery systems, and to implement a process or outcome-based payment system that rewards workers for connecting underserved populations with the most appropriate services at the most appropriate time. Appropriates sums necessary for each of FYs 2010-2014. [Sec. 5313 of the Act/Sec. 399V of the PHSA] *Fellowship Training in Public Health*: The Secretary may carry out activities to address documented workforce shortages in state and local health departments in the areas of applied public health epidemiology and public health laboratory science and informatics, and may expand the Epidemic Intelligence Service. Appropriates $39,500,000 for each of FYs 2010-2013, of which $5,000,000 shall be made available in each FY for epidemiology fellowship training program activities, $5,000,000 in each FY for laboratory fellowship training programs, $5,000,000 in each FY for the Public Health Informatics Fellowship Program, and $24,500,000 for expanding the Epidemic Intelligence Service. [Sec. 5314 of the Act/Sec. 778 of the PHSA] *Continuing Educational Support for Health Professionals Serving in Underserved Communities*: The Secretary shall make grants, and contract with, eligible entities to improve health care, increase retention, increase representation of minority faculty members, enhance the practice environment, and provide information dissemination and educational support to reduce professional isolation through the timely dissemination of research findings using relevant resources. An entity seeking funding must submit an appropriate application. Appropriates $5,000,000 for each of FYs 2010-2014, and sums necessary for each subsequent year. [Sec. 5304 of the Act/Sec. 752 of the PHSA]

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	State Grants to Health Care Providers Who Provide Services to a High Percentage of Medically-Underserved Populations or Other Special Populations: States may award grants to health care providers who treat a high percentage (as determined by the state) of such populations. [Sec. 5606 of the Act, as added by Sec. 10501 of the Manager's Amendment] *Rural Physician Training Grants*: The Secretary, acting through the Administrator of the Health Resources and Services Administration, shall establish a grant program to assist eligible entities in recruiting students most likely to practice medicine in underserved rural communities. "Eligible entity" means an accredited school of allopathic or osteopathic medicine, or a consortium of such schools, which submits the appropriate application. Appropriates $4,000,000 for each of FYs 2010-2013. [Sec. 749B of the PHSA, as added by Sec. 10501 of the Manager's Amendment]
Supporting the Existing Health Care Workforce	*Centers of Excellence*: Applies a formula for allocations appropriated under subsection (i) of section 736 of the PHSA to make grants available to health professions schools. The Secretary may not make a grant to a center of excellence unless the center agrees to maintain expenditures of non-federal amounts at a level that is no less than the level of such expenditures maintained by the center for the FY preceding the FY for which the school receives such a grant. Centers receiving grants shall expend the federal amounts obtained from sources other than the grant before expending the grant, unless given prior approval from the Secretary. Appropriates $50,000,000 for each of FYs 2010-2015 and sums necessary for each subsequent FY. [Sec. 5401 of the Act/Sec. 736 of the PHSA] *Health Care Professionals Training for Diversity*: Amends amounts relating to loan repayments scholarships for disadvantaged students. Appropriates $5,000,000 for each of FY 2010-2014 for reauthorizing loan repayments and fellowships regarding faculty positions, and $60,000,000 for fiscal year 2010 and sums necessary for each of FYs 2011-2014 for reauthorizing educational assistance in the health professions regarding individuals from disadvantaged backgrounds. [Sec. 5402 of the Act/Secs. 738 and 740 of the PHSA] *Area Health Education Centers*: Amends the existing section on Area Health Education Centers to provide infrastructure development awards and point of service maintenance and enhancement awards to eligible entities. (The term "eligible entity" means a school of medicine or osteopathic medicine, an incorporated consortium of such schools, or the parent institutions of such a school.) Requires eligible entities to use funds to recruit minorities into health professions, prepare individuals to more effectively provide health services to underserved areas and health disparity populations, conduct inter-disciplinary training, and deliver or facilitate continuing education. Entities receiving grants shall adhere to a number of requirements and shall provide matching funds of no less than 50 percent (25 percent of which shall be in cash), with the opportunity to apply for a waiver. Such grant awards shall be no less than $250,000 per year per center. Appropriates $125,000,000 for each of FYs 2010-2014. [Sec. 5403 of the Act/Sec. 751 of the PHSA] *Workforce Diversity Grants*: Expands upon the diversity workforce grant program to include additional scholarship services, including bridge or degree completion programs and accelerated nursing degree programs. [Sec. 5404 of the Act/Sec. 821 of the PHSA] *Primary Care Extension Program*: Requires the Secretary, acting through the director of AHRQ, to establish the Primary Care Extension Program to provide support and assistance to primary care providers to educate providers about preventive medicine, health promotion, chronic disease management, mental and behavioral health services, and evidence-based therapies and techniques. The

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	Secretary shall grant awards to states for the establishment of state- or multistate-level Primary Care Extension Program State Hubs ("Hubs"). Hubs shall consist of designated state health agencies and may include health professionals, consumer groups, hospital associations, and other appropriate entities. Directs the Hubs to assist in the development of patient-centered medical homes, develop means to disseminate research findings for evidence-based practice, and develop a plan for financial sustainability to provide for reduction in federal funds after an initial 6-year period. Permits Hubs to provide technical assistance and training for community health teams, collect quality and outcome data, and collaborate with local health departments and community health centers to identify health priorities and workforce needs. Appropriates $120,000,000 for each of FYs 2011-2012, and sums necessary for each of FYs 2013-2014. [Sec. 5404 of the Act/Sec. 399W of the PHSA]
Fraud and Abuse Oversight	*Authority to Disclose Return Information Concerning Outstanding Tax Debts for Purposes of Enhancing Medicare Program Integrity*: the Secretary of the Treasury, upon request from the Secretary of HHS, shall disclose to HHS employees return information with respect to a taxpayer who has applied to enroll, or reenroll, as a provider of services or supplier under the Medicare program. [Sec. 1303 of the Reconciliation Bill/Sec. 6103(l) of the IRC) *Provider Screening*: Requires the Secretary to screen all providers and suppliers before granting Medicare, Medicaid and CHIP billing privileges (at a minimum, would be subject to licensure checks). Imposes an application fee on institutional providers and suppliers (and a hardship exemption to that fee) to cover the cost of screening and allows a waiver of the fee for Medicaid providers for whom the state can demonstrate the fee would impede beneficiary access to care. Excludes individual providers and suppliers from this fee. Also imposes new disclosure requirements on providers and suppliers enrolling in Medicare, and gives states authority to impose similar screening procedures in Medicaid, including subjecting providers and suppliers to enhanced oversight and establishing new disclosure requirements. In reviewing a provider application, the Secretary shall determine, based on information supplied by the Secretary f the Treasury, whether to deny such application or to apply enhanced oversight if determined that the provider owes a debt. [Sec. 6401 of the Act, as amended by Sec. 10603 of the Manager's Amendment/Sec. 1866(j) of the SSA/Sec. 1303 of the Reconciliation Bill] *Data Matching*: Requires CMS to complete development of the comprehensive Integrated Data Repository, which would expand existing program integrity data sources and expand data sharing and data matching across federal health care claims and payment data. [Sec. 6402 of the Act/Sec. 1128J of the SSA] *Overpayments*: The 60 days that providers and suppliers have to repay Medicare overpayments would be modified to either 60 days after the date on which the overpayment was made or the date the corresponding cost report is due. [Sec. 6402 of the Act/Sec. 1128J of the SSA] *Program Integrity Funding and Reporting Requirements*: Increases Health Care Fraud and Abuse Control (HCFAC) funding by $10 million each year for 10 years. Funds would remain available until expended. In addition, appropriates $95,000,000 for FY 2011, $55,000,000 for FY 2012, $30,000,000 for each of FYs 2013 and 2014, and $20,000,000 for each of FYs 2015 and 2016, allocated in the same proportion as the total funding allocated with respect to FY 2010, and shall be available until expended. The Medicare and Medicaid Integrity Programs evaluation requirements would be amended, and reporting requirements would be established for Medicare MIP contractors, modeled on those established for the Medicaid MIP. Requires states to use the National Correct Coding Initiative

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	(NCCI) in Medicaid. [Secs. 6402 and 6507of the Act/Secs. 1817(k) and 1903(r) of the SSA/Sec. 1304 of the Reconciliation Bill] *Consolidate and Expand Existing Provider Databases*: Expands and consolidates existing provider databases (HIPDB and NPDB) with a national patient fraud and abuse registry into a centralized sanctions data system. [Sec. 6403 of the Act/Secs. 1128E and 1921 of the SSA] *90-Day Period of Enhanced Oversight for Initial Claims of DME Suppliers:* Beginning after January 11, 2011, if the Secretary determines that there is a significant risk of fraudulent activity among suppliers of durable medical equipment, the Secretary shall withhold payment during the 90-day period beginning on the first submission of a claim for DME furnished by the supplier. [Sec. 6401 of the Act/Sec. 1866(j) of the SSA/Sec. 1305 of the Reconciliation Bill] **Provider Compliance and Penalties** *Payment*: The maximum period for submission of Medicare claims would be reduced to no more than 12 months. [Sec. 6104 of the Act/Sec. 1814(a) of the SSA] *Physician Required to be Enrolled in Medicare*: Requires a physician who orders items or services to be a Medicare enrolled physician or eligible professional. [Sec. 6405 of the Act/ Secs. 1834(a)(11)(b), 1814(a)(2), and 1835(a)(2) of the SSA] *Conditions of Participation and Coverage*: Medicare and Medicaid providers and suppliers would be required to implement compliance programs as a condition of participation and to keep documentation on referrals to programs at high risk of fraud and abuse and provide access to such documentation upon the Secretary's request. [Sec. 6406 of the Act/Sec. 1842(h) of the SSA] *Required Face-to-Face Encounter*: Requires a 1) physician, 2) nurse practitioner or clinical nurse specialist, if working in collaboration with the physician, or 3) nurse midwife to have a face-to-face encounter with a patient before a physician may certify eligibility for home health services or DME under Medicare. [Sec. 6407 of the Act, as amended by Sec. 10605 of the Manager's Amendment/Sec. 1814(a)(2)(C) of the SSA] *Provider Self-Disclosure Protocol*: The Secretary would be required to establish, within 180 days, a mechanism for providers to voluntarily self-disclose specific information regarding actual and potential violations of the self-referral law. [Sec. 6409] *Adjustments to the Medicare Durable 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 program from 79 of the largest MSAs to 100 of the largest MSAs by including the next largest 21 by population. Requires that the Secretary extend the competitive acquisition program, or apply competitively-bid rates, to the remaining areas by 2016. [Sec. 6410 of the Act/Sec. 1847(a)(1) of the SSA] *Recovery Audit Contractors (RAC)*: Extends the RAC program to Medicare Parts C and D, and to Medicaid. [Sec. 6411 of the Act/ Secs. 1902(a)(42) and 1893(h)]

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	Health Care Fraud Enforcement: Requires the United States Sentencing Commission to review sentencing guidelines and policy statements regarding federal health care offenses. Outlines the level of punishment for health care fraud crimes. Allows the Attorney General to issue a subpoena to access health care information and protects that information from disclosure. [Sec. 10606 of the Manager's Amendment]
Prohibition of False Statement and Representations	Prohibits any person in connection with a plan or other arrangement that is a MEWA from making a knowingly false statement or false representation of fact in connection with the marketing or sale of such plan or arrangement to any employee, any member of an employee organization, any beneficiary, any employer, an employee organization, the Secretary, or any state, or the representative or agent of any such person, state, or the Secretary concerning: • the financial condition or solvency of such plan or arrangement; • the benefits provided by such plan or arrangement; • the regulatory status of such plan or other arrangement under federal or state law governing unions, collective bargaining or other labor management relations; or • the regulatory status of such plan or other arrangement regarding exemption from state regulatory authority under the Act. This section does not apply to any plan or arrangement that does not fall within the meaning of a MEWA under current law. Establishes additional criminal penalties under ERISA for violations, including imprisonment of not more than 10 years, a fine, or both for any violation. [Sec. 6601 of the Act/ Adds Sec. 519 of ERISA]
Uniformity in Fraud and Abuse Reporting	Requires the Secretary to request the NAIC to develop a model uniform report form for a private health insurance issuer seeking to refer suspected fraud and abuse to state insurance departments or other responsible state agencies for investigation. Requires the Secretary to request that the NAIC develop recommendations for uniform reporting standards for such referrals. [Sec. 6603 of the Act/ Adds Sec. 2795 of the PHSA]
Applicability of State Law to Combat Fraud and Abuse	Permits the Secretary, for the purposes of identifying, preventing, or prosecuting fraud and abuse, to adopt regulatory standards establishing (or issue an order relating to a specific person establishing) that a person providing insurance through a MEWA is subject to the laws of the states in which the person operates regardless of whether the state law is preempted. Does not apply to any plan or arrangement that does not fall within the meaning of the term MEWA as defined in current law. [Sec. 6604 of the Act/Adds Sec. 520 of ERISA]
DOL Cease and Desist	Permits the Secretary to issue a cease and desist (ex parte) order if it appears to the Secretary that the alleged conduct of a MEWA is

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Orders and Summary Seizures Orders	fraudulent, or creates an immediate danger to the public safety or welfare, or is causing or can be reasonably expected to cause significant, imminent, and irreparable public injury. Allows a person adversely affected by the issuance of a cease and desist order to request a hearing by the Secretary. The burden of proof in any hearing is on the party requesting the hearing to show cause why the order should be set aside. Based on the evidence presented at the hearing, permits the Secretary to affirm, modify, or set aside the cease and desist order. Permits the Secretary to issue a summary seizure order if it appears that a MEWA is in a financially hazardous condition. Permits the Secretary to issue regulations necessary to carry out this section. Does not apply to any plan or arrangement that does not fall within the meaning of the term MEWA under current law. [Sec. 6605 of the Act/Adds Sec. 521 of ERISA]
MEWA Registration	Requires MEWAs to register with the DOL prior to operating in any state. [Sec. 6606 of the Act/ Sec. 101(g) of ERISA]
Evidentiary Privilege and Confidential Communication	Permits the Secretary to issue regulations that provide an evidentiary privilege for, and provide for confidential communications between and among, any of the following entities or their agents, consultants, or employees: • a state insurance department or attorney general; • NAIC; • DOJ, DOT, DOL, and HHS; and • any other federal or state authority that the Secretary determines is appropriate. [Sec. 6607 of the Act/ Sec. 504 of ERISA]
Qualifying Therapeutic Discovery Project Credit	Creates a temporary credit, subject to $1 billion/2 year overall cap beginning in 2009, to encourage investment in new therapies to treat or prevent disease, diagnose diseases or conditions, and develop a product, process, or technology to further the delivery or administration of therapeutics. Limited to small companies (250 or fewer employees), the credit would be equal to 50 percent of investments in "qualified therapeutic discovery projects." A taxpayer eligible for the credit can elect, in lieu of taking the credit, to obtain a grant from the Treasury in an amount equal to the credit amount. [Sec. 9023 of the Act/Sec. 48D of the IRC]
Pathway for Biosimilars	*Licensure of Biological Products as Biosimilar or Interchangeable:* Any person may file an application for licensure of a biological product. This application shall include: • Information demonstrating that the biologic is biosimilar to the reference; • Information demonstrating that the biological product utilizes the same mechanism(s) of action as the reference for the condition(s) of use prescribed, recommended, or suggested in the proposed labeling, but only to the extent that the

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	mechanism(s) of action are known for the reference product; • Information to show that the condition(s) of use prescribed, recommended, or suggested in the proposed labeling for the biologic have been previously-approved for the reference; • Information to show that the route of administration, dosage form, and strength of the biologic are the same as those of the reference; • Information demonstrating that the facility in which the biologic is manufactured, processed, packed, or held meets standards designed to ensure safety, purity, and potency; • Publicly-available information regarding the Secretary's previous determination that the reference product is safe, pure, and potent; and • Any additional information in support of the application. [Sec. 7002 of this Act/Sec. 351 of the PHSA] *Evaluation by Secretary*: Upon review of an application (or supplement to an application), the Secretary shall license the biologic if it is biosimilar to the reference or meets the standards for interchangeability; and the applicant consents to an inspection of the facility. [Sec. 7002 of this Act/Sec. 351 of the PHSA] *Safety Standards for Determining Interchangeability*: Upon review of an application, the Secretary shall determine a biologic to be interchangeable if the biologic is biosimilar to the reference product and can be expected to achieve the same clinical result as the reference, and the risk of alternating between the use of the biologic and reference product is no greater than the risk of using the reference without such switch. A biologic may not be evaluated against more than 1 reference product, and an application shall be reviewed by the FDA division responsible for the review and approval of the application under which the reference is licensed. [Sec. 7002 of this Act/Sec. 351 of the PHSA] *Exclusivity for the First Interchangeable Biologic*: Upon review of an application relying on the same reference for which a prior biologic has received a determination of interchangeability, the Secretary shall not make a determination of interchangeability for the second biologic until the earlier of: • (a) 1 year after the first commercial marketing of the first interchangeable biologic to be approved as interchangeable for that reference, 18 months after a) a final court decision on all patents in suit in an action instituted against the applicant that submitted the application for the first approved interchangeable biosimilar biologic, **or** • b) 18 months after a final court decision on all patents in suit in an action instituted against the applicant that submitted the application for the first approved interchangeable biosimilar biologic **or** 18 months after the dismissal with or without prejudice of an action instituted against the applicant that submitted the application for the first approved interchangeable biosimilar biologic; **or**

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	• c) 42 months after approval of the first interchangeable biosimilar biologic if the applicant that submitted the application has been sued and such litigation is ongoing within such 42-month period **or** 18 months after approval of the first interchangeable biosimilar biologic if the applicant that submitted the application has not been sued. [Sec. 7002 of this Act/Sec. 351 of the PHSA] *Exclusivity for Reference Product*: Approval may not be made effective by the Secretary until 12 years after the date on which the reference was first licensed. An application may not be filed with the Secretary until 4 years after the date on which the reference was first licensed. These directives shall **not** apply to a license for or approval of: 1) a supplement for the biologic that is the reference, or 2) a subsequent application filed by the same sponsor of the biologic that is the reference for a change that results in a) a new indication, route of administration, dosing schedule, dosage form, delivery system, delivery device, or strength, **or** b) a modification to the structure of the biologic that does not result in a change in safety, purity, or potency. The Secretary may, after opportunity for public comment, issue guidance with respect to the licensure of a biologic. There is no requirement for application consideration. The Secretary may issue a product class-specific guidance that includes the criteria the Secretary will use whether a biological product is highly similar to a reference in such product class and the criteria that the Secretary will use to determine whether a biological product meets the required standards. [Sec. 7002 of this Act/Sec. 351 of the PHSA] **Patents** *Confidential Access to Application*: The applicant shall provide confidential access to the information pertaining to the process used to manufacture the biologic, as well as to any additional requested information, to outside counsel, in-house counsel, and the patent owner to be used for the sole purpose of determining whether a claim of patent infringement could be reasonably asserted. In the event that a reference product sponsor files an infringement suit, the information shall still be treated as confidential until a court enters a protective order regarding the information (even in this instance, the information shall not appear in any publicly-available complaint or other pleading). If the reference product sponsor does not file suit, the reference product sponsor must return or destroy all confidential information received. Should any disclosure of confidential information be deemed to have caused the applicant irreparable harm for which there is no adequate legal remedy, the court shall consider immediate injunctive relief for any violation or threatened violation. [Sec. 7002 of this Act/Sec. 351 of the PHSA] *Application Information:* Not later than 20 days after the Secretary notifies the applicant that the application has been accepted for review, the applicant: 1) shall provide to the reference product sponsor a copy of the application submitted to the Secretary and other information that describes the process or processes used to manufacture the biological product; and 2) may provide to the reference product sponsor additional information requested by or on behalf of the reference product sponsor. [Sec. 7002 of this Act/Sec. 351 of the PHSA]

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	List and Description of Patents: No later than 60 days after receipt of the application and information, the reference product sponsor shall provide to the applicant a list of patents for which the sponsor believes a claim of infringement could be reasonably asserted by the sponsor, and an identification of the patents on the list that the sponsor would be prepared to license to the applicant. No later than 60 days after receipt of this list, the applicant may provide to the sponsor a list of patents to which the applicant believes a claim of infringement could reasonably be asserted by the sponsor; a detailed statement that describes, on a claim by claim basis, the factual and legal basis of the opinion that such patent is invalid, unenforceable, or will not be infringed by the commercial marketing of the biologic that is the subject of the application **or** a statement that the applicant does not intend to begin commercial marketing of the product before the date of expiration; and a response regarding each patent identified by the sponsor. No later than 60 days after receipt of the applicant's list, the sponsor shall provide a detailed statement that describes, on a claim by claim basis, the factual and legal basis of the opinion of the reference sponsor. [Sec. 7002 of this Act/Sec. 351 of the PHSA] *Patent Resolution*: After the applicant receives the sponsor's statement, the sponsor and applicant shall engage in good faith negotiations. If, within 15 days of beginning negotiations, an agreement is not reached, the applicant shall notify the sponsor of the number of patents that the applicant will provide to the sponsor when the parties exchange patent lists. Requires the applicant and reference product sponsor to simultaneously exchange the list of patents each party believes should be subject to infringement action. Prohibits a reference product sponsor from listing more than the applicant except when the applicant lists zero. [Sec. 7002 of this Act/Sec. 351 of the PHSA] *Immediate Patent Infringement Action*: If the applicant and sponsor agree on patents, no later than 30 days after the agreement, the sponsor shall bring an action for infringement with respect to each such patent. If no agreement is reached, the sponsor shall bring an action for infringement with respect to each patent included on the lists. No later than 30 days after a complaint is served to the applicant, the applicant shall provide the Secretary with notice and a copy of such complaint, and the Secretary shall publish it in the *Federal Register*. [Sec. 7002 of this Act/Sec. 351 of the PHSA] *Newly Issued or Licensed Patents*: In the case of a patent that is issued to, or licensed by, the reference sponsor after the date that the sponsor provided the patent list to the applicant **and** the reference sponsor reasonably believes that, due to the issuance of such patent, a claim of infringement could reasonably be asserted by the sponsor if a person not licensed by the sponsor engaged in the making, using, offering to sell, selling, or importing into the U.S. of the biologic that is the subject of the application, no later than 30 days after such issuance or licensure, the sponsor shall provide to the applicant a supplement to the list provided by the sponsor that includes such patent. No later than 30 days after such supplement is provided, the applicant shall provide a statement to the sponsor. [Sec. 7002 of this Act/Sec. 351 of the PHSA]

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	Notice of Commercial Marketing and Preliminary Injunction: The applicant shall provide the sponsor with no less than 180 days notice of the beginning of commercial marketing. The sponsor may seek a preliminary injunction, with which the applicant shall reasonably cooperate to expedite further discovery. [Sec. 7002 of this Act/Sec. 351 of the PHSA] *Limitation on Declaratory Judgment Action*: If the applicant provides the required application and information, neither the sponsor nor the applicant may, prior to the date notice is received, bring any action for a declaration of infringement, validity, or enforceability of any patent. If an applicant fails to complete a required action or to provide the application and required information, the sponsor may bring an action for a declaration of infringement, validity, or enforceability of any patent included in the list. [Sec. 7002 of this Act/Sec. 351 of the PHSA] *Follow-on Biologics User Fees*: No later than October 1, 2010, the Secretary shall develop recommendations to present to Congress for the review process of biologic applications, consulting with the Senate HELP Committee, the House Energy & Commerce Committee, scientific and academic experts, health care professionals, representatives of patient and consumer advocacy groups, and the regulated industry. After opportunity for public review of the recommendations, the Secretary shall transmit to Congress the revised regulations no later than January 15, 2012. Based on the recommendations submitted to Congress, Congress shall authorize a program, effective October 1, 2012, for the collection of user fees relating to the submission of applications. Exactly two years after first receiving a user fee applicable to an application for a biologic, the Secretary shall conduct an audit of the costs of reviewing such applications. Appropriates funds necessary for each of FYs 2010-2012. [Sec. 7002 of this Act/Sec. 351 of the PHSA] *Pediatric Studies of Biological Products:* If, prior to approval of an application, the Secretary determines that information related to the use of a new biological product in the pediatric population may produce health benefits in that population, the Secretary may, with the permission of the applicant, request pediatric studies including timeframes for the studies. The Institute of Medicine must conduct studies to: 1) review and assess the number and importance of biological products for children that are being tested as a result of the amendments made by the Biologics Price Competition and Innovation Act of 2009 and the importance for children, health care providers, parents, and others of labeling changes resulting from testing; 2) review and assess the number, importance, and prioritization of any biological products not being tested for pediatric use; and 3) offer recommendations for ensuring pediatric testing of biological products. [Sec. 7002 of this Act/Sec. 351 of the PHSA] *Orphan Products:* If a reference product has been designated for a rare disease or condition, a biological product seeking approval as biosimilar to or interchangeable with such reference may be licensed with the Secretary only after the expiration for such reference of

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	the later of the seven year period under the FDA Act and the 12 year period under the licensing of biological products laws. [Sec. 7002 of this Act/Sec. 351 of the PHSA] Savings incurred from enactment shall be used for deficit reduction. [Sec. 7003 of the Act] *Expanded Participation in 340B Program*: Expands covered entities receiving discounted prices, extends discounts to inpatient drugs, prohibits group purchasing arrangements, and authorizes hospitals to issue a credit to state Medicaid programs for inpatient covered drugs provided to Medicaid recipients. Effective January 1, 2010. [Sec. 7101 of the Act/Sec. 340B of the PHSA] *Improvements to 340B Program Integrity*: From amounts appropriated, the Secretary shall provide for improvements in compliance by manufacturers and covered entities. In addition, the Secretary shall promulgate regulations to establish and implement an administrative process for the resolution of claims by covered entities that they have been overcharged, and claims by manufacturers. Effective January 1, 2010. Appropriates necessary funds for each FY beginning in 2010. [Sec. 7102 of the Act/Sec. 340B of the PHSA] *GAO Study to Make Recommendations on Improving the 340B Program*: No later than 18 months after enactment, the Comptroller General shall report to Congress on whether those individuals served by the covered entities under the program under section 340B are receiving optimal health care services. The report shall include recommendations on whether the program shall be expanded, whether mandatory sales of certain products could hinder patient access to those therapies under any provider, and whether income from the program is being used by the covered entities under the program to further program objectives. [Sec. 7103 of the Act]
Elder Justice Act	*Elder Justice Coordinating Council*: Creates an Elder Justice Coordinating Council ("the Council") to make recommendation to the Secretary for the coordination of activities of relevant federal, state, local, and private agencies and entities relating to elder abuse, neglect, and exploitation, and other crimes against elders. [Sec. 6703 of the Act/Sec. 2021 of the SSA] *Advisory Board on Elder Abuse, Neglect, and Exploitation*: Establishes such Board to create short- and long-term multidisciplinary strategic plans for the development of the field of elder justice, and to make recommendations to the Council. [Sec. 6703 of the Act/Sec. 2022 of the SSA] Establishes and provides funding for the establishment and operation of elder abuse, neglect, and exploitation forensic centers. [Sec. 6703 of the Act/Sec. 2031 of the SSA] Provides for a number of enhancements to long-term care, including grants and incentives for staffing, certified EHR technology, and the adoption of electronic standards for the exchange of data. Also provides for grants to enhance the provision of adult protective services on the state and local levels. [Sec. 6703 of the Act/Secs. 2041-45 of the SSA]
Community	Definitions:

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Living Assistance Services and Supports - Definitions	• *Active enrollee* means an individual who is enrolled in and pays premiums due to the CLASS program. • *Actively employed* means an individual who reports for work and is able to perform all the usual and customary duties. • *Activities of daily living* include each of the following: eating, toileting, transferring, bathing, dressing, and continence. • *Eligibility Assessment System* means the entity designated by the Secretary, established to make functional eligibility determinations for the CLASS program. • *Eligible beneficiary* means an active enrollee in the CLASS program who has 1) paid premiums for at least 60 months; 2) earned, with respect to at least 3 calendar years that occur during the first 60 months for which the individual has paid premiums for enrollment, at least an amount equal to the amount of wages and self-employment income which an individual must have to be credited with a quarter of Social Security coverage for that year; and 3) paid premiums for at least 24 consecutive months if a lapse in premium payment of more than 3 months has occurred. To be deemed "eligible," the enrollee must have a functional limitation expected to last for a continuous period of more than 90 days. The Secretary shall promulgate regulations on exceptions to minimum earnings requirements for purposes of determining eligible beneficiary for certain populations. • The terms *hospital, nursing facility, intermediate care facility for the mentally retarded, and institution for mental diseases* have the meanings given such terms for purposes of Medicaid. • *CLASS Independence Advisory Council* means the advisory council formed to advise the Secretary on the CLASS benefit plan. • *CLASS Independence Benefit Plan* means the plan developed to implement the CLASS Act. • *CLASS Independence Fund* means the fund established for the program. • *Medicaid* means the program established under Title XIX of the Social Security Act. • *Poverty Line* has the same meaning as given in the SSA. • *Protection and Advocacy System* means the system for each state established under section 143 of the Developmental Disabilities Assistance and Bill of Rights Act of 2000. [Sec. 8002 of the Act/Sec. 3202 of the PHSA]
CLASS Independence Benefit Plan	*Process for Development*: Requires the Secretary, in consultation with actuaries and experts, to develop at least 3 actuarially-sound benefit plans that would be considered for the CLASS Independence Benefit Plan. Taking recommendations from the CLASS Advisory Council, the Secretary must designate a CLASS benefit plan by October 1, 2012. Plan alternatives need to be consistent with the following requirements: • *Premiums:* Beginning with the first year of the program (and for each year thereafter), the Secretary shall establish premium amounts for all enrollees for the year based on an actuarial analysis of the 75-year costs of the program that ensures solvency throughout that period. Establishes a nominal premium ($5/month, increasing yearly with CPI) for eligible enrollees with incomes below the poverty line and for full-time students under the age of 22. Also, calls for the Secretary to review level of reserves after the CLASS program has been in operation for 10 years. • *Vesting Period:* A 5-year vesting period for eligibility of benefits. • *Benefit Triggers:* Require a determination that an individual has a functional limitation expected to last more than 90 days due to inability to perform 2 or 3 ADLs; cognitive impairment; or a level of similar limitation prescribed by Secretary. • *Cash Benefit:* Provides beneficiary with a cash benefit that is no less than an average of $50/day, which may be scaled from 2

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	to 6 levels, based on beneficiary's level of disability. Cash benefit may be paid daily or weekly and is not subject to a lifetime limit. *Adjustment of Premium:* Except as provided below, requires the premium determined for an individual upon enrollment to remain the same for as long as the individual is an active enrollee in the program. Permits premium changes under the following conditions: • If required for program solvency (a nominal premium shall be maintained for enrollees with incomes below the poverty line and full-time students) (premium increase does not apply to persons age 65 and older, who have paid premiums for at least 20 years, and who are not actively at work); • Reenrollment of an individual after a 90-day period during which the individual failed to pay the premium shall be treated as an initial enrollment for purposes of age-adjusting the premium (credit will be given for prior months if the individual re-enrolls before the end of 5-year vesting period); • For individuals whose status as a full-time student changes (requires them to pay the same monthly premium that an individual of the same age who first enrolls in the program would pay); and • For individuals who reenroll in the CLASS program after the end of the 5-year vesting period, the monthly premium shall be age-adjusted and increased by an amount determined by the Secretary or 1 percent of the applicable premium (whichever is greater). *Administrative Expense*: The Secretary may factor in costs for administering the program, not to exceed 3 percent of premium for any year in which the program is in effect. *Underwriting*: Prohibits the use of underwriting to determine the monthly premium for enrollment in the program or to prevent an individual from enrolling in the program. *Self Attestation and Verification of Income:* The Secretary shall establish procedures to permit an individual who is eligible for a nominal premium to self-attest that their income does not exceed the poverty line or that their status as a full-time student who is actively employed; verify the validity of such self-attestation; and require an individual to confirm, at least annually, that their income does not exceed the poverty line or that they continue to maintain such status. [Sec. 8002 of the Act/Sec. 3203of the PHSA]
CLASS Enrollment and Disenrollment Requirements	Requires the Secretary, in coordination with the Secretary of the Treasury, to establish procedures allowing eligible individuals to automatically enroll employees in the CLASS program. Requires the development of alternative enrollment procedures for individuals who are self-employed, have more than one employer, or whose employer does not elect to participate in the automatic enrollment process. Requires the Secretary, with the Secretary of Treasury, to create an enrollment form for the CLASS program, and to ensure that individuals are not automatically enrolled by more than one employer. An individual may elect to opt-out at any time in such manner as the Secretaries shall prescribe.

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	Individuals are eligible to enroll in the CLASS program if they: • are 18 years of age; • receive wages or income that are subject to the Social Security tax; • are actively at work; • are not a patient in a hospital or nursing facility, an intermediate care facility for the mentally retarded, or an institution for mental disease and receives Medicaid; or • are not confined in a penal institution or correction facility. *Payroll Deduction*: Requires the Secretary, in coordination with Secretary of Treasury, to develop procedures for allowing monthly premiums to be deducted from the wages or self-employment income and to establish alternative procedures for the payment of monthly premiums for persons who do not have an employer who elects to deduct and withhold premiums or who do not earn wages or derive self-employment income. *Transfer of Premiums Collected*: During each calendar year, the Secretary of the Treasury shall deposit into the CLASS Independence Fund a total amount equal, in aggregate, to 100 percent of the premiums collected that year, transferred in at least monthly payments on the basis of estimates by the Secretary and certified by the Secretary of the Treasury of the amounts collected. *Other Enrollment and Disenrollment Opportunities*: The Secretary, in coordination with the Secretary of the Treasury, shall establish procedures under which 1) an individual, who, in the year of initial eligibility, has not enrolled in the program, is eligible to elect to enroll, in such form and manner as the Secretaries shall establish, only during an open enrollment period established by the Secretaries that is specific to the individual and that may not occur more frequently than biennially after the date on which the individual first elected to waive enrollment; and 2) an individual shall only be permitted to disenroll (other than for nonpayment of premiums) during an annual disenrollment period established by the Secretaries. [Sec. 8002 of the Act/Sec. 3204 of the PHSA]
CLASS Benefits	*Determination of Eligibility*: Requires the Secretary to establish procedures for active enrollees to apply for benefits. Not later than January 1, 2012, requires the Secretary to: • Establish an Eligibility and Assessment System for each state to provide for eligibility assessments, • Enter into an agreement with the Protection and Advocacy System for each state to provide advocacy services as outlined under this Act, and • Enter into an agreement with public and private entities to provide advice and assistance counseling in accordance with this Act. Requires the Secretary to promulgate regulations to develop an expedited eligibility determination process, an appeals process, and redetermination process, including whether an enrollee is eligible for a cash benefit under the program and appropriate amount of cash benefit (in accordance with sliding scale established under the plan).

	Summary of the "Patient Protection and Affordable Care Act," (as passed by the Senate on December 24, 2009, and by the House on March 21, 2010) and the "Health Care and Education Reconciliation Act of 2010" (highlighted, as passed by the House on March 21, 2010)
	Presumptive Eligibility: Deems an enrollee presumptively eligible if the enrollee: • has applied and attests eligibility for benefits; • is a patient in a hospital (for long-term care), nursing facility, intermediate care facility for the mentally retarded, or an institution for mental diseases; and • is in the process of planning to discharge from the hospital, facility or institution. Requires the Secretary to establish procedures for an applicant to appeal an adverse benefit determination. *Benefits*: Includes a daily cash benefit of at least $50 that increases by CPI annually, advocacy services, and advice and assistance counseling. Advocacy services and advice and assistance counseling services shall be included as administrative expenses of the program. *Payment of Benefits*: Requires the Secretary to establish procedures (including crediting the account with the daily cash benefit, issuing debit cards, and accounting for withdrawals) under which benefits would be deposited into a Life Independence Account established by the Secretary on behalf of each beneficiary. Requires daily cash benefits to be used to purchase non-medical services and support services that the beneficiary needs to maintain his or her independence at home or in another residential setting of their choice in the community (e.g, home modifications, assistive technology, accessible transportation, homemaker services, respite care, personal assistance services, and home care aides). Cash benefits may also be used for obtaining assistance with decision making concerning medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives, or other written instructions recognized under state law, in cases where an injury or illness causes the individual to be unable to make health care decisions. The Secretary shall also establish procedures for electronic management of funds in crediting a beneficiary's account with the cash benefits of the program, allowing beneficiary access through debit cards, and accounting for withdrawals of benefits by the beneficiary. *Payment Rules for Beneficiaries Enrolled in Medicaid*: Applies the following rules for beneficiaries who are also enrolled in Medicaid: • If a patient is a beneficiary in a hospital, nursing facility, intermediate care facility for the mentally retarded, or an institution for mental diseases, designates 5 percent of the daily cash benefit to the beneficiary, and the remainder toward the facility's cost of providing care. Requires Medicaid to provide secondary coverage for such care. • If a beneficiary is receiving home and community based services under Medicaid, designates 50 percent of the daily cash benefit to the beneficiary and the remainder toward the cost to the state of providing such assistance (subject to qualifications of a state's Medicaid home and community based waiver). Requires Medicaid to provide secondary coverage for such care. • If a beneficiary is enrolled in a PACE program, beneficiary retains 50 percent of the benefit and the remainder is applied to the PACE program. *Authorized Representatives:* Allows daily cash benefits to be accessed by an authorized representative of the beneficiary. Requires the Secretary to establish standards of conduct for the authorized representative to ensure that they provide quality services on behalf of the beneficiary, do not have conflicts of interest, and do not misuse benefits or engage in fraud or abuse.

	Summary of the "Patient Protection and Affordable Care Act," (as passed by the Senate on December 24, 2009, and by the House on March 21, 2010) and the "Health Care and Education Reconciliation Act of 2010" (highlighted, as passed by the House on March 21, 2010)
	Rollover Options for Lump-sum Payments: Allows a beneficiary to defer payment of the daily cash benefit and rollover such amounts from month-to-month, but not from year-to-year. Prohibits a lump sum payment of such deferred payments from exceeding the lesser of the total amount of the accrued deferred benefits or the applicable annual benefit. *Period for Determination of Annual Benefits*: Defines the applicable period for the annual benefit for a beneficiary as the 12-month period that commences with the first month in which the beneficiary began to receive such benefits, and each 12-month period thereafter. Requires the Secretary to establish procedures for paying benefits should a tier I beneficiary qualify for tier II benefits before the end of a 12-month benefit period. Requires the Secretary, in coordination with the Secretary of the Treasury, to recoup unpaid and accrued benefits in the case of the death of a beneficiary or the failure of a beneficiary to receive the deferred daily cash benefits as a lump-sum payment before the end of the 12- month period in which such benefits accrued. *Recertification of Eligibility*: Requires a beneficiary to periodically recertify by submission of medical evidence the beneficiary's continued eligibility for benefits and to submit records of expenditures attributable to the aggregate daily cash benefit received by the beneficiary in the preceding year. *Benefits to Supplement Other Health Care Benefits*: Requires that benefits received under this Act shall supplement, but not supplant, other health care benefits for which the beneficiary is eligible under Medicaid or any other federally funded program that provides health care benefits or assistance. *Advocacy Services*: Requires a state Protection and Advocacy System to assign, as needed, an advocacy counselor to each eligible beneficiary. Requires the counselor to provide the beneficiary with information regarding how to access the appeals process, assistance with respect to the recertification, and other such services as the Secretary requires by regulation. *Advice and Assistance Counseling*: Requires agreements between the Secretary and public and private entities to provide advice and assistance counseling to require the entity to assign a counselor who provides information on: • accessing and coordinating long term services and supports in the most integrated setting; • possible eligibility for other benefits and services; • development of a service and support plan; • information about programs established under the Assistive Technology Act of 1998 and the services offered under such programs; • available assistance with decision making concerning medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives, or other written instructions recognized under State law, in cases where an injury or illness causes the individual to be unable to make health care decisions; and • such other services as the Secretary may require by regulation. *No Effect on Eligibility for Other Benefits*: Declares that benefits paid under the CLASS program shall be disregarded for purposes of determining or continuing the beneficiary's eligibility for receipt of benefits under any other federal, state, or locally funded assistance program.

	Summary of the "Patient Protection and Affordable Care Act," (as passed by the Senate on December 24, 2009, and by the House on March 21, 2010) and the "Health Care and Education Reconciliation Act of 2010" (highlighted, as passed by the House on March 21, 2010)
	Protection Against Conflict of Interests: Requires the Secretary to establish procedures to ensure that the Disability Determination Service and Protection and Advocacy System for a state, advocacy counselors for beneficiaries, and any other entities that provide services to active enrollees and beneficiaries under the CLASS program comply with the following: • ensure that counseling or planning services are in the best interest of the active enrollee or beneficiary; • establish operating procedures that are designed to avoid or minimize conflicts of interest between the entity and the active enrollee or beneficiary; • provide information about all services available to the active enrollee or beneficiary, including services available through other entities or providers; • assist the active enrollee or beneficiary to access desired services regardless of the provider; • report the number of active enrollee or beneficiaries provided with assistance by age, disability, and whether such enrollees and beneficiaries received services from the entity or another entity; • ensure that an active enrollee or beneficiary is informed of any financial interest the entity has in a service provider; and • provide the active enrollee or beneficiary with a list of available service providers that can meet the needs of the active enrollee or beneficiary. [Sec. 8002 of the Act/Sec. 3205 of the PHSA]
CLASS Independence Fund	*Establishment of an Independence Fund*: Establishes a trust fund called the CLASS Independence Fund (Fund) with the Secretary of the Treasury serving as the managing trustee. The Fund will consist of all amounts derived from premiums and any amounts received by investments. Dictates funds to pay benefits, pay administrative expenses, and to be invested on behalf of enrollees. Requires the Secretary of the Treasury to invest funds in the same manner and to the same extent as the Federal Supplementary Medical Insurance Trust Fund. *Board of Trustees*: A Board of Trustees of the CLASS Independence Fund (Fund) composed of the Secretary of the Treasury, the Secretary of Labor, and the Secretary of Health and Human Services, all ex officio, and of two members of the public (both of whom may not be from the same political party), who shall be nominated by the President for a term of 4 years and subject to confirmation by the Senate. The Board shall meet at least once a year. The duties of the of the Board of Trustees are: holding the Fund, reporting to Congress by April 1st of each year on the status of the Fund, reporting to Congress when the Fund is not actuarially sound, reviewing general policies in managing the Fund, and recommending necessary changes. The report shall include a statement of the Fund's assets and disbursements, expected income, actuarial status, an actuarial opinion (done by the Chief Actuary of CMS) certifying the techniques and methodologies used are generally accepted with actuarial profession and assumptions and cost estimates are reasonable, and be printed as a House document. If the Board determines that the Fund is not actuarially sound, they will recommend legislative action if deemed appropriate to include premium adjustments and enrollment

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	moratorium. [Sec. 8002 of the Act/Sec. 3206 of the PHSA]
CLASS Independence Advisory Council	A CLASS Independence Advisory Council will be created and composed of no more than 15 individuals who shall be appointed by the President, a majority of whom shall be representatives who participate or are likely to participate in CLASS program, including older and younger workers, disabled, caregivers, long term care insurance or disability insurance experts, actuaries, economists, and others. Requires Council members to serve 3 year terms but not more than 2 consecutive terms. The President shall appoint a Chair for this Council. Duties of the Council include advising the Secretary on administration and regulation of the CLASS program including development of CLASS Benefit Plan, the Plan's monthly premiums and the financial solvency of the program. [Sec. 8002 of the Act/Sec. 3207 of the PHSA]
CLASS Regulations; Annual Report	*Solvency*: Requires the Secretary to regularly consult with the Board and the Council to ensure that premiums are adequate to ensure financial solvency over 20-year and 75-year windows. *Taxpayer Funds*: Prohibits the use of taxpayer funds to pay benefits under a CLASS Benefit Plan. Taxpayer funds are any federal funds from a source other than CLASS premiums deposited in the CLASS Independence Fund. *Regulations*: Authorizes the Secretary to promulgate regulations necessary to carry out the CLASS program, including provisions to prevent fraud and abuse under the program. *Annual Report*: Beginning January 1, 2014, requires the Secretary to submit an annual report to Congress on the CLASS program including the number of enrollees, the number of beneficiaries, the total amount of cash benefits provided, a description of instances of fraud or abuse, and recommendations for administrative or legislative action deemed necessary to improve the program, ensure solvency, or prevent fraud or abuse. [Sec. 8002 of the Act/Sec. 3208 of the PHSA] Requires the Inspector General of the HHS Department to submit an annual report to the Secretary and Congress on the overall progress of the CLASS program and on waste, fraud and abuse in the program, including findings on: • the eligibility determination process; • the provision of cash benefits; • quality assurance and protection against waste, fraud and abuse; and • recouping of unpaid and accrued benefits.

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	[Sec. 8002 of the Act/Sec. 3209 of the PHSA]
Tax Treatment of the CLASS Program	*Tax Treatment*: Treats the CLASS program in the same manner as a qualified long term care insurance contract for qualified long term care services. *Coordination of Benefits with Medicaid*: Requires that a state comply with regulations regarding the application of primary and secondary payer rules with respect to individuals who are eligible for Medicaid and eligible CLASS program beneficiaries. *Adequate Provider Infrastructure*: Not later than 2 years after enactment of this Act, requires each state to assess the extent to which providers of long term care services are serving or have the capacity to serve individuals receiving benefits under the CLASS program. Instructs states to designate or create entities to serve as fiscal agents for employing an adequate supply of workers for individuals receiving benefits under this program. Directs that a state's creation of such entities must not negatively alter the existing programs and providers of long term care services and that such entities must not impede the ability of individuals to direct and control their home and community services. *Personal Care Attendants Workforce Advisory Panel*: Requires the Secretary to create the Personal Care Attendants Workforce Advisory Panel in order to examine and advise the Secretary and Congress on workforce issues, including the adequacy of the number of workers, salaries, wages, and benefits of such workers, and access to the services provided by such workers. Requires that members of this panel include individuals with disabilities of all ages, seniors, representatives of individuals with disabilities, representatives of seniors, representatives of workforce and labor organizations, representatives of home and community-based service providers, and representatives of assisted living providers. *Inclusion of CLASS Program Information in National Clearinghouse for Long Term Care Information/ Extension of Funding*: Requires the inclusion of information on the CLASS program in the National Clearinghouse for Long Term Care Information and extending its funding from 2010 to 2015. [Sec. 8002 of the Act/Sec. 3210 of the PHSA]
Medicare Advantage Payment	**Changes for 2011:** • ***2011 county rates:*** County rates for 2011 would be frozen at 2010 levels. • ***2011 coding intensity adjustment:*** The authority for a coding intensity adjustment would be extended. (See details below.) **Changes for 2012 and future years:** • ***Phase-in of modified benchmarks:*** New payment rates would be phased in over 2 years (2012 – 2013) and would be determined by adjusting base payment amounts according to the assignment of counties to quartiles reflecting relative underlying county FFS costs.

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	+ *Base payment amounts*: Beginning in 2012, base payment amounts would be set at 100% of county FFS costs (adjusted to account for the phase-out of IME). -- These amounts would be increased annually by the national per capita growth percentage except in years when rebasing occurs (no less often than every 3 years as under current law. + *Modified benchmarks*: The base amounts would be adjusted to reflect the percentage applicable to each county's assigned quartile, and the resulting modified benchmarks would be phased-in as follows: -- 2012 – 1/2 current law benchmark + 1/2 modified benchmark (100% FFS times the applicable quartile percentage) -- 2013 – 100% modified benchmark Longer phase-in schedules would apply to MA organizations experiencing the greatest negative impact from the new payment methodology. (See details below.) • ***Quartile percentages:*** To determine quartile percentages for calculating the modified benchmark, counties would be ranked from high to low FFS costs, divided into quartiles, and assigned the following differing percentages. + Highest-cost quartile counties → 95% of base payment rate + Second highest-cost quartile counties → 100% of base payment rate + Third highest-cost quartile counties → 107.5% of base payment rate + Lowest-cost quartile counties → 115% of base payment rate Quartiles would be redetermined no less often than every 3 years. Whenever the quartile ranking of a county changes, a one year transition would apply using a blended percentage (e.g., 100% → 95% quartile = 97.5% of base payment rate). • ***Quality adjustment:*** Beginning in 2012, quality adjustments to base payment amounts would apply for 4 – 5 star plans and for other plans, at the Secretary's discretion, if they make "meaningful improvement" in their quality scores. + *All 4 – 5 star plans*: All 4 – 5 star plans would receive a 5% increase in base county payment amounts phased in over 3 years starting in 2012 (i.e., 2012 – 1.5%; 2013 – 3%; 2014 and thereafter – 5%). + *Additional adjustment for 4 - 5 star plans in certain counties*: The increase would be doubled to 10% for 4 – 5 star plans in counties that meet specified criteria – historical urban floor, at least 25% MA penetration, and below national average per capita FFS spending. + *Low enrollment plans*: For 2012, a low enrollment plan that CMS determines would not be able to receive a quality ranking would be treated as a 4 – 5 star plan and receive the 1.5% quality bonus. For 2013 and subsequent years, CMS would be required to establish a method to compute a quality rating for such plans. + *New plans*: Beginning in 2012, a new plan (i.e., a plan offered by an organization that has not had an MA contract for the preceding 3 years) that meets criteria established by CMS could also receive an increase in the base county payment. The following phase-in schedule would apply: -- 2012 – 1.5%; 2013 – 2.5%; 2014 and thereafter – 3.5%. ***Extended phase-in:*** MA plans experiencing the greatest impact from the payment changes would have a longer phase-in schedule of either 4 or 6 years. The year to year reduction would be determined by comparing: -- 2010 benchmark and

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	-- 1/2 of the 2010 benchmark + 1/2 of a "projected 2010 benchmark" that reflects the adjustments applicable under the new methodology in 2012 (including quality bonuses). + *Phase-in from 2012 – 2015* would apply for MA plans with a reduction for a year of more than $30 – less than $50. + *Phase-in from 2012 – 2017* would apply for MA plans with reduction for a year of more than $50. • ***Cap on rates:*** New payment rates (with quality bonuses included) could not exceed rates that would have applied under current law. • ***Rebates:*** Completion of a 2012 – 2014 phase-in would fully implement reductions in the rebates generated when MA organizations bid below the benchmark: + *2012* – 2/3 based on the current law rebate of 75% – 1/3 quality-based rebate equal to: -- MA plans with ratings of 4.5 or more stars → 70% -- MA plans with ratings of 3.5 – 4 stars → 65% -- MA plans with ratings below 3.5 stars → 50% For 2012, low enrollment plans would be treated as 4.5 star plans and new plans would be treated as 3.5 star plans for the purpose of determining rebates. + *2013* – 2/3 based on the current law rebate of 75% – 1/3 quality-based rebate + *2014* – All rebate percentages would be quality-based + *Low enrollment plans*: For 2012, a low enrollment plan that CMS determines would not be able to receive a quality ranking would be treated as a 4.5 star plan. (This provision appears to assume that such plans would receive quality ranking in subsequent years because as noted above, CMS is required to establish a ranking methodology.) + *New plans*: For 2012 and subsequent years, a new plan (i.e., a plan offered by an organization that has not had an MA contract for the preceding 3 years) that meets criteria established by CMS would be treated as a 3.5 star plan. [Sec. 1102 of the Reconciliation Bill (Substitute to H.R. 4872)] ~~Phases-in competitive bidding in order to base MA benchmarks on actual plan costs.~~ ~~In 2011, retains the current payment methodology and reduces the national MA per capita growth percentage by three percentage points.~~ ~~In 2012 and 2013, blends local MA benchmarks under current law with competitive bidding benchmarks based on the weighted average of plan bids. (Weighting would be based on the most recent month for which data is available).~~ • ~~2012 local MA benchmarks = 33 percent based on weighted average bids; 67 percent based on current law.~~ • ~~2013 local MA benchmarks = 67 percent based on weighted average bids; 33 percent based on current law.~~

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	~~In 2014, local MA benchmarks would be equal to 100 percent of the enrollment weighted average of the 2013 plan bids increased by the national MA growth percentage for 2014.~~ ~~Beginning 2015, the MA local benchmarks would be determined by the enrollment weighted average of all MA bids in each payment area.~~ • ~~In the case of a payment area where only a single plan is offered, the weight would be equal to one. In the case of a payment area where no MA plans were offered in a prior year and multiple plans bid in the following year, the Secretary would use a simple average to calculate the MA benchmark in that area.~~ ~~Does not allow local benchmarks to exceed the levels that would have existed under current law. Provides that bids from all local MA plans (except regional plans, PACE plans, and 1876 cost plans) would be used to set MA benchmarks. Regional plan benchmarks would continue to be calculated as a weighted blend of the regional bid and local MA benchmarks. The statutory portion would be based on the new MA benchmarks instead of statutory rates.~~ ~~Rebates for local and regional MA plans:~~ • ~~In 2011, 2012, and 2013, local and regional MA plans would still receive 75 percent of the difference between their bids and the benchmark rates as a rebate payment.~~ • ~~Beginning 2014, MA plans that bid below the new benchmark rate would receive a rebate amount equal to 100 percent of the difference between their bid and the new benchmark.~~ • ~~As required under current law, local and regional MA plans that bid equal to or above the new benchmark rate would be paid the benchmark amount and must charge an enrollee premium equal to the difference between the benchmark and the bid.~~ ~~Risk adjusts total payments to plans as under current law. MA plans would be required to use 100 percent of any rebate amount to provide additional benefits to their enrollees. Plans would be allowed to offer supplemental benefits for which beneficiaries would be charged an added premium.~~ ~~Exempts PACE plans from changes to the MA benchmarks beginning with the transition to competitive bidding in 2012.~~ ~~Bidding rules:~~ • ~~Requires MA plan bids to be certified by a Member of the American Academy of Actuaries (MAAA). The Secretary would continue to use current statutory authority to review and negotiate plan bids and set guidelines for the actuarial standards that bids must meet.~~ • ~~Beginning 2012, requires the Secretary to establish bidding rules to protect the integrity and fairness of the bidding process.~~ • ~~Requires the Secretary to deny bids that do not meet the actuarial standards and guidelines or abide by the rules for competitive bidding.~~ • ~~Requires the Secretary to report plan actuaries who repeatedly do not comply with bidding rules and standards to the Actuarial Standards Board for Counseling and Discipline.~~

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	~~Payment areas:~~ • ~~Beginning in 2012, in urban areas, requires payment areas to be based on the Core-Based Statistical Area (CBSA) as determined by the Office of Management and Budget. Requires the Secretary to divide CBSAs that cover more than one state, and allows CBSA-based payment areas to be adjusted to reflect recent analyses of actual health care use.~~ • ~~Beginning in 2015, permits the Secretary to adjust MA local plan service areas in urban and rural areas to better reflect research on actual patterns of care.~~ • ~~Provides the Secretary with additional authority to make limited exceptions to payment area requirements for plans that have historical licensing agreements that preclude the offering of benefits throughout an entire payment area or that have historical limitations on their structural capacity to offer benefits throughout an entire payment area.~~ • ~~Beginning in 2010, makes bidding areas the same as payment areas and requires MA plans to bid and serve an entire payment area.~~ ~~[Sec. 3201 of the Act/ Sec. 1853(j) of the SSA]~~
Minimum Medical Loss Ratio	• ***Requirement for .85 MLR:*** Beginning in 2014, if the Secretary determines for a contract year that an MA plan that does not have a minimum medical loss ratio of at least .85: + The MA plan must pay to the Secretary the product of: -- Total revenue of the MA plan for the contract year; and -- Difference between .85 and the MLR + If the MA plan does not meet the standard for 3 consecutive years, the MA plan would not be permitted to enroll new enrollees under the plan during the second succeeding contract year; and + If the MA plan does not meet the standard for 5 consecutive years, the plan contract would be terminated. [Sec. 1103 of the Reconciliation Bill (Substitute to H.R. 4872)]
Grandfathered Plans	~~Beginning in 2012, requires the Secretary to identify MA local areas with respect to 2009 average bids submitted by an MA organization and allows MA plans to grandfather the extra benefits for their current enrollees in certain areas of the country where average plan bids are at or below 75 percent of local FFS costs. Applies only to beneficiaries enrolled in MA on the date of enactment and excludes rebate payments or performance bonus payments under competitive bidding. Reduces the amount of extra benefits by 5 percent each year beginning in 2013. Requires plans that grandfather their current enrollees to submit bids under competitive bidding in those areas. Bids for Medicare-covered benefits submitted by an organization would be the same for competitive bidding and grandfather plans except for the extra benefits. Excludes grandfathered plans from being eligible for performance bonus payments under competitive bidding. Bids and extra benefits for grandfathered enrollees would be risk adjusted, as under competitive bidding, except extra benefits for grandfathered plans would also be adjusted for differences in utilization that could result from differences in extra benefits. The Secretary shall review the utilization factor for grandfathered plans and only allow factors that reasonably capture~~

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	~~added use of care from the extra benefits allowed by the grandfather provision based on historical bids. [Sec. 3201(g) of the Act/Sec. 1853 of the SSA)~~
Transitional Benefits	~~*Transitional Benefits:* Requires the Secretary to provide for transitional extra benefits in 2012 to beneficiaries who enroll in MA plans and experience a significant reduction in extra benefits under competitive bidding. Directs the Secretary to provide for these transitional benefits in certain areas:~~ ~~1. the two largest metropolitan areas of the country if extra benefits in those areas are greater than $100 per member per month in 2009; and~~ ~~2. counties where the MA benchmark amount in 2011 is equal to the legacy urban floor amount, the MA enrollment penetration is greater than 30 percent, and the MA plans bid below the local fee-for-service costs.~~ ~~Permits the Secretary to also provide transitional benefits in counties contiguous to these areas and requires the Secretary to review plan bids to ensure that transitional benefits made available are passed on to beneficiaries. Appropriates $5 billion through 2019. [Sec. 3201(p) of the Act/Sec. 1853 of the SSA]~~
Private Fee-For-Services Plans	Starting in plan year 2011 the Secretary shall extend the 2008 service area extension waiver policy to employers who contract directly with the Secretary as a Medicare Advantage Private Fee-for-Service Plan and that had enrollment as of October 1, 2009. [Sec. 3207 of the Act/ Sec. 1852(d)(5)(B) of the SSA]
~~Quality Bonus Payments~~	~~*Bonus payments*: Beginning in 2014 and available to all MA plans, would establish two new bonus payments for local and regional MA plans. When added together, the new bonus payments would equal a maximum of five percent of the national U.S. Per Capita Costs of Medicare (USPCC) on a per member per month basis. Would only be available to plans that meet certain performance criteria and would not depend on benchmark rates.~~ ~~• Creates a new bonus payment for care coordination and management activities that are conducted by MA plans. Up to two percent of the USPCC would be available to MA plans that demonstrate they conduct activities in four of eight areas. Plans are eligible to earn ½ percent of the USPCC for each of the following separate areas in which they conduct activities:~~ ~~1. Care management programs targeted to individuals with chronic conditions, identify gaps in care, and facilitate improved care;~~ ~~2. Patient education programs and self-management of health conditions;~~ ~~3. Transitional care interventions that focus on care provided around a hospital inpatient episode;~~ ~~4. Patient safety programs;~~ ~~5. Financial policies that promote systematic coordination of care by primary care physicians across the full spectrum of specialties and sites of care;~~ ~~6. Medication therapy management programs;~~ ~~7. Health information technology programs;~~ ~~8. Programs that address, identify, and ameliorate health care disparities.~~

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	~~Authorizes the Secretary to add care management and coordination programs as appropriate. Allows for plans to implement programs in ways that are appropriate for urban and rural areas.~~ • ~~Creates a second bonus for prior year achievement or improvement in plan quality performance. Performance would be measured based on a ranking system that measures clinical quality and enrollee satisfaction at the contract or plan level. MA plans would be eligible to receive 1) two percent of the USPCC if they achieve a three star rating on a five star ranking system, or 2) four percent of the USPCC if they achieve between four and five stars on a five star ranking system. Plans that do not receive at least a three star rating would be eligible for a one percent quality bonus if their ratings improve over a prior year. If the Secretary chooses not to use a five star ranking system, bonus payments would continue to be made available to plans that achieve a similar level of achievement. The Secretary would use the most recent rankings available when making quality bonus payments.~~ ~~Makes accommodations for quality bonuses for new and low-enrollment plans for limited time frames. New MA plans would be eligible for a two percent bonus for the first two years of operation if they meet criteria for structural measures of quality and network adequacy defined by the Secretary. For plans with low-enrollment, the Secretary would be required to use a regional or local mean for quality measures that precludes a plan with insufficient data from being evaluated for quality performance using a five star ranking system. Provides the Secretary with the authority to create alternative mechanisms for measuring quality for the purposes of quality bonus for plans with persistently low enrollment.~~ ~~Requires the Secretary to risk adjust both the care coordination and quality bonus payments to reflect the demographics and actual health status of each enrollee. MA plans would be required to use 100 percent of the bonus payment amounts to cover the cost of additional benefits offered to their enrollees. Plans would still be allowed to offer supplemental benefits for which they charge beneficiaries an added premium.~~ ~~[Sec. 3201 of the Act/ Sec. 1853(j) of the SSA]~~
Benefit Protection and Simplification	Beginning in 2011, prohibits MA plans from charging cost-sharing that is greater than the cost-sharing under the original Medicare program for certain services such as chemotherapy treatment, renal dialysis and skilled nursing care. Provides the Secretary authority to identify additional services for which this provision would apply. Continues to allow MA plans to charge cost sharing for Medicare covered services where there is no cost sharing under the traditional program. Modifies how plans may use their rebates and bonuses for additional benefits beginning in 2012. MA plans would be required to apply the full amount of rebates and to cover the cost of additional benefits in the following order: 1. Use most significant share to reduce Part A, B, and D cost-sharing relative to FFS program. MA plans would be prohibited from reducing or eliminating the Part B premium as additional benefit. Any out-of-pocket spending limits that plans offer would be required to apply to all of Part A and B benefits. 2. Add preventative and wellness benefits.

	Summary of the "Patient Protection and Affordable Care Act," (as passed by the Senate on December 24, 2009, and by the House on March 21, 2010) and the "Health Care and Education Reconciliation Act of 2010" (highlighted, as passed by the House on March 21, 2010)
	3. Add non-covered benefits. [Sec. 3202 of the Act/ Sec. 1852(a)(1)(B) of the SSA]
Coding Intensity Adjustment	• ***Coding intensity adjustment:*** The requirement for a coding intensity adjustment would be permanently extended, and for 2019 and subsequent years, the adjustment factor could be no less than 5.7%. + Starting in 2014, a minimum annual adjustment would be required: -- 2014 – Not less than the 2010 adjustment factor + 1.3 percentage points (i.e., 4.71%); -- 2015 through 2018 – Not less than the previous year's adjustment factor + .25 percent age points (i.e., 2015 not less than 4.96%; 2016 not less than 5.21%; 2017 not less than 5.46%; 2018 not less than 5.71%); -- 2019 and subsequent years – Not less than 5.7%. + The adjustment would no longer be required when the CMS implements risk adjustment based on MA data. + The existing authority would be amended to require that CMS perform *annually* an analysis of differences in coding patterns between MA plans and Medicare FFS providers and ensure that the results are incorporated *on a timely basis* into risk scores. CMS would be required to use data submitted with respect to 2004 and subsequent years, as available, *and updated as appropriate.* [Sec. 1102 of the Reconciliation Bill (Substitute to H.R. 4872)] ~~Applies the coding intensity adjustment during the transition (2011, 2012, and 2013) and grants the Secretary the authority to apply the results of the coding analysis into the risk scores for 2014 and subsequent years. [Sec. 3203 of the Act/ Sec. 1853(a)(1)(C) of the SSA]~~
Enrollment Periods	*Simplification of Annual Beneficiary Election Periods:* Effective 2011 creates the annual enrollment period for MA and Part D from October 15 to December 7 and eliminates the annual open enrollment period (January 1 through March 31) for MA plans. Creates a 45-day period (January 1 – February 15) beginning in 2011 in which beneficiaries who enroll in MA or prescription drug plans during the annual enrollment period may disenroll and return to traditional FFS and elect qualified prescription drug coverage. [Sec. 3204 of the Act/ Sec. 1851(e)(2)(C) of the SSA]
Cost Contracts	*Extension of Reasonable Cost Contracts:* Extends for three years from January 1, 2010, to January 1, 2013, the length of time cost plans may continue to operate regardless of any other MA plans in the area. [Sec. 3206 of the Act/Sec. 1876(h)(5)(C)(ii) of the SSA]
MA Regional Plan Stabilization Fund	Eliminates the MA Regional Plan Stabilization Fund. Any amounts remaining in the fund shall be transferred to the Part B Trust Fund. [Sec. 10327 of the Manager's Amendment]

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Authority to Deny Bids	Beginning January 1, 2011 authorizes Secretary to deny MA and PDP plan bids if it proposes significant increases in cost-sharing or decreases in benefits offered under the plan. [Sec. 3209 of the Act/Sec. 1854(a)(5) of the SSA].
Medigap	Requests that NAIC create new model plans for benefit packages C and F that include nominal cost sharing. The new models C and F would be available in 2015. [Sec. 3210 of the Act/ Sec. 1882 of the SSA]
Extension of SNPs	*Extension for Specialized MA plans for Special Needs Individuals:* • Extends SNP authority through December 31, 2013. • Creates a new payment adjustment for fully-integrated dual-eligible SNPs. Provides the Secretary authority to provide frailty adjustment for full-integrated dual eligible SNPs that have similar average levels of frail beneficiaries as PACE plans as defined by the Secretary. To qualify, dual-eligible SNPs would need to integrate Medicare and Medicaid benefits and payments through an MA contract with the Secretary and a contract with their state Medicaid agency that includes the provision of long-term care. • Requires the Secretary to transition beneficiaries enrolled in SNPs to other MA plans or original Medicare if they do not meet the requirements established for plans by 2013. Exceptions would be allowed to the transition requirements for dual-eligible beneficiaries who lost their Medicaid status in order to give them time to reapply for Medicaid benefits. Requires all dual-eligible SNPs to have established contracts with state Medicaid programs by January 1, 2013. • Directs the Secretary to require SNPs to be certified or otherwise approved by NCQA in order to participate in the MA program for 2012 and subsequent years. • Beginning 2011, requires the Secretary to use risk scores for new enrollees in SNPs that reflect the known underlying risk profile and chronic health status of each enrollee. The new risk score would be budget neutral. For 2011 and periodically thereafter, the Secretary would evaluate and revise the methodology used to risk adjust MA plan payments in order to accurately account for higher medical and care coordination costs associated with frailty, persons with multiple co-morbid chronic conditions, enrollees with mental illness, and also account for the costs that may be associated with higher concentrations of beneficiaries with these conditions. The Secretary would publish a description of its evaluation and modifications with the announcement of final payment rates. [Sec. 3205 of the Act/ Sec. 1859(f)(1) of the SSA]
Extension of Medicare Senior Housing Plans	Makes permanent a demonstration project that allows MA senior housing facility plans to operate. Defines such plans and allows a plan's service area to be limited to a senior housing facility in a geographic area. Effective on January 1, 2010, and applies to plan years beginning on or after such date. [Sec. 3208 of the Act/Sec. 1859 of the SSA]

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Elimination of Coverage Gap	Provides a $250 rebate to any beneficiary who enters the coverage gap in 2010. Starting 2011, establishes progressively lower beneficiary coinsurance for generic drugs dispensed to beneficiaries in the coverage gap such that the required coinsurance for generic drugs is 25 percent by 2020 in the coverage gap in the standard Part D benefit. Starting 2013, provides coverage in the standard Part D benefit for brand-name drugs such that by 2020, the required beneficiary coinsurance plus the discount made available in Section 3301 of the Act results in the beneficiary paying 25 percent of the cost of the drug or an actuarially equivalent amount. From 2014-2020, reduces that annual growth rate applied to the Part D catastrophic threshold. [Sec. 1102 of the Reconciliation Bill (Substitute to H.R. 4872)] ~~Beginning January 1, 2010, the initial coverage gap shall be increased by $500 and requires that no changes be made to premium bids or any other parameters under Part C. Requires the Secretary to establish procedures to fully reimburse PDP sponsors with respect to MA-PDPs for the reduction in beneficiary cost sharing. Requires the Secretary to develop an estimate the additional increased costs for increased drug utilization and financing and administrative costs and shall use the estimates to adjust payments to PDP sponsors with respect to prescription drug plans and MA organizations with respect to MA-PDPs under Part C. [Sec. 3315 of the Act/1860D-2(b) of the SSA]~~
Discount on Certain Part D Drugs in Original Coverage Gap	*Improving Coverage in the Part D Coverage Gap:* Establishes a discount program for beneficiaries who enroll in Part D and have drug spending that falls into the coverage gap. Provides for manufacturers' discounts on brand-name drugs that are covered under Part D and are on plan formularies or treated as being on a plan formulary through the exceptions and appeals process. Beginning January 1, 2011 ~~July 1, 2010~~, eligible beneficiaries would automatically receive a 50 percent discount off the negotiated price for brand-name prescription drugs that are covered under Part D and covered by their plan's formulary or treated as being on a plan formulary through the exception and appeals process. The negotiated price is the price that plans pay to pharmacies minus the amount of price concessions (i.e., rebates and discounts) that plans pass on to beneficiaries. • Applies the discount program to Medicare beneficiaries who enroll in Part D, who do not qualify for the low-income subsidy, are not enrolled in an employee-sponsored retiree drug plan, and do not have annual income that exceeds the Part B income limit thresholds as determined under current law. These requirements do not apply if the Secretary has determined that the availability of the drugs would be essential to the health of beneficiaries or the Secretary had determined that there are extenuating circumstances in the period between January 1, 2011, and December 31, 2011 ~~July 1, 2010, and December 30, 2010~~. • Allows for 100 percent of the negotiated price of discounted drugs to count toward the annual out-of-pocket threshold that is used to define the coverage gap each year. • Stipulates that drugs sold and marketed in the U.S. by a manufacturer would not be covered under Part D unless the manufacturer agrees to participate in the discount program described above. Requires manufacturers to sign an agreement with the Secretary of HHS in order to participate in the program and have their drugs covered by Part D. Agreements would be effective for an initial period of not less than one year and would be automatically renewed for a period of not less than one year unless terminated.

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	[Sec. 3301 of the Act as modified by Sec. 1101 of the Reconciliation Bill/ Adds Sec. 1860D-43]
Long-Term Care Pharmacies	Requires Part D and MA prescription drug plans to employ utilization management techniques in long-term care facilities to reduce waste associated with 30-day fills. Applies to plan years beginning on or after January 1, 2012. [Sec. 3310 of the Act/ Sec. 1860D-4(c) of the SSA]
TrOOP	Beginning January 1, 2011 , includes costs incurred in providing prescription drugs by AIDS drug assistance programs, a state pharmaceutical assistance program, and the Indian Health Service toward the annual out-of-pocket threshold under Part D. [Sec. 3314 of the Act/ Sec. 1860D-2(b)(4)(C) of the SSA]
Improving and Simplifying Financial Assistance for Low-Income Medicare Beneficiaries [under Part D]	*Improving the Determination of Part D Low-Income Benchmarks:* Effective January 1, 2011, requires the Secretary to exclude Medicare Advantage rebates and bonus payments from the MA-PDP premium amount when calculating the regional LIS benchmark amounts. [Sec. 3302 of the Act/ Sec. 1860D-14(b)(2)(B)(iii) of the SSA] *Voluntary De Minimus Policy for Low-Income Subsidy Plans:* Beginning in January 1, 2011, authorizes a policy through which plans that bid a nominal amount above the regional low-income subsidy (LIS) benchmark amount can choose to absorb the cost of the small difference between their bid and the LIS benchmark in order to qualify as a LIS-eligible plan. Authorizes the Secretary to auto-enroll LIS beneficiaries into these plans in order to maintain adequate LIS plan choices. De minimus threshold would be established by the Secretary. [Sec. 3303 of the Act/ Sec. 1860D-14(a) of the SSA] *Special Rule for Widows and Widowers regarding eligibility for Low-Income Assistance:* Beginning in January 1, 2011, stipulates that surviving spouses of an LIS-eligible couple would undergo a redetermination of his or her eligibility status no earlier than one year from the next redetermination that would have occurred after the death of a spouse. [Sec. 3304 of the Act/ Sec. 1860D-14(a)(3)(B) of the SSA] *Facilitation of Reassignments of Beneficiaries in Low-Income Subsidy Plans:* Beginning no later than January 1, 2011 requires plans whose bids exceed the regional benchmark amount and whose LIS beneficiaries are reassigned to other plans by CMS to transmit recent drug utilization data to the beneficiary's new plan within thirty days of notification of the reassignment. Requires the Secretary to provide these beneficiaries with information about formulary differences between old and new plans with respect to their drug regimen, as well as a description of the new plan's appeals process, grievance mechanisms and coverage determination/redetermination process. Requires that the Secretary develop a standard format for which plans are to provide this information to beneficiaries. [Sec. 3305 of the Act/ Sec. 1860D-14 of the SSA] *Funding Outreach and Education of Low-Income Programs:* Provides funding for outreach and education activities related to Medicare low-income assistance programs, including the Part D low-income subsidy (LIS) program and the Medicare Savings Programs (MSP). Funds would be allocated to State Health Insurance Programs, the Administration on Aging for area agencies on aging, Aging Disability

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	Resources Centers, and for those contracting with the National Center for Benefits Outreach and Enrollment in the same proportion under MIPPA. Funds would be available through 2012. [Sec. 3306 of the Act/ Sec. 119 of MIPPA]
Other Part D Provisions	*Strengthening Formularies with Respect to Certain Categories or Classes of Drugs:* Beginning in 2011, removes criteria specified in Section 176 of MIPPA that would have been used by the Secretary to identify protected classes of drugs. Provides the Secretary authority to identify classes of clinical concern. Codifies the six classes of clinical concern as they are currently specified through sub-regulatory guidance until the Secretary issues a rule regarding classes of clinical concern to be protected on plan formularies. [Sec. 3307 of the Act/ Sec. 1860D-4(b)(3)(G) of the SSA] *Reducing the Part D Premium Subsidy for High-Income Beneficiaries:* Beginning in 2011, reduces the Medicare premium subsidy amount for beneficiaries whose modified adjusted gross income (MAGI) exceeded the thresholds used under Part B ($85,000 for an individual and $170,000 per couple in 2009). The provision would be implemented similar to the current income-related reductions in Part B premium subsidies. Expands the authority for the IRS to disclose income information to SSA for purposes of adjusting the Part B subsidy to include the Part D subsidy adjustments and related appeals. [Sec. 3308 of the Act/ Sec. 1860D-13(a) of the SSA] *Medicare Part D Copayment Equity*: Eliminates cost sharing under Part D for full-benefit, dual eligible beneficiaries receiving care under a home and community-based services under section 1915, 1932, or 1115 waivers who would otherwise require institutional care. [Sec. 3309 of the Act/ Sec. 1860D-14(a)(1)(D)(i) of the SSA] *Part D Complaint System*: Directs the Secretary to develop and maintain a complaint system to collect information regarding MA-PDP and PDP complaints and the date they were resolved. Requires the development of a standard electronic complaint form. [Sec. 3311 of the Act] *Uniform Exceptions and Appeals*: Requires sponsors of PDPs and MA-PDPs to use a single, uniform exceptions and appeals process by 2012. [Sec. 3312 of the Act/ Sec. 1860D-4(b)(3) of the SSA] *Study on Medicare and Medicaid Drug Prices*: Directs the Inspector General of HHS to conduct a study comparing prescription drug prices paid by Medicare Part D insurers to those negotiated by state Medicaid plans for the top 200 drugs determined by both volume and expenditures. Requires the prices to include all rebates and discounts the Medicaid and Part D plans receive. [Sec. 3313 of the Act] *Medication Therapy Management Programs:* Establishes new requirements for Part D plan Medication Therapy Management Programs effective two years after enactment. • Requires such programs to include annual comprehensive medication reviews provided person-to-person or via telehealth by a licensed pharmacist or other qualified provider; • Mandates that such programs perform assessments on at least a quarterly basis of the medication use of at-risk individuals who are not enrolled in such programs; and • Requires such programs have processes to automatically enroll at-risk individuals with an opt out. [Sec. 10229 of the Manager's Amendment/ Sec. 1860D-4 of the SSA]

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Promoting Disease Prevention and Wellness: Medicare	*Coverage of Annual Wellness Visit Providing a Personalized Prevention Plan*: Beginning January 1, 2011, requires Medicare to cover a health risk assessment (HRA) based on guidelines developed by the Secretary, in consultation with relevant groups. This assessment would identify chronic diseases, injury risks, modifiable risk factors, and emergency or urgent health needs, and could be provided through an interactive web-based program, through community-based prevention programs, or through consultation with a health professional. Requires that a comprehensive health risk assessment be completed prior to or as part of the wellness visit. Authorizes Medicare payment for a visit to a primary care provider to create a personalized prevention plan. All enrolled beneficiaries would be eligible for one wellness visit each year. No copayment or deductible would apply. A beneficiary is eligible to receive only an initial physical examination during the 12-month period after the date that Part B coverage begins; thereafter, the beneficiary shall be eligible for personalized prevention plan services once every 12 months. [Sec. 4103 of the Act/Secs. 1861-1862, 1833 of the SSA] *Removal of Barriers to Preventive Services in Medicare*: Removes cost-sharing for preventive services graded A or B by the USPSTF for any population, and are appropriate for the individual. With respect to FQHCs for which payment is made under section 1834(o), the amount paid shall be 80 percent of the lesser of the actual charge or the amount determined under such section. [Sec. 4104 of the Act, as amended by Sec. 10501 of the Manager's Amendment/Secs. 1861, 1833 of the SSA] *Evidence-Based Coverage of Preventive Services in Medicare*: Beginning January 1, 2010, the Secretary may modify coverage of any preventive service to the extent consistent with USPSTF recommendations, as well as the services included in the initial physical examination, and may withdraw Medicare coverage for services not rated A, B, C, or I. *Development and Implementation of Prospective Payment System*: The Secretary shall develop a prospective payment system for payment for services furnished by FQHCs, including a process for appropriately describing the services, and shall establish payment rates for specific payment codes based on such appropriate descriptions. No later than January 1, 2011, the Secretary shall require FQHCs to submit the information required to implement the prospective payment system, effective for cost reporting periods beginning on or after October 1, 2014. In the year of implementation, the estimated aggregate amount of rates shall be 100 percent of the estimated amount of reasonable costs. In subsequent years, the amount shall be increased by: (1) in the first year after implementation, by the percentage increase in MEI for the year; and (2) in subsequent years, by the percentage increase in market basket of FQHC goods and services, or, if such index is unavailable, by the percentage increase in MEI for the year. [Sec. 4105 of the Act, as amended by Sec. 10501 of the Manager's Amendment /Sec. 1834 of the SSA]
Linking Hospital Payments to Quality Outcomes in the Medicare Program	*Hospital Value-based Purchasing*: Establishes a Hospital Value-based Purchasing (VBP) program that would provide value-based payments to hospitals that meet certain quality performance standards beginning in FY 2012. Measures for the VBP would be selected from the measures related to the Hospital Consumer Assessment of Healthcare Providers and Systems survey (HCAHPS) other than measures of readmissions. For VBP related to discharges the Secretary shall ensure the measures selected cover at least acute myocardial infarction (AMI), heart failure, pneumonia, surgeries, and healthcare-associated infections, but may not include readmission measures. Beginning in 2014, the Secretary shall include efficiency measures. Requires the Secretary to establish performance

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	standards, a performance period, and a performance assessment methodology for the VBP. Distributes hospital VBP payments based on performance scores with the highest performance scores receiving the largest payment. Hospitals that meet or exceed performance standards would receive value-based incentive payments. Establishes procedures for determining the total amount available for VBPs and the method for determining amounts for each hospital. Allows a hospital to appeal the calculation of a hospital's performance assessment. Information would be made public regarding individual hospital performance on each specific quality measure, on each condition or procedure, and on total performance. Permits the Secretary to require hospitals to submit data on measures that are not used for determining VBP. The Secretary shall provide risk-adjustment as it relates to quality measures for outcomes of care to maintain incentives for hospitals to treat patients with severe illnesses or conditions. Requires the GAO and HHS to conduct separate studies on the performance of the hospital VBP program and report results to Congress. Establishes 3-year demonstration projects to test VBP models tailored toward critical access hospitals. [Sec. 3001 of this Act/Sec. 1886 of the SSA] *Quality Reporting for Cancer Care Hospitals:* Requires a cancer hospital to submit quality information to the Secretary by FY 2014. Requires the Secretary, not later than October 1, 2012, to publish the measures required to be reported in 2014. Requires the selected measures of quality to cover, to the extent feasible and practicable, all dimensions of quality as well as efficiency of care. The Secretary shall establish procedures for making data available to the public. [Sec. 3005 of this Act/Sec. 1866 of the SSA] *Reducing Hospital Acquired Conditions*: Applies a new payment adjustment to hospitals ranked in the top quartile of national, risk-adjusted hospital acquired condition (HAC) rates. Requires the Secretary to collect national and hospital-specific data on the HAC rates and share this data with hospitals starting in FY 2013. Permits a hospital the opportunity to review and submit corrections before the information is made public. Requires the data to be posted on the Hospital Compare internet website. Prior to FY 2015, hospitals in the top quartile of national HAC rates would receive 99 percent of their otherwise applicable Medicare payments. [Sec. 3008 of this Act/Sec. 1886 of the SSA] (See also **Reducing and Reporting Hospital Readmissions** section below.)
Payment for Quality – Other Medicare Providers	IRFs and LTCHs: Requires the Secretary to establish quality reporting programs for inpatient rehabilitation facilities (IRFs), long term care hospitals (LTCHs) and hospices by FY 2014. Fines entities that fail to report. Requires the selected measures of quality to cover, to the extent feasible and practicable, all dimensions of quality as well as efficiency of care. The Secretary shall establish procedures for making data available to the public. [Sec. 3004 of this Act/Sec. 1886(m) of the SSA] HHAs and SNFs: Requires the Secretary to complete Medicare value-based purchasing implementation plans for home health agencies and SNFs by 2010 and 2011, respectively. The following issues would be considered by each plan: 1) The development, selection and modification process of measures of quality and efficiency; 2) The reporting, collection, and validation of quality data; 3) The structure of proposed value-based payment adjustment; and 4) The methods for public disclosure of information on performance. [Sec. 3006] Physicians: Requires the Secretary to apply a separate, budget-neutral payment modifier to the FFS physician payment formula that will not be used to replace any portion of the Geographic Adjustment Factor. Requires the modifier to be budget-neutral and pay physicians or groups of physicians differentially based upon the relative quality of care they achieve for Medicare beneficiaries relative to cost.

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	Outlines the methodology the Secretary must use to determine physician costs and quality measures. Requires the Secretary to abide by the following timeline: • publish, by January 1, 2012, the specific measures of quality and cost, the specific dates for implementation of the payment adjustment, and the initial performance period; • implement the value-based payment modifier in the 2013 rulemaking process; • initiate the performance period in 2015 and provide, to the extent feasible, information to physicians about the value of care they provide; • implement payment consequences beginning in 2015 based on the value of care delivered during the performance period. Requires the payment modifier to be applied in a way that promotes systems-based care; and • require, by 2017, all physician payments to be subject to this payment modifier. The Secretary shall coordinate the VBP modifier with other programs such as the Physician Feedback Program. [Sec. 3007 of this Act/Sec. 1848 of the SSA] Implements a value-based purchasing program for payments for ambulatory surgical centers (ASC) taking into consideration the following: • The ongoing development, selection, and modification process for measures of all dimensions of quality and efficiency in ASCs; • The reporting, collection, and validation of quality data; • The structure of value-based payment adjustments; • Methods for the public disclosure of information on the performance of ASCs; and • Any other issues deemed appropriate by the Secretary. [Sec. 3006 of this Act, as added by the Manager's Amendment] Requires the Secretary to establish pilot programs for pay-for-performance no later than January 2016 for the following providers: psychiatric hospitals, long-term care hospitals, rehabilitation hospitals, PPS exempt hospitals, and hospice programs. [Sec. 10326 of the Manager's Amendment]
Improving Payment Accuracy	*Hospice Payment Reforms*: Requires the Secretary to collect additional data and information in order to revise payments for hospice care after consulting with hospice providers and MedPAC, and to implement changes to the payment methodology for hospice care as appropriate based on the additional data collected. The Secretary would impose certain requirements on hospice providers to ensure accountability. [Sec. 3132 of the Act/ Sec. 1814(i) of the SSA] *Medicare DSH Changes*: Beginning no later than FY ~~2015~~ 2014 and continuing on an annual basis, makes disproportionate share payments of 25 percent of the disproportionate share payment that would otherwise be made. Makes other changes to DSH payments in future years. In addition to this amount, a payment would be made to reflect hospitals' continued uncompensated care costs. [Sec. 3133 of the Act as modified by Section 1104 of the Reconciliation Bill/ Sec. 1886 of the SSA]

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	Hospital Wage Index Improvement: Requires application of budget neutrality on a national basis in the calculation of the Medicare hospital wage index floor for each all-urban and rural state. The Secretary shall use the hospital wage index promulgated in the *Federal Register* on August 27, 2009, subject to certain exceptions. By December 31, 2011, the Secretary would be required to provide a plan to Congress on how to comprehensively reform the Medicare wage index system, taking into account goals set by the MedPAC June 2007 report. [Sec. 3137 of the Act/ Sec. 106 of the Tax Relief and Health Care Act of 2006] *Medicare HCC Demonstration*: Creates the Medicare Hospice Concurrent Care (HCC) 3-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. [Sec. 3140] *Application of Budget Neutrality on a National Basis in the Calculation of the Medicare Hospital Wage Index Floor:* Beginning on October 1, 2010, applies a uniform national adjustment to the area wage index for discharges occurring during fiscal year 2008. [Sec. 3141]
Incorporating Productivity Improvements into Market Basket Updates	Makes the following changes to Medicare provider payments: • Home Health Providers: Reduces market basket updates for home health providers by 1 percent in 2011-2013, and for hospice providers by 0.3 percent in 2013-2019 in addition to productivity adjustments. • Hospitals: Requires a market basket minus 0.25 percent reduction in 2010 (effective January 1, 2010) and 2011 for inpatient and outpatient hospitals and market basket minus 0.1 percent for fiscal years 2012 and 2013, 0.3 percent in 2014, 0.2 percent in 2015 and 2016, and 0.75 percent in 2017, 2018, and 2019. • Long Term Care Hospitals: Reduces market basket updates by 0.5 percent in FY 2011 and by 0.1 percent in 2012 and 2013, 0.3 percent in 2014, 0.2 percent in 2015 and 2016, and 0.75 percent in 2017, 2018, and 2019. • Psychiatric Hospital: Requires a market basket minus 0.25 percent reduction in 2010 (effective January 1, 2010) and 2011 and a 0.1 percent reduction in 2012 and 2013, 0.3 percent in 2014, 0.2 percent in 2015 and 2016, and 0.75 percent in 2017, 2018, and 2019. Starting 2014, reduces the payment update for psychiatric hospitals that fail to report quality data required by the Secretary. • Inpatient Rehabilitation: Requires a 0.1 percent reduction in 2012 and 2013 in addition to productivity adjustments 0.3 percent in 2014, 0.2 percent in 2015 and 2016, and 0.75 percent in 2017, 2018, and 2019. If in any year from 2014-2019 the previous year's total percentage of insured population (as reflected in the share of the total, non-elderly population) is more than 5 percent below projections at time of enactment, the Secretary shall "give back" the payment reduction to hospitals via an adjustment to the otherwise applicable market basket increase in the current year. [Sec. 3401 of the Act as modified by Sec. 1105 of the Reconciliation Bill/ Sec. 1886(b)(3)(B) of the SSA]
Payments to Skilled Nursing Facilities	Delays implementation of the SNF prospective payment system until October 1, 2011. [Sec. 10325 of the Manager's Amendment]

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Part B Premiums	*Temporary Adjustment to the Income-Related Premium for Part B of Medicare*: Freezes current income thresholds related to premium subsidies for the period of 2011-2019. [Sec. 3402 of the Act/ Sec. 1839(i) of the SSA]
Medicare DSH Report and Payment Adjustments in Response to Coverage Expansion	*HHS Study on Urban Medicare Dependent Hospitals:* Requires the Secretary to conduct a study on the need for additional payment for urban Medicare dependent hospitals for inpatient hospital services. Requires the Secretary to submit a report to Congress no later than 9 months after the enactment of this act. [Sec. 3142 of the Act]
Resource-based Feedback Program for Physicians in Medicare	Requires the Secretary beginning in 2012 to provide reports to physicians that compare their resource use with that of other physicians caring for patients with similar conditions. Outlines the processes for creating such reports and making appropriate adjustments for demographics and health status as well as the effect of geographic adjustments in payment rates. Beginning in 2014, requires the payment rates to be reduced by five percent if the physician's resource use is at or above the 90th percentile of national utilization. Requires the Secretary to use claims data to provide confidential reports to physicians that measure the resources involved in furnishing care to individuals. The Secretary shall develop an episode grouper that combines separate but clinically related items and services into an episode of care for an individual. Establishes procedures for analyzing and reporting the episode of care data. [Sec. 3003 of this Act/Sec. 1848(n) of the SSA]
Misvalued Codes Under the Physician Fee Schedule	*Misvalued Relative Value Units (RVUs):* Requires the Secretary to periodically identify physician services as being potentially misvalued and make appropriate adjustments to the relative value units of such services under the Medicare physician fee schedule. Adjustments to codes would be subject to budget neutrality requirements. [Sec. 3134 of the Act/ Sec. 1848(c)(2) of the SSA]
Modifications to the Physician Quality Reporting Initiative	Proposes a new PQRI participation option by allowing eligible professionals to receive PQRI incentive payments for two successive years if the physicians: 1) participate in a qualified American Board of Medical Specialties Maintenance of Certification (MOC) or equivalent program; and 2) complete a qualified MOC practice assessment. Defines MOC and qualified MOC practice assessment. Outlines assessment component requirements for MOC programs. Improvements to the PQRI program would require CMS to: 1) Establish an appeals process for participating providers who did not qualify for incentive payments; and 2) Provide more timely feedback to providers with respect to satisfactorily submitting data on quality measures. Bases the incentive payments and adjustments in payment on the allowed charges for all covered services furnished by the eligible professional, based on the applicable percent of the fee schedule amount. For 2013, the applicable percent would be calculated as 98.5

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	percent of their total allowed charges. For 2014 and in subsequent years, the penalties for non-reporting would be two percent, calculated as 98 percent of their total allowed charges. The penalty would be assessed on an annual basis and would not be cumulative. Requires CMS to develop a plan to integrate the PQRI program with the standards for meaningful use of certified electronic health records as created in the American Recovery and Reinvestment Act of 2009. Provides an additional .5 percent bonus payment in 2011-2014 to Medicare physicians who submit quality data through a Maintenance of Certification Program. [Sec. 3002 of this Act/Sec. 1848(m) of the SSA]
Power-Driven Wheelchairs	Effective January 1, 2011, adjusts payments for power-driven wheelchairs. Does not apply to items furnished pursuant to competitive bidding contracts. [Sec. 3136 of the Act/Sec. 1834(a)(7)(A) of the SSA]
Treatment of Certain Cancer Hospitals	Requires the Secretary to conduct a study to determine if the outpatient costs incurred by PPS-exempt cancer hospitals with respect to Medicare's APCs exceed those costs incurred by other hospitals reimbursed under OPPS. If the costs are excessive, the Secretary would be required to provide for an appropriate adjustment for services furnished starting January 1, 2011. [Sec. 3138 of the Act/ Sec. 183(t) of the SSA]
Payment for Imaging Services	Increases the utilization rate assumption for calculating the payment for advanced imaging equipment from 50 percent to 75 percent staring 2011 ~~65 percent for 2010-2013, and further increasing the rate to 70 percent before 2014 and 75 percent after 2014~~. The GAO would study the impact of the change. [Sec. 3135 of the Act as modified by Section 1107 of the Reconciliation Bill/ Sec. 1848 of the SSA]
Payments for Biosimilar Biological Products	Allows a Part B biosimilar product approved by the Food and Drug Administration and assigned a separate billing code to be reimbursed at the ASP of the biosimilar plus six percent of the ASP of the reference product. [Sec. 3139 of the Act/ Sec. 1847A of the SSA]
DME	Expands "round 2" of the DME competitive bidding program to the next 21 largest metropolitan statistical areas by total population. Requires the Secretary, for covered items furnished on or after January 1, 2016, to continue to make adjustments under the competitive acquisition programs, and phase in or update additional covered items or information as contracts are recompeted in accordance with federal law. [Sec. 5010 of the Act/Sec. 1847(a)(1) of SSA]

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Payments for Home Health Care	Beginning in calendar year 2014, directs the Secretary to rebase payments to reflect the number and mix of home health services, level of intensity of services, and the average cost of providing care, taking into account (1) differences between hospital-based and freestanding HH providers, (2) differences in for-profit and non-profit providers, and (3) differences in resource costs between urban and rural HH providers. Phases-in the new reimbursement system according to a specified schedule. The Secretary would be directed to ensure adjustments would be no greater than 3.5 percent per year during the 4-year transition relative to home health payment levels at the date of enactment. MedPAC would be directed to report to Congress in CYs 2014 and 2016 on the implementation of the new system. The Secretary would continue to withhold 5 percent from episodic payments for the outlier pool, with payouts capped at 2.5 percent. Beginning in 2011, the Secretary would be directed to establish a provider-specific annual cap of 10 percent of revenues that a HH agency may be reimbursed in a given year from outlier payments. [Sec. 3131(a)(b) of the Act/ Sec. 1895(b)(3)(A) of the SSA] During 2010-2015, directs the Secretary to provide for a 3 percent add-on payment for HH providers serving rural areas. [Sec. 3131(c) of the Act/ Sec. 1895(b)(3)(A) of the SSA] Requires the Secretary to conduct a study and provide recommendations to revised Medicare home health payments to best ensure access to care and payment for severity of illness. Such study shall be delivered to Congress by March 1, 2014. The Secretary may subsequently establish a 4-year demonstration project that tests the implications of the recommendations included in the report. [Sec. 3131(d) of the Act/ Sec. 1895(b)(3)(A) of the SSA]
Limitation on Medicare Exceptions to the Prohibition on Certain Physician Referrals	Declares that only hospitals meeting certain requirements addressing conflict of interest, bona fide investments, and patient safety would be exempt from the prohibition on self-referral. Hospitals that have physician ownership and a provider agreement in operation on ~~August 1, 2010~~ December 31, 2010, and that meet other specified requirements would be exempt from this ban. Requires a hospital to provide to the Secretary an annual report containing a detailed description the identity of each physician owner or investor and any other owners or investors of the hospital and the nature and extent of the ownership or investment. Requires the hospital have in place procedures for a referring physician to disclosure his ownership or investment in the hospital. [Sec. 6001 of the Act, as amended by Sec. 10601 of the Manager's Amendment and modified by Section 1106 of the Reconciliation Bill/ Sec. 1877 of the SSA]
Rural Extenders	*Extend Hospital Outpatient Department Hold Harmless for Small Rural Hospitals; Extend and Expands Hospital Outpatient Department Hold Harmless for Sole Community Hospitals:* Establishes that in 2010 and 2011, small rural hospitals would receive 85 percent of the payment difference between payments under the PPS and those that would have been made under the previous payment system. Sole community hospitals, without regard to the 100-bed limit, would receive 85 percent of the payment difference in CY2010 and CY2011. [Sec. 3121 of the Act/ Sec. 1833(t)(7)(D)(i) of the SSA] *Extend Reasonable Cost Reimbursement for Laboratory Services in Small Rural Hospitals:* Reinstates reasonable cost reimbursement

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	for clinical diagnostic laboratory services for qualifying rural hospitals with under 50 beds from July 1, 2010, and extended for two years ending July 1, 2012. [Sec. 3122 of the Act/ Sec. 1833(t)(7)(D)(i) of the SSA] *Extend Rural Community Hospital Demonstration Program:* Extends the Rural Community Hospital Demonstration Program for an additional 5 year period beginning at the end of the initial five year period. Expands the maximum number of participating hospitals to 30, and expands eligible sites to rural areas in 20 states. [Sec. 3123 of the Act/ Sec. 410A of MMA] *Extend Medicare Dependent Hospital Program and Study on Applying the MDH program to Urban Hospitals:* Extends the Medicare Dependent Hospital Program classification until October 1, 2012. [Sec. 3124 of the Act/ Sec. 1886(d)(5)(G) of the SSA] *Temporary Improvements to the Medicare Inpatient Hospital Payment Adjustment:* Provides for a temporary adjustment that would increase payment in FY2011 and FY2012 for certain low-volume hospitals. Authorizes the Secretary to determine the applicable percentage increase using a continuous linear sliding scale ranging from 25 percent for low-volume hospitals with 200 or fewer discharges of individuals with Medicare Part A benefits to no adjustment for hospitals with greater than 1,600 discharges of individuals with Medicare Part A benefits. [Sec. 3125 of the Act/ Sec. 1886(d)(12) of the SSA] *Revisions to the Demonstration Project on Community Health Integration Models in Certain Rural Counties:* Strikes the limitation on the number of eligible counties that may participate in the demonstration project on community health integration models within the qualifying states. Deletes references to rural health clinic services and replaces these with a requirement that physician services may also be included within the scope of the demonstration project. [Sec. 3126 of the Act/ Sec. 124 of MIPPA] *MedPAC Study on Adequacy of Medicare Payments for Health Care Providers:* Requires MedPAC to review payment adequacy for rural health care providers serving the Medicare program and provide a report to Congress by January 1, 2011. [Sec. 3127] *Technical Correction related to Critical Access Hospitals (CAHs)*: Clarifies that CAHs are eligible to receive 101 percent of reasonable costs for providing outpatient services regardless of billing method and for providing qualifying ambulance services. [Sec. 3128 of the Act/ Sec. 1834 of the SSA] *Extend Medicare Rural Hospital Flexibility Program:* Extends the FLEX grant program for states to develop rural health care plans and designate critical access hospitals for two years through FY 2012. Permits SHIP funding to also be used to support small rural hospitals' participation in the delivery system reform programs outlined in this Act. [Sec. 3129 of the Act/ Sec. 1820(j) of the SSA]
Miscellaneous Improvements	*Medicare Part B Special Enrollment Period for Displaced TRICARE Beneficiaries:* Creates a twelve-month special enrollment period (SEP) 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 of the Act/ Sec. 1837 of the SSA] *Part B Special Enrollment Period for Disabled TRICARE Beneficiaries:* Establishes a special enrollment period for disabled TRICARE

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	beneficiaries. The special enrollment period is the 12 month period beginning on the day after the last day of the initial enrollment period of the individual or the 12 month period beginning with the month the individual is notified of enrollment under this section. Coverage for individuals who enroll during the special enrollment period will begin on the first day of the month in which the individual enrolls or at the option of the individual, the first month after the end of the individual's enrollment period. Enrollment during the special enrollment period is only allowed one time during the individual's lifetime. Requires the Secretary to ensure that materials relating to coverage are provided prior to an individual's initial enrollment period and contain information concerning the impact of not enrolling, including the impact on health care benefits under the TRICARE program. Requires that the Secretary of Defense coordinate with the Secretary of Health and Human Services and the Commissioner of Social Security to provide accurate identification of any eligible individuals. [Sec. 3110 of the Act/Sec. 1837 of the SSA] *Medicare Improvement Fund:* Eliminates the funding in FY 2014 for the Medicare improvement fund. [Sec. 3112 of the Act/ Sec. 1898(b)(1)(A) of the SSA] *Permitting Physician Assistants to Order Post-Hospital Extended Care Services:* Allows physician assistants who do not have direct or indirect employment relationships with a SNF but who are working in collaboration with a physician to certify the need for post-hospital extended care services for Medicare payment purposes. Provision applies to items and services furnished on or after January 1, 2011. [Sec. 3108 of the Act/ Sec. 1848(d) of the SSA] *Exemption of Certain Pharmacies from Accreditation Requirements:* Authorizes that beginning January 1, 2011, implementing quality standards will not apply to pharmacies where: • the total billings by the pharmacy for items and services are less than 5 percent of total pharmacy sales based on the average total pharmacy sales for the previous 3 calendar years, 3 fiscal years, or any other yearly period determined by the Secretary; • the pharmacy has been enrolled as a supplier of durable medical equipment, prosthetics, orthotics, and supplies and has been issued a provider number for at least 5 years and for which a final adverse action has not been imposed in the past 5 years; • the pharmacy submits to the Secretary an attestation specified by the Secretary that the pharmacy meets the specific criteria; and • the pharmacy agrees to submit materials requested by the Secretary during the course of an audit conducted on a random sample of pharmacies selected annually to verify that the pharmacy meets specified criteria. [Sec. 3109 of the Act/Sec.1834(a)(20) of the SSA]
Accountable Care Organization Pilot Program	*Accountable Care Organizations*: Allows ACOs to be eligible to share in cost-savings they achieve for the Medicare program beginning on January 1, 2012. Defines eligible ACOs as groups of providers and suppliers who have an established mechanism for joint decision making, such as for capital purchases. Outlines the criteria an organization must meet to be a qualifying ACO, including a minimum

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	three-year commitment and a Medicare beneficiary base of at least 5,000 individuals. Outlines the quality thresholds an organization must meet, including such measures as clinical processes and outcomes and utilization and costs. Requires CMS to direct beneficiaries to ACOs based on their use of Medicare items and services in the preceding periods. Directs CMS to set a minimum threshold of savings that would need to be achieved by an ACO before savings would be shared. Allows the Secretary to use partial capitation or other payment models determined to improve the quality and efficiency of items and services furnished under this title. Preference may be given to ACOs who are participating in similar arrangements with other payers. [Sec. 3022 of the Act/Sec. 1899(a) of the SSA]
Transforming the Health Care Delivery System: Encouraging Development of New Patient Care Programs	*National Pilot Program on Payment Bundling*: Requires the Secretary, starting in 2013 and continuing for five years, to establish a pilot program for integrated care during an episode of care around a hospitalization and develop, test and evaluate alternative payment methodologies through a national, voluntary pilot program. Outlines the conditions that must be included in the pilot program and the type of health care services that the program may cover. Requires the Secretary to develop payment methods for the pilot program that may include bundled payments and bids from entities for episodes of care, as well as quality measures related to care provided under the program. Requires the Secretary to separately pilot test continuing care hospitals. Requires the Secretary to conduct an independent evaluation of the pilot program and report, within 2 years after the program's inception, to Congress on the results of the evaluation. Allows the Secretary to expand the duration and the scope of the pilot program after January 1, 2016. [Sec. 3023 of the Act/ Adds Sec. 1866C of the SSA] *Extension of Gainsharing Demonstration*: Extends the gainsharing demonstration until September 30, 2011, and extends the relevant reporting requirements. Appropriates an additional $1.6 million in FY 2010, available through FY 2014. [Sec. 3027 of the Act/ Sec. 5007 of the Deficit Reduction Act of 2005] *Access to Dialysis Services:* Directs the GAO to submit a report no later than one year after the date of enactment on the impact of including specified oral drugs in the bundled payment program on beneficiary access to dialysis services. [Sec. 10336 of the Manager's Amendment]
Reducing and Reporting Hospital Readmissions	*Reducing Avoidable Hospital Readmissions*: Requires the Secretary to establish a Hospital Readmissions Reduction Program, beginning on or after October 1, 2012, under which payments to specified hospitals are reduced for certain readmissions. Requires CMS to begin calculating national and hospital-specific data on readmission rates of certain Medicare hospitals related to the eight conditions with the highest volume and rates of readmission. Requires CMS, in 2012, to provide such information and its relation to national benchmarks to participating hospitals and the public. Beginning in FY 2013, hospitals with readmission rates above a certain threshold would make adjustments to payments for the original hospitalization if a patient with a selected condition is re-hospitalized with a preventable readmission with seven days, and by 10 percent if a patient is re-hospitalized with a preventable readmission within 15 days. Defines readmissions. Three years after implementation of the readmissions policy, grants the Secretary the authority to expand the policy to other conditions. [Sec. 3025 of the Act/ Adds Sec. 1866(q) of the SSA] *Transitional Care Program to Reduce Preventable Readmissions*: Requires the Secretary to establish a three-year Medicare pilot

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	program called the Community Care Transitions Program. Beginning in 2011, directs the Secretary to fund eligible hospitals and community-based partnership organizations to provide patient-centered, evidence-based care transition services to Medicare beneficiaries at the highest risk of preventable re-hospitalization (such as above the 75th percentile for select conditions). Appropriates $500 million over for FY 2011 through 2015. [Sec. 3026] (See also **Linking Hospital Payments to Quality Outcomes in the Medicare Program** section above.)
Independence at Home Demonstration Program	*Independence at Home Pilot Program:* Requires the Secretary to conduct a pilot program to test a payment incentive that utilizes home-based primary care teams to reduce expenditures and improve health outcomes. Requires the pilot program to test results in: • Reducing preventable hospitalizations; • Preventing hospital readmissions; • Reducing emergency room visits; • Improving health outcomes for chronic illnesses; • Improving efficiency of care by reducing diagnostic and laboratory tests; • Reducing costs of health care services; and • Achieving beneficiary and family care giver satisfaction Requires the Secretary to develop quality performance standards for participating practice and establish target spending levels with designated aggregate annual savings amounts. A report shall be submitted to Congress of an independent evaluation of the pilot program detailing best practices and the impact of the pilot program on coordination of care, expenditures, access, and quality of health care services. Transfers $5 million from the Federal Hospital Insurance Trust Fund and Federal Supplementary Medical Insurance Trust Fund for FY 2010-2015. [Sec. 3024 of the Act/ Adds Sec. 1866D of the SSA]
Transforming the Health Care Delivery System: Strengthening Primary Care and Other Workforce Improvements	*Primary Care/General Surgery Bonus*: Establishes a 10 percent bonus for certain primary care providers for select codes (office visits, home visit, etc.) and for certain primary care providers furnishing major surgical procedures in health professional shortage areas. Requires that the bonuses begin on January 1, 2011, and continue for five years. [Sec. 5501 of the Act/Sec. 1833 of the SSA] *Distribution of Additional Residency Positions*: Provides for the redistribution of currently unused residency training slots to encourage increased training, especially in primary care and general surgery. CMS would calculate the number of unused slots over the last three fiscal years, and 65 percent of the unused slots would be included in a pool for redistribution. Rural teaching hospitals with less than 250 beds and hospitals having an approved voluntary reduction plan would be exempt from redistribution. Authorizes the Secretary to increase the resident limit for each qualifying hospital that submits a timely application addressing the specified criteria. Reserves 70 percent of slots for distribution to hospitals in states with a resident-to-population ratio in the lowest quartile, and 30 percent of slots for hospitals located in a state or territory that is among the top 10 in terms of ratio of total population living in a health professions shortage area to total population, and hospitals in rural areas. [Sec. 5503 of the Act/Sec. 1886 of the SSA/Sec. 422 of the MMA of 2003]

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	Promoting Greater Flexibility for Residency Training Programs: Provides more flexibility in laws and regulations governing GME funding in the Medicare program. These include: • Providing flexibility in the operation of residency programs involving more than one teaching hospital. [Sec. 5504 of the Act/Sec. 1886 of the SSA] • Allowing time spent by an intern or resident in an approved medical residency training program in a nonhospital setting furnishing patient care to be counted toward the determination of full-time equivalency; [Sec. 5505 of the Act/Sec. 1886 of the SSA] and • Requiring the Secretary to establish a process to increase the otherwise applicable resident limit in cases where a hospital with an approved medical residency program closes on or after the date that is 2 years before the date of enactment. Residency limits may only be increased if the Secretary determines that the hospital has demonstrated a likelihood of filling the positions within 3 years. [Sec. 5506 of the Act/Sec. 1886 of the SSA] *Demonstration Project to Address Health Professions Workforce Needs; Extension of Family-to-Family Health Information Centers*: Creates a demonstration grant program 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. Establishes a demonstration program to competitively award grants to up to six states for three years to develop core training competencies and certification programs for personal and home care aides. Appropriates $85,000,000 per year for five years (FY 2010-2014) for these demonstrations, with no more than $5,000,000 per year for three years (FYs 2010-2012) allowed for the personal and home care aid demonstration. Extends funding for family-to-family health information centers for FYs 2009-2012. [Sec. 5507 of the Act/Secs. 2008 and 501 of the SSA] *Increasing Teaching Capacity:* Establishes Teaching Health Centers Development Grants to establish newly-accredited or expanded primary care residency programs. "Teaching Health Centers" are community-based ambulatory care facilities that operate a primary care residency program. Appropriates $25,000,000 in FY 2010, $50,000,000 in FY 2011, $50,000,000 in FY 2012, and sums necessary beyond. *Program of Payments to Teaching Health Centers That Operate Graduate Medical Education Programs*: The Secretary shall make payments for direct and indirect expenses to qualified teaching health centers that are listed as sponsoring institutions by the relevant accrediting body for expansion of existing of establishment of new approved GME residency training programs. Each year, a qualified teaching health center shall submit a report providing information for the residency academic year, as specified by the Secretary. Appropriates sums necessary, not to exceed $230,000,000, for the period of FYs 2011-2015 [Sec. 5508 of the Act/Secs. 749A and 340H of the SSA] *Graduate Nurse Education Demonstration Program:* Requires the Secretary to establish a program to reimburse hospitals for

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	educational and clinical instruction costs attributable to providing advanced practice nurses with qualified training. Specifies hospital eligibility and qualified training and appropriates $50,000,000 from the Treasury for each of FYs 2012-2015. [Sec. 5509]
Increased Reimbursement Rate for Certified Nurse-Midwives	Provides for 100 percent payment for services furnished on or after January 1, 2011. [Sec. 3114 of the Act/Sec. 1833(a)(1)(K) of the SSA].
Medicare Physician Payments	*Extension of Floor on Medicare Work and Revisions to the Practice Expense Geographic Adjustment:* Extends the 1.00 floor for the geographic work index for physician work From January 1, 2010 to January 1, 2011. For services furnished beginning in 2010, the employee wage and rent portions of the practice expense geographic index shall reflect ¾ of the difference between the relative costs of employee wages and rents in each of the different fee schedule areas and the national average of such employees' wages and rents. For services furnished during 2011, the employee wage and rent portions of the practice expense geographic index shall reflect ½ of the difference between the relative costs of employee wages and rents in each of the different fee schedule areas and the national average of such employees' wages and rents. Establishes a hold harmless provision for the practice expense portion of the geographic adjustment factor for services furnished in 2010 and 2011. Requires the Secretary to analyze current methods of establishing practice expense geographic adjustments and to evaluate data that fairly and reliably establishes distinctions in the costs of operating a medical practice in the different fee schedule areas. Requires that the Secretary, no later than January 1, 2012, make adjustments to the practice expense geographic adjustment index to ensure accurate geographic adjustments across fee schedule areas. [Sec. 3102 of the Act/ Sec. 1848(e)(1) of the SSA] *Extension of Treatment of Certain Physician Pathology Services:* Extends the treatment of certain physician pathology services provisions under Medicare first adopted in the MMA until January 1, 2012. [Sec. 3104 of the Act/ Sec. 542(c) of the Medicare, Medicaid, and SCHIP Act of 2000] *Extension of Ambulance Add-Ons:* • *Ground Ambulance:* Extension for services furnished on or after April 1, 2010 and before January 1, 2011. [Sec. 1834(I)(13)(A) of the SSA] • *Air Ambulance:* Extension of MIPPA provisions through December 31, 2010. [Sec. 146(b)(1) of MIPPA] • *Super Rural Ambulance:* Extension of add-on for services furnished after January 1, 2010. [1834(I)(12)(A) of the SSA] [Sec.

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	3105] *Extension of the Physician Fee Schedule Mental Health Add-On:* Extends the physician fee schedule mental health add-on from December 31, 2009 to December 31, 2010. [Sec. 3107 of the Act/Sec. 138(a)(1) of MIPPA]
Therapy Caps	*Therapy Caps:* Extends the exceptions process for therapy caps for two years through December 31, 2011. [Sec. 3103 of the Act/ Sec. 1833(g)(5) of the SSA]
Changes to Medicare GME	See "Distribution of Additional Residency Positions" and "Program of Payments to Teaching Health Centers That Operate Graduate Medical Education Programs" in **Transforming the Health Care Delivery System: Strengthening Primary Care and Other Workforce Improvements** section above.
Medicare Coverage for Individuals Exposed to Environmental Health Hazards	Establishes Medicare eligibility for individuals determined to have been exposed to environmental health hazards. [Sec. 1881A of the Act, as amended by Sec. 10323 of the Manager's Amendment]
Other Medicare Payment Provisions	*Extension of Long-Term Care Hospital Provisions and of Moratorium on the Establishment of Certain Hospitals and Facilities:* Extends provision exempting certain long-term hospitals from new payment provisions for a4 year period. Extends the moratorium on the establishment of certain hospitals and facilities from a 3 year period to a 5 year period. [Sec. 3106 of the Act/ Sec. 114(c) of the Medicare, Medicaid, and SCHIP Extension Act of 2007] *Reimbursement for Bone Mass Scans*: Reinstates reimbursement for dual energy x-ray absorptiometry (DXA) services to 70 percent of the 2006 payment rates for 2010 and 2011. Authorizes the IOM to study the effect of Medicare reimbursement reductions for DXA on beneficiary access to bone density tests. [Sec. 3111 of the Act/ Sec. 1848 of the SSA] *Treatment of Certain Complex Diagnostic Laboratory Tests:* Requires that the Secretary conduct a demonstration project under Part B title XVIII of the SSA under which separate payments are made for complex diagnostic laboratory tests provided to individuals. Requires the Secretary to establish appropriate payment rates for such tests. Complex laboratory tests include analysis of gene protein expression, topographic genotyping, or a cancer chemotherapy sensitivity assay or any test that the Secretary determines that there is not an alternative test having equivalent performance characteristics; and which is billed using HCPCS codes and any tests approved or cleared by the FDA.

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	Frontier Areas: Establishes floors on area wage and practice expense indexes for hospitals and physicians serving frontier areas. [Sec. 10324 of the Manager's Amendment/ Secs. 1848, 1886 of the SSA.] *Hospitals in Low Payment Areas:* Provides $400 million in 2011 and 2012 to qualifying hospitals participating in areas that rank within the lowest quartile of fee-for-service expenditures. [Sec. 1109 of the Reconciliation Bill]
Enhanced Program and Provider Protections under Medicare, Medicaid, and CHIP	If the Secretary determines that there is significant risk of fraudulent activity with respect to a category of provider or supplier in the Medicare, Medicaid, and CHIP programs, authorizes the Secretary to carry out enhanced screening, periods of enhanced oversight, and enrollment moratoria. Also requires additional disclosures by providers applying for program participation. [Sec. 5001]
Conforming Civil Monetary Penalties to False Claims Act Amendments	Makes amendments to Section 1128A of the SSA as amended by sections 1611, 1612, 1613, and 1615 of the False Claims Act regarding civil monetary penalties. [Sec. 5008 of the Act/Sec. 1128(a) of SSA]
Changes to Medicaid Eligibility and Benchmark Benefits	Effective January 1, 2014 creates a new mandatory eligibility category of non-elderly, non-pregnant individuals (childless adults) who are not entitled to or enrolled for Medicare benefits, with incomes at or below 133 percent FPL. At a minimum, benefit coverage for this newly-eligible mandatory category shall consist of the benchmark benefit package consistent with section 1937 as amended by this Act. Requires states offering Medicaid Benchmark Benefits to any Medicaid beneficiary to include: coverage of prescription drugs and mental health services; coverage of at least the minimum essential health benefits as defined by this Act; inpatient hospital benefits; and mental health services parity (EPSDT benefits for children are deemed in compliance with this requirement). Individuals with incomes exceeding 100 percent FPL but less than 133 percent FPL may elect subsidized Exchange coverage in lieu of Medicaid. Effective January 1, 2014 the mandatory Medicaid income eligibility level for children ages six to 19 increases from 100 percent to 133 percent of FPL. States have the option of providing Medicaid coverage to all non-elderly individuals above 133 percent of FPL through a state plan amendment effective April 1, 2010. A state may elect to provide for a period of presumptive eligibility for medical assistance for the new mandatory eligibility category of childless adults (not to exceed 60 days) the state has elected to provide a period for presumptive eligibility for pregnant women or

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	children. If an eligible individual is the parent of a child under the age of 19 (or such higher age as the state elected) who is eligible for medical assistance under the state plan or under a waiver of such plan, the individual may not be enrolled under the state plan unless their child is enrolled under the plan or a waiver, or enrolled in other coverage. A state may elect, through a state plan amendment, to provide medical assistance to the newly-eligible mandatory category of individuals beginning with the first day of any fiscal quarter that begins on or after January 1, 2011, and before January 1, 2014. A state may elect to phase-in eligibility based on income, provided that it does not make individuals with higher incomes eligible before making eligible those with lower incomes. Beginning January 2015 and annually thereafter, the state shall report to the Secretary on new enrollment, outreach and enrollment processes used by the state, and any other data determined necessary by the Secretary to monitor enrollment and retention of Medicaid eligibles. Beginning April 2015 and annually thereafter, the Secretary shall report to Congress on enrollment on national and state-by-state bases, and include recommendations for administrative or legislative changes to the program. [Sec. 2001of the Act/Secs. 1902 and 1937 of the SSA] *Income Eligibility for Nonelderly Determined Using Modified Gross Income (MGI):* Unless otherwise provided, the MGI of an individual or family shall be used for purposes of determining income eligibility for assistance. During the transition to MGI, a state shall establish an equivalent income test that ensures individuals eligible for Medicaid at the time of enactment remain eligible for the program. No type of expense, block, or other income disregard shall be applied by a state, nor any asset or resources test. Exceptions to this practice include: individuals who are eligible because of other aid or assistance, elderly individuals who are Title II disability beneficiaries, medically-needy individuals, individuals eligible for Medicare cost-sharing, and optional targeted low-income children. Medicare prescription drug subsidies and individuals applying for long-term care services are also exceptions. States that elect the Express Lane option may rely on a finding from such agency relating to an individual's income. An individual who is enrolled in the state plan or under a waiver on the effective date and who would be determined ineligible solely because of the application of the MAGI standard shall be grandfathered until the date of the next regular redetermination. Effective January1, 2014. [Sec. 2002 of the Act/Sec. 1902 of the SSA]
CHIP Extension	Extends the CHIP program through FY 2015 and provides the following federal allotments: • For FY 2013, $17.4 billion; • For FY 2014, $19.1 billion;

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	• For FY 2015, two semi-annual allotments of $2.85 billion. [Sec. 10203 of the Manager's Amendment/ Sec. 2015 of the SSA]
Changes in CHIP Eligibility	Directs the state CHIP program to use MAGI to determine eligibility for CHIP. Any child who is determined to be ineligible for Medicaid as a result of the elimination of an income disregard shall be provided coverage under the CHIP program. [Sec. 2101 of the Act/Sec. 210 of the SSA]
Changes in Medicaid and CHIP FMAP	*Enhanced Medicaid FMAP for Expansion Population:* Beginning January 1, 2014 additional FMAP assistance would be provided to all states to defray the costs of covering newly eligible mandatory beneficiaries The applicable percentage point increases for helping to defray the costs of the expansion varies by year: • ~~During the period that begins on January 1, 2014 and ends on December 31, 2016, the federal FMAP shall be 100 percent~~ • ~~For 2017 and 2018 the states will receive a percentage point increase between 30.3 and 34.3 in their FMAP depending upon whether a state is an expansion or non-expansion state.~~ • ~~Increases the FMAP by additional percentage points for states meeting specified conditions.~~ o Increases the FMAP by an additional 2.2 percent from 2014-2015~~2019~~ for individuals who are not newly eligible for states that are ~~not~~ expansion states as defined in the act, would not receive additional FMAP for newly eligible individuals, and have not been approved by the Secretary to divert a portion of its DSH allotment to the costs of providing health benefits coverage under a waiver that is in effect on July 2009; o ~~Increases the FMAP by an additional 0.5 percent for states that are not expansion states as defined in the act, would not receive additional FMAP for newly eligible individuals, and is the state with the highest percentage of its population insured during 2008;~~ o ~~Starting 2017, increases the FMAP for Nebraska to 100 percent for all newly eligible beneficiaries.~~ o ~~The previous sections do not apply to the DSH or CHIP expenditures.~~ o For non expansion states, provides 100 percent federal FMAP for calendar years 2014, 2015, and 2016; provides 95 percent federal match for calendar year 2017, 94 percent for calendar year 2018, 93 percent for calendar year 2019, and 90 percent for 2020 and each year thereafter. o For expansion states, the state share of the additional costs shall be decreased by 50 percent in calendar year 2014, by 60 percent in 2015, by 70 percent in 2016, 80 percent in 2017, and 90 percent in 2018. Thereafter, the federal FMAP rate will be the identical to the rate for non expansion states (i.e., 93 percent federal FMAP for 2019 and 90 percent FMAP for each year thereafter). • The previous provisions do not apply to any state that requires political subdivisions to contribute a larger portion of the non-Federal share of such expenditures than was required by the state as of December 31. 2009. • Provides a DSH allotment to Hawaii for the second, third, and fourth quarters of 2012 of $7.5 million. Specifies that Hawaii will be treated as a low DSH state for purposes of calculating the annual DSH allotment for fiscal year 2013 and succeeding years. Makes other changes to the calculation of the annual allotment for low DSH states. For 2019 and thereafter, all states will receive a 32.3 percentage point increase. From 2017 and thereafter, no state may receive more

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	than a 95 percent federal match. A state is an "expansion state" if, on the date of enactment, the state offers health benefits coverage to parents and nonpregnant, childless adults whose income is at least 100 percent of FPL, that is not dependent on access to employer coverage or employment, and is not limited to premium assistance, hospital-only benefits, a high-deductible health plan purchased through an HSA, or a health opportunity account demonstration program A state which offers health benefits coverage to only parents or only nonpregnant childless adults shall not be considered an "expansion state." [Sec. 2001 of the Act as modified by Section 1201 of the Reconciliation Bill/Sec. 1905 of the SSA] *Special Adjustment for Certain States Recovering From a Major Disaster:* Provides additional Medicaid FMAP for a state in which during the previous 7 fiscal years the President has declared a major disaster and determined that every county or parish in the state warranted individual and public assistance. [Sec. 2006 of the Act/Sec 1905 of the SSA] *Additional Federal Financial Participation for CHIP:* For the period from October 1, 2015 and ending on September 30, 2019 the enhanced FMAP for a state shall be increased by 23 percentage points, but in no case shall exceed 100 percent. Specifies that children who are unable to enroll in a CHIP program due to the state's exhaustion of federal CHIP allotments are deemed eligible for low-income subsidies in Exchange plans. Requires such children be enrolled in Exchange plans that are certified by the Secretary to offer CHIP-comparable coverage [Sec. 2101 of the Act/Sec 2105 of the SSA]
Mandatory Offering of Premium Assistance	Requires a state to offer premium assistance for employer-sponsored insurance and wrap–around benefits to all Medicaid beneficiaries who are offered employer-sponsored insurance if it is cost-effective to do so. A state may not require that the individual apply for enrollment in qualified employer-sponsored coverage as a condition of an individual being or remaining eligible for assistance. Effective January 1, 2014. [Sec. 2003 of the Act/Sec. 1906A of the SSA]
Medicaid and the Exchange	*Enrollment Simplification and Coordination with the State Health Insurance Exchanges and CHIP:* Requires states to establish procedures to allow individuals to enroll and reenroll in Medicaid through a website and may determine an individual's eligibility for Medicaid and CHIP. The website shall be operational not later than January 1, 2014. The state website shall be linked with the Exchange's website and enable an individual to compare the Medicaid and CHIP benefits, premiums, and cost-sharing with those of an Exchange plan. The state shall establish procedures to ensure that individuals who are determined to be ineligible for Medicaid or CHIP are screened for eligibility for an Exchange plan, as well as for premium assistance for such plan. If determined eligible, the state shall ensure that the individual is enrolled in such a plan without having to submit an additional or separate application, and that such individuals receive information regarding any assistance or subsidies available for Exchange coverage. For children who are enrolled in Medicaid or CHIP and have Exchange coverage, the state shall ensure the coordination of EPSDT services.

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	The state shall conduct outreach and enrollment efforts to such vulnerable populations as children, unaccompanied homeless youth, children with special health needs, pregnant women, racial and ethnic minorities, rural populations, victims of abuse or trauma, individuals with mental health or substance-related disorders, and individuals with HIV/AIDS. The Medicaid and CHIP agencies may enter into an agreement with an Exchange under which the agencies may determine eligibility for Exchange premium assistance so long as the agreement meets the Secretary of the Treasury's conditions for reducing administrative costs and the likelihood of eligibility errors and disruptions in coverage. The Medicaid and CHIP agencies shall participate and comply with the requirements for streamlining procedures for enrollment through an Exchange, Medicaid, and CHIP. [Sec. 2201 of the Act/Sec 194 of the SSA]
CHIP and Medicaid Maintenance of Effort / Eligibility	*CHIP Maintenance of Effort:* Beginning with the date of enactment and ending on September 30, 2019, a state shall not have in effect CHIP eligibility standards, methodologies, or procedures that are more restrictive than those in effect on the date of enactment except that a state is permitted to have more restrictive standards for any fiscal year in order to limit CHIP expenditures to those for which federal financial participation is available for the fiscal year. A state is allowed to apply less restrictive standards. Directs the state to establish procedures to ensure a child who is otherwise eligible for CHIP but unable to enroll due to insufficient federal funding is provided coverage through an Exchange. Ends the Enrollment Bonus Payments for CHIP after fiscal year 2013. [Sec. 2101 of the Act/Sec. 2105 of the SSA] *Medicaid Maintenance of Effort*: During the period that is between enactment and the date on which the Secretary has determined that an Exchange established by a state is fully-operational, a state shall not have in effect Medicaid eligibility standards, methodologies, or procedures that are more restrictive than those in effect upon enactment as a condition for receiving any federal payments. This Maintenance of Effort (MOE) requirement shall remain in effect until an Exchange is fully-operational with the following exceptions: • For children under 19 years of age (or such higher age as the state may have elected), the MOE shall continue through September 30, 2019. • For non-pregnant, nondisabled adults whose income exceeds 133 percent of the FPL the MOE does not apply during the period from January 1, 2011 through December 31, 2013 if the state certifies it has or is projected to have a budget deficit during that period. Clarifies that a state that applies eligibility standards, methodologies, or procedures that are less restrictive than those in effect upon the

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	date of enactment of this act, shall not be considered in non-compliance with the MOE requirements. States may expand eligibility or move waivered populations into coverage under the state plan. [Sec. 2001 of the Act/Sec. 1902 of the SSA]
Payments to Primary Care Physicians	Mandates that for calendar years 2013 and 2014 payment for primary care services provided by primary care physicians be at a rate not less than 100 percent of the Medicare payment rate that applies to such services and physicians. Payments by Medicaid managed care plans must be consistent with the mandated minimum payment rates. States will receive a 100 percent FMAP for the additional costs in increasing the payment rates. [Sec. 1202 of the Reconciliation Act/ Sec. 1902 of the SSA]
Promoting Disease Prevention and Wellness: Medicaid or CHIP	*Improving Access to Preventive Services for Eligible Adults in Medicaid*: Increase the FMAP by 1 percentage point for states that provide coverage for all recommended preventive services and immunizations for adults with no cost-sharing. Effective January 1, 2013. [Sec. 4106 of the Act/Sec. 1905 of the SSA] *Coverage of Comprehensive Tobacco Cessation Services for Pregnant Women in Medicaid*: Beginning October 1, 2010, states would be required to provide Medicaid coverage for tobacco cessation for pregnant women with no cost-sharing. [Sec. 4107 of the Act/Secs. 1905, 1927, and 1916 of the SSA] *Incentives for Prevention of Chronic Disease in Medicaid*: Beginning January 1, 2011, the Secretary shall award grants to states to carry out initiatives to provide incentives to Medicare beneficiaries who successfully participate in a wellness program established in this section, and, upon completion, demonstrate changes in health risk and outcomes. Requires a participating state to conduct an outreach and education campaign to raise awareness about the incentive program. Requires a state to set standards and health status targets for beneficiaries and evaluate the success of the program in reaching those targets and the effectiveness of the program, and to develop and implement a system to track participation, establish standards and targets, evaluate effectiveness, and report to the Secretary on progress. The Secretary shall contract with an independent entity to evaluate the states' initiatives. In addition, a participating state shall report to the Secretary on a semi-annual basis the uses of the funds, an assessment of the program and lessons learned, and a cost savings estimate. No later than July 1, 2016, the Secretary shall report to Congress on the results of the independent assessment and recommendations for action. Authorizes $100,000,000 in grants for this program for a 5-year period beginning January 1, 2011. [Sec. 4108] *Public Awareness of Preventive and Obesity-Related Services Under Medicaid:* Requires the Secretary to issue guidance and information to states and health care providers regarding Medicaid's coverage for obesity-related services and preventive services. Requires each state to design a public awareness campaign to educate Medicaid enrollees regarding the availability and coverage of such services. Requires the Secretary to report to Congress on the status and effectiveness of the outreach. [Sec. 4004]
Reduction in Medicaid	Reduces the aggregate DSH allotments for the period of fiscal year 2014 through fiscal year 2019 by $14.1 billion, plus an additional $4

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DSH	billion reduction in fiscal year 2020. Directs the Secretary to develop a DSH payment methodology to implement the aggregate reduction. Extends through fiscal year 2013 the federal DSH allotment for a state that has a zero allotment after fiscal year 2011. [Sec. 1203 of the Reconciliation Bill/Sec. 1203 of the SSA]~~Reduces a state's DSH allotment once a state's uninsured rate decreases by at least 45 percent compared to the state's uninsured rate in 2009. Once trigger is tripped, state DSH allotments would be decreased by 25 percent in low DSH states and by 50 percent in the other states.~~ ~~If a state's uninsured rate continues to decrease in following years, the state's DSH allotment would be further reduced by a percentage equal to the product of the percentage point reduction in uninsurance and 25 percent for low DSH states and by 50 percent for any other state. In no event shall the DSH allotment for fiscal year 2013 and thereafter be less than 35 percent of the DSH allotment for fiscal year 2012. Includes specified exceptions for Hawaii and states meeting other conditions.~~ ~~Any portion of a state's DSH allotment being used to expand eligibility through a section 1115 waiver is exempt from such reductions.~~ ~~Effective October 1, 2011.~~ [Sec. 2551 of the Act as modified by Section 1203 of the Reconciliation Bill/Sec. 1923 of the SSA]
Required Coverage of Preventive Services	Effective January 1, 2013, mandates coverage of any clinical preventive services that are assigned a grade of A or B by the USPSTF. Mandates coverage of vaccines recommended by the Advisory Committee on Immunization Practices for adults. Also includes coverage of any medical or remedial services recommended by a physician or other licensed practitioner for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level. Provides a one percentage point FMAP increase for services and vaccines, and prohibits cost-sharing for such services and vaccines. [Sec. 4106 of the Act/Sec. 1905 of the SSA] Also see "Improving Access to Preventive Services for Eligible Adults" in **Promoting Disease Wellness and Prevention: Medicaid** section.
Coverage of Tobacco Cessation Services	Requires coverage of counseling and pharmacotherapy for cessation of tobacco use by pregnant women, and prohibits cost-sharing for such services to pregnant women. Effective October 1, 2010. [Sec. 4107 of the Act/Secs. 1905,1916, and 1916A of the SSA]
Coverage of Home Visitation Services	Creates a home visitation program under Title V of the SSA, the "Maternal and Child Health Services Block Grant Program," to improve coordination of services for at-risk communities and to identify and provide comprehensive services to improve outcomes for families who reside in at-risk communities. Grants are available for early childhood home visitation programs. Priority for providing services is given to families residing in communities of need, low-income families, families who are pregnant women who

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	have not attained age 21, families with a history of child abuse or neglect, families with a history of substance abuse, families that have users of tobacco products in the home, and families that are or have children with developmental delays or disabilities. States shall conduct needs assessments of communities with concentrations of premature birth, low-birth weight infants, and other indicators of at-risk prenatal, maternal, newborn, or child health submitting results to the Secretary. The Secretary shall make grants to eligible entities to enable the delivery of services. The eligible entities shall establish 3- and 5-year benchmarks and, no less than 30 days after the 3-year mark, shall report to the Secretary on improvements in at least 4 of the specified areas of evaluation, with a final report to the Secretary no later than December 31, 2014. The Secretary shall conduct an evaluation of the needs assessments and the grants made and, no later than March 31, 2015, report to Congress on the results, making them publicly-available. [Sec. 2951 of the Act/Sec. 511 of the SSA]
Better Diabetes Care	Directs the Secretary, in collaboration with the Director of the CDC, to prepare a national diabetes report card on a biennial basis. The report card shall contain aggregate health outcomes related to individuals diagnosed with diabetes and prediabetes, and shall include trend analyses for the nation and, if possible, for each of the states. The Secretary, acting through the Director of the CDC and in collaboration with the appropriate agencies, shall improve vital statistics collection through the training of physicians on the importance of such data, encouraging states to adopt the latest standard revisions of birth and death certificates, and working with states to re-engineer their systems. The Secretary, in collaboration with IOM and appropriate councils, shall conduct a study on the appropriate level of diabetes medical education, and report to the appropriate committees of Congress no later than 2 years after enactment. [Sec. 10407 of the Manager's Amendment]
Education Initiatives	*Support, Education, and Research for Postpartum Depression*: Encourages the Secretary to continue activities on postpartum conditions, and make grants available for the establishment, operation, and coordination of effective and cost-efficient systems for the delivery of essential services. [Sec. 2951 of the Act/Sec. 512 of the SSA] *Personal Responsibility Education for Adulthood Training*: The Secretary shall allot funding to states to enable the state (or local organization or entity) to carry out personal responsibility education for adulthood programs addressing abstinence/contraception and "adult preparation subjects," which include healthy life skills, financial literacy, and healthy relationships including marriage and family interactions. Appropriates $75,000,000 for each of FYs 2010-2014. [Sec. 2953 of the Act/Sec. 513 of the SSA] Restores funding for abstinence education. [Sec. 2954 of the Act/Sec. 510 of the SSA] *Inclusion of Information about the Importance of Having a Health Care Power of Attorney:* Requires that transition planning for children aging out of foster care and foster care independent living programs includes information about the importance of designating another individual to make health care treatment decisions on behalf of the child or adolescent if the child or adolescent becomes unable

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	to participate in such decisions. [Sec. 2955 of the Act/Secs. 475 and 477 of the SSA]
Centers of Excellence for Depression	The Secretary, acting through the Administrator, shall award 5-year grants on a competitive basis to eligible entities to establish national centers of excellence ("Centers") for depression, which shall engage in activities related to the treatment of depressive disorders. "Eligible entity" means an institution of higher education or a public or private nonprofit research institution which submits the appropriate application to the Secretary. The Secretary may not reward a grant or contract unless the entity agrees that it will provide matching funds of $1 for every $5 of federal funds provided. Each Center shall integrate basic, clinical, or health services interdisciplinary research and practice in the development, implementation, and dissemination of evidence-based interventions; involve a broad cross-section of stakeholders; provide training and technical assistance to mental health professionals and engage in and disseminate translational research focusing on meeting the needs of individuals with depressive disorders; and educate policymakers, employers, community leaders, and the public about these disorders. The Secretary, acting through the Administrator, shall designate 1 Center to act as the "coordinating center," which shall coordinate the network of Centers, oversee and coordinate a national database, lead a strategy to disseminate findings and activities of the Centers, and serve as a liaison to the Administration, the National registry of Evidence-based Programs and Practices of the Administration, and any other federal interagency or interagency forum on mental health. Centers shall collaborate in the improvement of treatment standards, clinical guidelines, diagnostic protocols, and care coordination practices. The Secretary, acting through the Administrator, shall establish performance standards for each Center, as well as for the network of Centers, and, no later than 3 years after establishment of each center and annually thereafter, issue report cards to the coordinating center to rate performance of each Center, and, no later than 3 years after the first grant is established and annually thereafter, issue report cards to Congress to rate performance of the network as a whole. Based upon the report cards, no later than September 30, 2015, the Secretary shall recommend improvements to the Centers, and recommend to Congress strategies for expanding the Centers to serve individuals with other types of mental disorders. No later than 3 years after the first grant is awarded, and annually thereafter, the Secretary shall arrange for an independent third party evaluation of the network of Centers. Appropriates $100,000,000 for each of FYs 2011-2015 and $150,000,000 for each of FYs 2016-2020. Of these amounts, the Secretary shall determine the amount appropriated to the Centers, with no more than $5,000,000 going to each, except that the Secretary may allocate no more than $10,000,000 to the coordinating center. [Sec. 10410 of the Manager's Amendment/Sec. 520B of the PHSA]

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Programs Relating to Congenital Heart Disease	*National Congenital Heart Disease Surveillance System*: The Secretary, acting through the Director of the CDC, shall establish the National Congenital Heart Disease Surveillance System to facilitate further research into the types of health services patients use, and to identify possible areas for educational outreach and prevention in accordance with CDC practice. The Secretary shall also award a grant to an eligible entity to undertaking the activities associated with the System. "Eligible entity" means a public or private nonprofit entity with specialized experience in congenital heart disease which submits the appropriate application to the Secretary, [Sec. 10411 of the Manager's Amendment/Sec. 399V-2 of the PHSA] *Congenital Heart Disease*: Allows the Director of the Institute to expand, intensify, or coordinate the Institute's congenital heart disease-related activities. Appropriating sums necessary for each of FYs 2011-2015. [Sec. 10411 of the Manager's Amendment/Sec. 425 of the PHSA]
Young Women's Breast Health Awareness and Support of Young Women Diagnosed with Breast Cancer	*Public Education Campaign*: The Secretary, acting through the Director of the CDC, shall conduct a national evidence-based education campaign to increase young women's (ages 15-44) knowledge of breast health and breast cancer, as well as of the availability of health information for young women diagnosed with breast cancer. The Secretary shall award grants to entities to establish national multimedia campaigns, which may include television, radio, and print media advertising, as well as internet media. An Advisory Committee established by the Secretary, acting through the Director of the CDC, shall assist in creating and conducting these campaigns. *Health Care Professional Education Campaign*: The Secretary, acting through the Director of the CDC, shall also conduct an education campaign for health care professionals to increase awareness of breast health and the treatment of breast cancer in young women, and how to counsel young women. *Prevention Research Activities*: The Secretary, acting through the Director of the CDC, shall conduct prevention research on breast cancer in younger women and, acting through the Director of NIH, shall conduct research to develop and validate new screening tests and methods for prevention and early detection of breast cancer in young women. *Support for Young Women Diagnosed with Breast Cancer*: The Secretary shall award grants to organizations to provide health information and assistance to young women diagnosed with breast cancer and pre-neoplastic breast diseases. The Secretary shall avoid duplication of other federal breast cancer education efforts. *Measurement; Reporting*: No less than every 3 years, the Secretary, acting through the Director of the CDC, shall measure young women's awareness regarding breast health, the percentage of young women utilizing information on fostering healthy behaviors, the number of young women receiving regular clinical exams, and the number of young women who perform self-exams, and report to Congress on the findings.

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	Appropriates $9,000,000 for each of FYs 2010-2014. [Sec. 10413 of the Manager's Amendment/Sec. 399NN of the PHSA]
State Eligibility Option for Family Planning Services	Creates an optional categorically-needy group for coverage of family planning services. Allows the state to consider the income of the applicant or recipient as the only criterion to determine eligibility. The benefit includes family planning services and supplies, and medical diagnosis and treatment services provided pursuant to a family planning service. Creates a state option to provide presumptive eligibility for family planning services including medical diagnosis and treatment services provided in conjunction with a family planning service in a family planning setting. Allows qualified entities to make presumptive eligibility determinations. A state may not provide enrollment of an individual with benchmark coverage or benchmark-equivalent coverage unless such coverage includes medical assistance for family planning services and supplies [Sec. 203 of the Act/Secs. 1902, 1905, 1920C and 1937 of the SSA]
Medical/Health Home Programs	Creates a new option for Medicaid beneficiaries with chronic conditions to designate a provider, a team of health care professionals operating with such a provider, or a health team as their health home. The provider or team shall provide health home services that are defined as: • Comprehensive care management • Care coordination and health promotion • Comprehensive transitional care, including appropriate follow-up, from impatient to other settings • Patient and family support • Referral to community and social support services • Health information technology A designated health home provider means a physician, clinical practice or clinical group practice, rural clinic, community health center, community mental health center, home health agency, or any other entity or provider that is determined by the state and approved by the Secretary to be qualified to be a health home provider. Such providers must have systems and infrastructure in place to provide health home services. Requires a state to coordinate these services with substance abuse and mental health services to address prevention and treatment among those with chronic conditions. Designated providers would be required to report to the state on all applicable quality measures in the state Medicaid program. The state would develop a mechanism to pay for the health home services rendered. Hospitals participating in Medicaid would be required to refer any Medicaid beneficiary with a chronic condition seeking treatment in an emergency department to a health home provider.

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	Provides an enhanced match of 90 percent FMAP for the first 2 years a state elects the health home option. Permits the Secretary to award a matching planning grant to states up to $25 million for all states. Requires the participating state to report to the Secretary on processes developed and lessons learned under this program. Requires the Secretary to conduct an independent evaluation and report to Congress. [Sec. 2703 of the Act/Sec. 1945 of the SSA]
Medicaid Coverage for Former Foster Care Children	Requires individuals below the age of 25 who were formerly in foster care under the responsibility of the state on their 18th birthday and were enrolled in Medicaid while in foster care to be eligible for Medicaid and receive all benefits under Medicaid including EPSDT. Creates a state option to provide presumptive eligibility for this population. Effective January 1, 2014. [Sec. 2004 of the Act/Secs. 1902 and 1920 of the SSA]
Elimination of Exclusion of Coverage of Certain Drugs	Removes smoking cessation drugs, barbiturates, and benzodiazepines from Medicaid's excludable drug list. Effective January 1, 2014. [Sec. 2502 of the Act/Sec. 1927 of the SSA]
Concurrent Care for Children	Directs states to make available all services covered under the Medicaid and CHIP programs to children receiving hospice services. [Sec. 2302 of the Act/Secs. 1905 and 2110 of the SSA]
Optional Coverage for Freestanding Birth Center Services	Provides state Medicaid programs with the option to cover freestanding birth center services and other ambulatory services that are offered by a freestanding birth center. Defines a freestanding birth center and a licensed birth attendant that performs care at the center. [Sec. 2301 of the Act/Sec. 1905 of the SSA]
Quality Measures for Adult Health Services Under Medicaid and CHIP	Directs the Secretary, in consultation with the states, to develop a recommended core set of health care quality measures specific to Medicaid adults in the same manner as the core set for children's health care measures (section 1139A of the SSA) as required by CHIPRA 2009. No later than January 1, 2011, the Secretary shall identify and publish for comment a recommended core set of measures. No later than January 1, 2013, the Secretary, in consultation with states, shall develop a standardized format for reporting information based on the initial core set of measures, and create procedures to encourage states to use such measures to voluntarily report the information to the Secretary. No later than January 1, 2014, and every 3 years thereafter, the Secretary shall include in a report to Congress information on the established measures. No later than 12 months after release of the recommended core set of measures, the Secretary would also establish the Medicaid Quality Measurement Program to develop, test, and validate emerging and innovative evidence-based measures. No later than 24 months after

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	establishment of the Program and annually thereafter, the Secretary shall publish recommended changes to the initial core set of measures to reflect the Program's work. Each state shall annually report on the measures applied by the state under its plan, and specific information on the quality of care furnished to Medicaid-eligible adults under the plan. No later than September 30, 2014, and annually thereafter, the Secretary shall collect, analyze, and make public the information provided by the states. Appropriates $60,000,000 for each of FYs 2010-2014. [Sec. 2701 of the Act/Sec. 1139B of the SSA]
Medicaid Accountable Care Organization Pilot Program	*Pediatric Accountable Care Organization Demonstration Project:* Establishes a demonstration project under Medicaid and CHIP that allows pediatric medical providers who meet certain criteria to be recognized as ACOs similar to the Medicare ACOs established by Section 3022 of this Act. Requires states to establish a minimum level of savings that would need to be achieved by an ACO in order for it to share in the savings. Directs the Secretary to develop guidelines to ensure that the quality of care delivered by the ACOs would be at least as high as it would have been absent the demonstration project. The project is to begin January 1, 2012 and shall end on December 1, 2016. Authorizes sums necessary to carry out this provision. [Sec. 1675]
Coverage of School-Based Health Clinics	Establishes a grant program to be used to fund facilities, equipment, or similar expenditures for school-based health centers (as defined in CHIPRA 2009). Provides preferences in grant awards to centers that serve a large population of Medicaid children. Appropriates $50,000,000 annually for FY 2010 through FY 2013. [Sec. 4101 of the Act/Title II of the PHSA]
Provisions Relating to Community Living Assistance Services and Supports (CLASS)	Requires states to comply with primary and secondary payor rules established by the Secretary with respect to the CLASS program established under section 8002 of this Act. Also requires states to designate or create fiscal agents for personal care attendant workers serving CLASS beneficiaries. Effective January 1, 2011. [Sec. 8002 of the Act/Sec. 1902(a) of the SSA]
Sense of Congress Regarding Community First Choice Option to Provide Medicaid Coverage of Community-Based Attendant Services and	Creates a Medicaid option for states to provide home and community-based attendant services and supports beginning October 1, ~~2010~~ 2011. The services are to be provided to individuals whose incomes do not exceed 150 percent FPL, or, if greater, the income level applicable for an individual who, but for the provision of home and community-based services, would require institutional care. The state shall receive an FMAP increase of six percentage points for services provided under the First Choice Option. In providing such services, the state shall assure that: • The individual chooses to receive the home and community-based attendant services and supports

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Supports	• The services are included in a person-centered plan based on an assessment of functional need • The services are provided in a home or community setting • The provider of the services is selected, managed and dismissed by the individual or their representative • The provider is qualified to provide such services The services do not include room and board, special education provided under the Individuals with Disabilities Education Act, assistive technology (other than back-up systems to ensure continuity of services), medical supplies and equipment, or home modifications. The state shall: • Adhere to a collaborative process in developing the First Choice Option • Provide the services, on a statewide basis, in the most integrated setting, and without regard to the individual's age, type or severity of disability, or the form of home and community-based services • Maintain or exceed the level of expenditures for total home or community-based services during the first full fiscal year in which the First Choice Option is implemented • Establish a comprehensive, continuous quality assurance system • Collect and report information as determined necessary by the Secretary The Secretary shall conduct an evaluation of the First Choice Option and shall submit an interim report to Congress no later than December 31, 2013 and a final report no later than December 31, 2015. [Sec. 2401 of the Act as modified by Sec. 1205 of the Reconciliation Bill/Sec. 1915 of the SSA] Provides new federal "balancing incentive payments" to states in the form of FMAP increases to increase the availability of home-and-community based services. Establishes conditions for states to receive these funds. [Section 10202 of the Manager's Amendment]
Removal of Barriers to Providing Home and Community- Based Services	The Secretary shall promulgate regulations to ensure that all states develop services systems designed to : • Allocate resources in a way that is responsive to changing needs and choices of beneficiaries receiving non-institutionally-based long-term care services and supports (including such services and supports that are provided under programs other than Medicaid) • Provide support and coordination needed • Improve coordination among providers of such services under federally- and state-funded programs in order to achieve a more consistent administration of policies and procedures across programs; to oversee and monitor all service system functions to assure coordination and effectiveness of eligibility determinations and individual assessments; to develop a monitoring system for complaints; and to assure an adequate number of qualified direct care workers to provide self-directed personal assistance services Provides for additional state options to provide home and community-based services to individuals eligible for services under a waiver,

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	and to offer home and community-based services to specific, targeted populations for an initial period up to five years and with five-year renewals. [Sec. 2402 of the Act/Secs. 1902, 1903 and 1915 of the SSA]
Money Follows the Person Rebalancing Demonstration	Extends through September 30, 2016 the "Money Follows the Person Demonstration" program that awards competitive grants to increase the availability and use of home and community based services. Also extends the due date of the program's evaluation to September 30, 2016. [Sec. 2403 of the Act/Sec. 6071 of the Deficit Reduction Act]
Protection for Recipients of Home and Community-Based Services Against Spousal Impoverish-ment	During the five-year period beginning January 1, 2014, requires states to apply the same spousal impoverishment rules used for spouses of nursing home residents in Medicaid to the Medicaid home and community based services. [Sec. 2402 of the Act/Sec. 1924 of the SSA]
Funding to Expand State Aging and Disability Resource Centers	Allocates $10,000,000 for each of FYs 2010-2014 to continue funding of Aging and Disability Resource Centers. [Sec. 2405 of the Act/Sec. 202 of the Older Americans Act]
Sense of the Senate Regarding Long-Term Care	Expresses the Sense of the Senate that this Congress should address long-term services and supports in a comprehensive way that guarantees elderly and disable individuals the care they need, and that long term services should be made available in the community in addition to in institutions. [Sec. 2406]
Payments to Pharmacists	Directs the Secretary to calculate the federal upper reimbursement limit as no less than 175 percent of the weighted average of monthly average manufacturer prices. Excludes from determination of average manufacturer price in this calculation: • customary prompt pay discounts to wholesalers; • bona fide service fees paid by manufacturers; • reimbursement by manufacturers for recalled, damaged, expired or otherwise unsalable returned goods; and • payments received from and rebates or discounts provided to pharmacy benefit managers, managed care organizations, HMOs, insurers, hospitals, clinics, mail order pharmacies, long term care providers, manufacturers, or any other entity that does not conduct business as a wholesaler or a retail community pharmacy.

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	[Sec. 2503 of the Act/Sec. 1927 of the SSA]
Prescription Drug Rebates	Provides an additional rebate for new formulations of existing drugs. For a drug that is a line extension of a single source drug or an innovator multiple source drug that is an oral solid dosage form, the rebate for such drug shall be the amount computed under section 1927 or, if greater, the product of the average manufacturer price, the highest additional rebate (as a percentage of AMP), and the total number of units of each dosage form and strength. Eliminates the exception from the rebate for new formulations of orphan drugs. Increases the minimum rebate for outpatient drugs other than single source drugs and innovator multiple source drugs from 11 percent to 13 percent. Increases the minimum rebate percentage for single source drugs to 23.1 percent. The minimum rebate is 17.1 percent for single source/innovator multiple source drug that has a clotting factor with a separate payment under Medicare or are approved exclusively for pediatric indications. The effective date for these provisions is December 31, 2009. [Sec. 2501 of the Act as modified by Section 1206 of the Reconciliation Bill/Sec. 1927 of the SSA]
Extension of Prescription Drug Discounts to Enrollees of Medicaid Managed Care Organizations (MCOs)	Extends the Medicaid drug rebate to include outpatient drugs provided to enrollees of Medicaid MCOs. The rebate for the drugs provided by Medicaid MCOs is to be paid to the state. The MCO shall report to the state on such timely and periodic bases as specified by the Secretary and include in the information submitted by the state to a manufacturer and the Secretary information on the total number of units of each dosage form and strength and package size of each covered outpatient drug dispensed to Medicaid beneficiaries enrolled in the MCO. Capitation rates paid to the MCOs shall be based on actual cost experience related to rebates and subject to the federal regulations requiring actuarially sound rates. The effective date is January 1, 2010. [Sec. 2501(c) of the Act/Secs. 1903 and 1927 of the SSA]
Health Care-Acquired Conditions	Prohibits Medicaid payments for health care-acquired conditions. Directs the Secretary to identify current state practices that prohibit payment for health care-acquired conditions and shall incorporate those practices which the Secretary determines appropriate for application to the Medicaid program into regulations that are to be effective July 1, 2011. The Secretary shall apply the Medicare health care-acquired regulations as appropriate for the Medicaid program. [Sec. 2702]

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Evaluations and Reports Required Under Medicaid Integrity Program	Directs the state entity responsible for the Medicaid Integrity Program to provide the Secretary with performance statistics (including such data as the number and amount of overpayments recovered, and the number of fraud referrals) as the Secretary may request. The Secretary shall conduct evaluations of the Medicaid Integrity Programs not less frequently than every 3 years. [Sec. 6402 of the Act/Sec. 1936 of the SSA]
Require Providers and Suppliers to Adopt Programs to Reduce Waste, Fraud, and Abuse	Provides that any Medicaid or CHIP provider or supplier shall establish a compliance program to reduce waste, fraud, and abuse. [Sec. 6401 of the Act/Secs. 1902 and 2107 of the SSA]
Provider Screening and Enrollment Requirements Under Medicare, Medicaid, and CHIP	Requires the Secretary, in consultation with the HHS Office of Inspector General, to establish procedures for screening providers and suppliers participating in Medicare, Medicaid, and CHIP. Such providers would be required to disclose current or previous affiliations with any provider or supplier that has uncollected debt, has had their payments suspended, or has been excluded from participating in a federal health care program. [Sec. 6401 of the Act/Secs. 1902 and 2107 of the SSA]
Overpayments Due to Fraud	Extends the current 60-day time period which the state has to recover or attempt to recover overpayments due to fraud before an adjustment is made in the federal payment to the state, to one year. [Sec. 6506 of the Act/Sec. 1903 (d)(2) of the SSA]
Termination of Provider Participation Under Medicaid and CHIP if Terminated Under Medicare or Other State Plan or Child Health Plan	Requires state Medicaid and CHIP programs to terminate the participation of entities or individuals if the entity or individual is terminated under Medicare, any other state Medicaid program, or any other CHIP program. [Sec. 6501 of the Act/Sec. 1902(a)(39) of SSA]
Medicaid and CHIP Exclusion from Participation Relating	Requires the state to exclude any individual or entity from participation in Medicaid or CHIP if such individual or entity owns, controls, or manages an entity that has unpaid overpayments that are delinquent, is suspended or excluded from participation in Medicaid or CHIP, or is affiliated with an individual or entity that has been suspended, excluded or terminated from participation in Medicaid or

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to Certain Ownership, Control, and Management Affiliations	CHIP. [Sec. 6502 of the Act/Sec. 1902(a) of SSA]
Requirement to Report Expanded Set of Data Elements Under MMIS to Detect Fraud and Abuse	For contracts beginning January 1, 2010, requires states to include data elements from the automated data system that the Secretary determines to be necessary for program integrity, program oversight, and administration, at such frequency as the Secretary shall determine. [Sec. 6504 of the Act/Secs. 1903(r)(1)(F) and 1903(m)(2)(A)(xi) of the SSA]
Billing Agents, Clearinghouses, or Other Alternate Payees Required to Register Under Medicaid	Provides that any agent, clearinghouse, or other alternate payee that submits claims on behalf of a health care provider must register with the state and the Secretary in a form and manner specified by the Secretary. [Sec. 6503 of the Act/Sec. 1902(a) of the SSA]
Prohibition on Payments to Institutions or Entities Located Outside of the U.S.	Prohibits state payments for items or services provided under the state plan under a waiver to any financial institution or entity located outside the U.S. [Sec. 6505 of the Act/Sec. 1902(a) of SSA]
Mandatory State Use of National Correct Coding Initiative under Medicaid	Requires state Medicaid plans, for claims filed on or after October 1, 2010, to incorporate compatible methodologies of the National Correct Coding Initiative administered by the Secretary and other such initiatives as identified by the Secretary. Requires the Secretary, not later than September 1, 2010, to: • identify those methodologies of the National Correct Coding Initiative administered by the Secretary which are compatible to claims filed under this title; • identify those methodologies of such Initiative that should be incorporated into claims filed under this title with respect to items and services for which states provide medical assistance and no national correct coding methodologies have been established; and • notify states of the methodologies identified and how states are to incorporate such methodologies into claims filed.

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	[Sec. 6507 of the Act/Sec. 1903(r) of the SSA]
Payments to the Territories	Beginning July 1, 2011 and ending September 30, 2019 increases payments to Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa by $2 billion ~~for the 30 percent for the second, third, and fourth quarters of FY 2011, and thereafter.~~ Increases the FMAP from 50 to 55 percent, effective ~~January~~ July 1, 2011. [Sec. 2005 of the Act/Sec. 1108(g) and 1905(b) of the SSA] [Sec. 1204 of the Reconciliation Bill/Sec. 1108(g) of the SSA]
Technical Corrections	Amends CHIPRA 2009 by replacing the term "legal residents" with "lawfully residing in the United States." Replaces "school or school system" with "local educational agency" as defined under the Elementary and Secondary Education Act of 1965. [Sec. 2102 of the Act/Secs. 2104, 2105, and 2110 of the SSA] Clarifies that the original intent of Congress for the term "medical assistance" as used in various sections of the SSA was to encompass both the payment for service provided and the services themselves. [Sec. 2304 of the Act/Sec. 1905(a) of the SSA]
Assuring Transparency of Hospital Information	Directs each hospital to make public, in accordance with guidelines developed by the Secretary, a list of the hospital's standard charges for items and services provided by the hospital. This list is to be updated annually. Effective 2010. [Sec. 101 of the Act/Sec. 2718 of the PHSA]
Medicaid Waivers	Directs the Secretary to promulgate regulations within 180 days of enactment that establish processes for public notice and comment to state 1115 waiver applications and periodic evaluation by the Secretary of such waiver programs. [Sec. 10201 of the Manager's Amendment/ Sec. 1115 of the SSA]
GAO Study on Causes of Action	Directs the GAO to study whether specified provisions in this Act would result in the establishment of a new cause of action or claim and report to Congress within two years of enactment. [Sec. 10201 of the Manager's Amendment]
Medicaid and CHIP Payment and Access Commission	Expands MACPAC's mission to include assessment of adult services in Medicaid, including for dual eligibles, and directs MACPAC to review Medicaid and CHIP regulations. Expands the scope of provider payment policies for review to include payments to managed care entities, long-term care providers, dental providers and providers of other covered items and services. Adds the following topics for MACPAC review: eligibility policies, enrollment and retention processes, benefit and coverage policies, quality of care, and the interactions with Medicare and Medicaid. Directs MACPAC to consult and coordinate with MedPAC on issues related to dual eligibles. Directs MACPAC to regularly consult with states in carrying out its duties and to ensure that input from states is taken into account and represented in MACPAC's recommendations and reports. Changes reporting dates to March 15 and June 15 of each year beginning

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	June 2010. Authorizes $11,000,000 for MACPAC for FY2010. [Sec. 2801 of the Act/Sec. 1900 of the SSA]
Independent Payment Advisory Board	*Medicare Commission*: Establishes a 15-member, Independent Payment Advisory Board ("the Board") that would submit proposals to Congress, on January 15, 2014, to improve health outcomes, promote greater quality and efficiency, improve beneficiary access to necessary and evidence-based items and services, maintain affordability, and improve the long-term solvency of Medicare. The Board would be tasked with presenting proposals to Congress that would reduce Medicare spending by targeted amounts compared to the trajectory of spending under current law, except in years when the Medicare growth rate does not exceed the percentage increases under the CPI category for medical care expenditures. The Board would be prohibited from presenting proposals to increase beneficiary premiums, increasing burdens on low-income beneficiaries, increase cost-sharing, rationing health care, or recommending proposals that would impact, prior to December 31, 2019, providers of services (as defined in section 1861(u)) and suppliers (as defined in section 1861(d)) under certain conditions. As appropriate, the Board shall include recommendations to reduce expenditures under Parts C and D, such as through reductions in federal premium subsidies to MA-PD and PDP plans, and performance bonuses to MA plans. The Board would be required to consider the unique needs of dual eligibles. Directs Congress to either amend the proposal or pass an alternative proposal with an equivalent amount of budgetary savings. Directs the Secretary to implement the provisions included in the original Board proposal should Congress not pass an alternative measure. Requires the CMS Actuary to implement a savings target (the lesser of a statutory percent (0.5 percent in 2015; up to 1.5 percent in 2018) and the difference between the Medicare growth and the percentage increases under the CPI category for medical care expenditures) that reduces Medicare cost growth. [Sec. 3403 of the Act/Sec. 1988A of the SSA]
Outreach and Enrollment of Medicaid and CHIP Eligible Individuals	Creates a grant program to support community health workers to educate and provide outreach in a community setting on a variety of issues, including outreach and enrollment in health insurance programs such as CHIP, Medicaid, and Medicare. [Sec. 5313 of the Act/Title III of the PHSA]
Demonstration Project for Stabilization of Emergency Medical Conditions by Institutions for Mental Diseases	Establishes a three-year, $75,000,000 demonstration project for up to eight states to expand the number of emergency inpatient psychiatric care beds available in communities. The institutions for mental diseases must not be publicly-owned or operated. The Secretary shall provide annual progress reports to Congress and, after completion, a determination shall be made as to whether to expand the project on a national basis after December 31, 2012. [Sec. 2707 of the Act/Sec. 1905 of the SSA]

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Application of Medicaid Improvement Fund	Rescinds amounts available to the Medicaid Improvement Fund for FYs 2014-2018. [Sec. 2007 of the Act/Sec 1941 of the SSA]
Improved Coordination and Protection for Dual Eligibles	*Establishes the Federal Coordinated Health Care Office:* No later than March 1, 2010, establishes a new office within CMS, the Federal Coordinated Health Care Office, which would be responsible for bringing together Medicare and Medicaid officials to 1) more effectively integrate benefits under the Medicare and Medicaid programs; and 2) improve the coordination between the federal and state governments for individuals eligible for benefits under both such programs. The goals of the Office are to: • Provide duals full access to benefits under both programs • Simplify the processes for duals to access items and services • Improve the quality of care and beneficiary satisfaction • Eliminate regulatory conflicts between rules under the two programs • Improve continuity of care and ensure safe transitions for duals • Eliminate cost-shifting between the programs and among health care providers • Improve the quality of performance of providers and suppliers The Office responsibilities include: • Providing states, SNP MA plans, physicians, and other relevant entities or individuals with the education and tools necessary to align benefits for the duals • Supporting state efforts to coordinate and align acute care and long-term services for duals • Providing support for coordination of contracting and oversight by states and CMS • Consulting with MedPAC and MACPAC on dual policy • Study the provision of drug coverage for new full-benefit dual eligible individuals Each year, the Secretary shall report to Congress on recommendations for legislation that would improve coordination. [Sec. 2602] *5-Year Period for Demonstration Projects:* Clarifies that Medicaid demonstration authority for coordinating care for dual eligibles may be conducted for a period of five years and renewed for additional five year periods. [Sec. 2601 of the Act/Sec. 1915 of the SSA]
Center for Medicare and Medicaid Payment	*CMS Innovation Center*: Creates a Center for Medicare and Medicaid Innovation (CMI) within CMS to test innovative payment and service delivery models to reduce program expenditures while preserving or enhancing the quality of care. Requires CMI to consult

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Innovation	with representatives from relevant federal agencies, clinical and analytical experts with expertise in medicine and health care management, as well as to conduct open door forums to seek input from interested parties. Requires CMI to test payment and service delivery models to determine the effect of applying models on program expenditures and quality of care. Requires the Secretary to select models to be tested where there is determined to be evidence that the model addresses a defined population with deficits in care leading to poor clinical outcomes or avoidable expenditures. Requires the Secretary to focus on models expected to reduce program costs while preserving and enhancing quality of care. Testing may be limited to certain geographic areas. Models may include: • Promoting broad payment and practice reform in primary care that transitions away from fee-for-service reimbursement toward comprehensive or salary-based payment; • Contracting directly with providers and suppliers to promote risk-based comprehensive or salary-based payment; • Promoting care coordination ; • Supporting care coordination for the chronically-ill through a Health IT network; • Varying payments to physicians ordering advanced diagnostic imaging services according to appropriateness criteria; • Utilizing medication therapy management; • Establishing community-based health teams to assist chronic care management; • Funding home-based primary care programs; • Assisting beneficiaries making informed choices by using decision-support tools; • Allowing states to test fully integrating care for dual-eligibles; • Allowing states to test all-payer payment reform systems; • Aligning evidence-based guidelines of cancer care with payment incentives; • Improving post-acute care; • Funding home health care providers offering chronic care management; • Developing collaborative of high-quality, low-cost health care institutions; • Promoting greater efficiencies and timely access to outpatient services; • Utilizing telehealth services in underserved areas and facilities of the Indian Health Service; and • Utilizing a diverse network of providers and supplies to improve coordination of care for individuals with two or more chronic conditions. Requires the Secretary to conduct an evaluation of each model tested, including an analysis of the quality of care furnished and the changes in spending. Permits the Secretary to limit the testing of a model to certain geographic areas. Requires the results of each evaluation to be made public in a timely fashion. Expands the scope of CMI to include the CHIP programs with the same requirements for testing and evaluation of patient-centered delivery and payment models that have shown evidence of success in CHIP populations as proposed for Medicare. Transfers $10,000,000,000 from the Treasury for FY 2011-2019, and for each subsequent 10-year period beginning with FY 2020. Requires CMI to be established by January 1, 2011

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	[Sec. 3021]
CMS Systems Improvements	Requires CMS to develop a plan to modernize its computer and data systems to support consistent evaluations of payment and delivery system reforms and post this plan on the agency's website no later than nine months after enactment. [Sec. 10330 of the Manager's Amendment]
Public Reporting of Performance Information	Requires the Secretary to establish a Physician Compare Internet website no later than January 1, 2011. Further requires the Secretary to report certain information on this website no later than January 1, 2013. Authorizes the Secretary to establish a demonstration program to provide financial incentives to beneficiaries who use high quality physicians no later than January 1, 2019. Effective January 1, 2012, directs the Secretary shall make available Part A, B, and D claims data to qualified entities to evaluate the performance of Medicare providers. [Sec. 10332 of the Manager's Amendment/ Sec. 1874 of the Act]
Amendments to Indian Laws	*Special Rules Relating to Indians:* Prohibits cost-sharing for Indians with Income at or below 300 percent of FPL who are enrolled in coverage through an exchange. Establishes health programs operated by the Indian Health Service, Indian tribes, tribal organizations and Urban Indian organizations shall be the payer of last resort for services. Facilitates enrollment of Indian under the Express Lane Option. [Sec. 2901 of the Act/Sec. 1902 of the SSA] *American Indian and Alaskan Native Providers and Medicare Part B:* Removes the sunset provision in current law to allow Indian tribes, tribal organizations, and urban Indian organizations to continue to receive payment for certain Medicaid covered items and services. Effective January 1, 2010. [Sec. 2902 of the Act/Sec. 1880(e)(1)(A) of the SSA] Eliminates the sunset for reimbursement for all Medicare Part B services furnished by certain Indian hospitals and clinics. Excludes the value of any qualified Indian health care benefit from gross income. [Sec. 2902 of the Act/Sec. 1880 of the SSA]

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