AMERICA'S HEALTHY FUTURE ACT OF 2009
CHAIRMAN'S MARK

Domain/Sub-Domain	Provisions of the Senate Finance Committee Chairman's Mark	Link to Legislative Text
1. Health Insurance Accessibility and Affordability		
A. Access To Health Insurance	• State Exchanges and Marketing Requirements, Plan Participation: States would be required to establish an exchange for the individual market and a Small Business Health Options Program exchange for the small group market in 2010. This requirement may encompass a single exchange with separate resources for individual and small-group customers. **[Page 18]**	**[Page 85]**
	• State Exchanges and Marketing Requirements, Plan Participation: Beginning in 2013, all private insurers in the individual and small group markets that operate nationally, regionally, statewide, or locally must participate in newly established state exchanges, if the insurers are licensed by a state (that is, a state has determined that the plans meet all the market-reform requirements). **[Page 18]**	**[Page 81]**
	• State Exchanges and Marketing Requirements, Establishment of State Exchanges: In 2010, 2011 and 2012, plans with annual and lifetime limits and so-called "mini-medical" plans with limited benefits and low-annual caps would be prohibited from being offered in the state exchanges. All other policies would be offered in the state exchange. **[Page 18]**	**[Page 90]**
	• State Option for a Basic Health Plan: Provides an opportunity for states to establish a federally-funded, non-Medicaid state plan for people with incomes above Medicaid eligibility but below 200 percent of the federal poverty level. Under this provision, the federal government would provide funds to participating states in order to allow such states to provide affordable health care coverage through private health care systems under contract. States would use their share of federal funding to negotiate with health care systems for high-quality, cost-effective coverage options to provide better value to individuals and families in their states. Eligible individuals and families would have access to several affordable pre-negotiated coverage options through the basic health plans rather than being limited to independent negotiating through the Exchange with individual tax-credit subsidies. By using negotiated purchasing, basic health plans could provide improved benefits and reduced costs. **[Page 15]**	**[Page 65]**
	• Creation of Health Care Cooperatives: Creates the Consumer Operated and Oriented Plan (CO-OP) program to foster the creation of non-profit, member-run health insurance companies that serve individuals in one or more states. CO-OP grantees would compete in the reformed individual and small group insurance markets on a level playing field with other plans. **[Page 44]**	**[Page 233]**
B. Pre-Existing Exclusions and Waiting Periods	• Insurance Market Reforms, Immediate Assistance for Those with Pre-Existing Conditions: Within one year of enactment, any uninsured individual who has been denied health care coverage due to a pre-existing condition can enroll in the high-risk pool that will be available through 2013 with five billion dollars in funding. **[Page 2]**	**[Page 37]**
	• Insurance Market Reforms, Rating Rules in the Individual Market: Prohibits issuers from excluding coverage for pre-existing health conditions in the individual market. **[Page 2]**	**[Page 18]**
C. Age and Gender	• Insurance Market Reforms, Rating Rules in the Individual Market: Premiums could vary no more than certain specified ratios for tobacco use (1.5:1), age (4:1), and family composition (1.1 for single to 3:1 for family). **[Page 2]**	**[Page 21]**

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E. Residence and Legal Status	• Health Care Affordability Tax Credits: In order to prevent undocumented immigrants from accessing the state exchanges or obtaining federal health care tax credits, the following data must be verified: name, social security number, and date of birth. The data will be substantiated with the Social Security Administration for those who claim to be U.S. citizens and with the Department of Homeland Security for those who claim only to be in the country legally. Individuals whose status is expected to expire in less than one year are not allowed to obtain the tax credit. Individuals whose claims of citizenship or lawful status cannot be verified with federal data must be allowed substantial opportunity to provide documentation or correct federal data related to their case that supports their contention. **[Page 27]**	**[Page 101]**
F. Premium Affordability in Relation to Family Income and Health Need	• Making Coverage Affordable, Benefit Options, Definition of Levels: For those between 100-200 percent of the federal poverty level, the benefit will include an out-of-pocket limit equal to one-third of the health savings account current law limit. For those between 200-300 percent of federal poverty level, the benefit will include an out-of-pocket limit equal to one-half of the health savings account current law limit. And for those between 300-400 percent of the federal poverty level, within the same actuarial value, the benefit will include an out-of-pocket limit equal to two-thirds of the HSA current law limit. **[Page 23]**	**[Page 165]**
	• Personal Responsibility Requirement: The Government Accountability Office shall undertake a study of the affordability of coverage, including the impact of the provision of small business and individual tax credits in maintaining and expanding coverage, the availability of affordable plans, and the ability of Americans to meet the personal responsibility requirement. **[Page 36]**	**[Page 208]**
	• State Option for a Basic Health Plan, Benefit Package and Premium Assistance, Benefit Package and Premium Assistance: Minimum benefit package and premium cost sharing levels in the basic health plan would be set at the levels provided for this population in the Making Coverage Affordable section of the Chairman's Mark. **[Page 16]**	**[Page 66]**
G. Subsidies	• Health Care Affordability Tax Credits: Provides a refundable tax credit for eligible individuals and families who purchase health insurance through the state exchanges. The premium tax credit will subsidize the purchase of certain health insurance plans through the exchanges and will be refundable and payable in advance directly to the insurer. The taxes would be available to individuals (single or joint filers) with modified gross incomes up to 300 percent of the federal poverty level. The Treasury would then pay the credit to the insurer and the individual would be responsible to pay the balance. If the individual fails to pay, they will be given a three-month grace period before they are terminated from the plan. **[Page 26]**	**[Page 146]**
	• Cost-Sharing Subsidy: A cost-sharing subsidy would be designed to buyout any difference in cost sharing between the insurance purchased and the actuarial values specified below. For individuals between 100-150 percent of the federal poverty level, the subsidy brings the value of the plan to 90 percent actuarial value. For those between 150-200 percent of federal poverty level, the subsidy brings the value of the plan to 80 percent actuarial value. For individuals above 200 percent of federal poverty level, no subsidy for cost sharing is provided. The amount received by an insurer in cost-sharing subsidy on behalf of an individual, as well as any spending by the individual out-of-pocket, counts towards the out-of-pocket limit. As with the premium credit, the Internal Revenue Service is authorized to disclose to the state exchange limited tax return information to verify a taxpayer's modified gross income based on the most recent return information available. **[Page 28]**	**[Page 163]**
	• State Option for a Basic Health Plan, Benefit Package and Premium Assistance: The premium assistance for the eligible population would be available through the Basic Health Plan instead of through the tax credits otherwise provided for in the Mark. The population above 200 percent of the federal poverty level would have access to tax credits as available in the mark. **[Page 16]**	**[Page 146]**
	• Disclosures to Carry out Eligibility Requirements for Certain Programs: An eligible individual would enroll in a plan offered through a state exchange and would report his or her modified gross income to the Exchange. States are permitted to enter into contracts with state Medicaid agencies to make eligibility determinations for the credit. In all cases, income eligibility will be reconciled annually on the individual's federal income tax return, subject to a "safe harbor." Name, social security number, and date of birth will be verified with SSA data. **[Page 26]**	**[Page 174]**

	• Employer-Provided Health Insurance Coverage: In general, if an employee is offered employer-provided health insurance coverage, the individual would be ineligible for a low income premium tax credit for health insurance purchased through a state exchange. An employee who is offered coverage that does not have an actuarial value of at least 65 percent or who is offered unaffordable coverage by their employer, however, can be eligible for the tax credit. The employee would seek an affordability waiver from the state exchange and would have to demonstrate family income and the premium of the lowest cost employer option offered to them. **[Page 38]**	**[Page 153]**
	• Small Business Tax Credit, Small Employers Eligible for the Credit: Provides a tax credit for a qualified small employer for contributions to purchase health insurance for its employees. A qualified small employer for this purpose generally would be an employer with no more than 25 full-time equivalent employees employed during the employer's taxable year, and whose employees have annual fulltime equivalent wages that average no more than $40,000. However, the full amount of the credit would be available to an employer with ten or fewer full-time equivalent employees and whose employees have average annual fulltime equivalent wages from the employer of less than $20,000. **[Page 28]**	**[Page 183]**
	• Small Business Tax Credit, Small Employers Eligible for the Credit: The credit would only be available to offset actual tax liability and would be claimed on the employer's tax return. The credit would not be payable in advance to the taxpayer or refundable. **[Page 28]**	**[Page 192]**
	• Small Business Tax Credit, Small Employers Eligible for the Credit: For tax years 2011 and 2012, the credit will be available to any qualified small business offering health insurance. In 2012 and beyond, however, the credit will only be available for a small employer that purchases health insurance coverage for its employees through the state exchange. **[Page 28]**	**[Page 190]**
	• Small Business Tax Credit, Small Employers Eligible for the Credit: The credit will amount to the applicable percentage of the small employer's contribution to the health insurance premium for each covered employee. **[Page 28]**	**[Page 185]**
	• Small Business Tax Credit, Small Employers Eligible for the Credit: The credit will be phased out for employers with more than ten full-time equivalent employees but not more than 25 full full-time equivalent employees by six percent of the base credit percentage for each employee above ten. **[Page 28]**	**[Page 183]**
	• Small Business Tax Credit, Small Employers Eligible for the Credit: Otherwise qualifying charitable organizations exempt from taxes are still eligible for the credit, although they are entitled to a lesser percentage. **[Page 28]**	**[Page 188]**
	• Small Business Tax Credit, Small Employers Eligible for the Credit: Self-employed individuals, including partners and sole proprietors, two percent shareholders of an S Corporation and five percent owners of a C Corporation would not be treated as employees for purposes of the credit, so no credit will be available for contributions to their premiums. **[Page 28]**	**[Page 187]**
	• State Option for a Basic Health Plan: 85 percent of the funds dedicated to providing individual tax credit subsidies for individuals from 133 to 200 percent of the federal poverty level would be distributed to states choosing to create basic health plans based upon the funding formula outlined above. To the extent a state chooses to create a basic health plan, no tax credit subsidy would be available to individuals otherwise eligible as members of the covered enrollee population. Tax credit subsidies would be available to citizens of states that have chosen not to create basic health plans. **[Page 17]**	**[Page 72]**
	• State Exchanges and Marketing Requirements, Child-Only and Dental Plans: Directs the Secretary to determine whether alternative means – such as direct subsidies and refinements to tax credit eligibility determinations – are necessary to provide support for the purchase of dental coverage for children in a state exchange. **[Page 18]**	*Not included in legislative text*
	• American Indians and Alaska Natives, Premiums and Cost-Sharing: Prohibits cost-sharing (including premiums, deductibles, copayments, co-insurance, etc.) for all American Indians and Alaska Natives with incomes at or below 300 percent of the federal poverty level for state exchange plans and public programs. **[Page 77]**	**[Page 441]**

H. Affordability for the Currently Insured	• Grandfathered Plans: Individuals and groups who wish to renew coverage in an existing policy would be permitted to do so. Plans could continue to offer coverage in a grandfathered policy, but only to those who were currently enrolled, dependents, or, in the case of an employer, to new employees and their dependants. Any individual who has an existing policy equal in value to the "young invincible" plan can renew that policy. The policy will be considered minimum creditable coverage for purposes of meeting the personal responsibility requirement. No tax credits will be offered for grandfathered plans. Beginning July 1, 2013, federal rating rules would be phased in for grandfathered policies in the small group market, over a period of up to five years, as determined by the state with approval from the Secretary. These plans could continue to exist after the transition period, but would be subject to the new rating rules. **[Pages 12-13]**	**[Page 48]**
2. Choice of Coverage, Enrollment, and Marketing		
A. Choice of Coverage or Plans	• American Indian and Alaska Natives, Other Policies Related to State Exchange Coverage: American Indian and Alaska Natives are subjected to the responsibility to obtain insurance, but exempt them from penalty for failing to do so. American Indian and Alaska Natives would be allowed a choice of providers, including Indian tribes, tribal organizations, and urban Indian organizations. Monthly special enrollment periods are also authorized American Indian and Alaska Natives in state exchanges. **[Page 79]**	**[Page 443]**
	• Employer-Provided Health Insurance Coverage: A Medicaid-eligible individual can always choose to leave the employer's coverage and enroll in Medicaid. In this circumstance, the employer is required to pay a fee. **[Page 38]**	**[Page 287]**
	• Medicaid Coverage for the Lowest Income Populations, Eligibility Standards and Methodologies: Beginning in 2014, individuals with income below 100 percent of the federal poverty level would be eligible for Medicaid and remain ineligible for tax credits in the state exchanges. Non-elderly, non-pregnant adults between 100 and 133 percent of federal poverty level would be able to choose between Medicaid and coverage through their state exchange. States would have to ensure that all children of parents who choose the state exchange coverage would continue to receive the benefits, including early and periodic screening, diagnostic, and testing (EPSDT) benefits, to which children are entitled under Medicaid. **[Page 51]**	**[Page 259]**
	• Medicaid Coverage for the Lowest Income Populations, Eligibility Standards and Methodologies: For any non-elderly, non-pregnant adult between 100 and 133 percent of federal poverty level who chooses the state exchange in place of Medicaid, states would be required to pay an amount equal to the state's average cost of coverage for individuals in that same Medicaid eligibility category. **[Page 52]**	**[Page 259]**
	• State Option for a Basic Health Plan, Eligibility: The basic health plan would be available to people with incomes from 133 to 200 percent of the federal poverty level. As of July 1, 2013, states could enroll the following income-eligible persons in their basic health plan, persons who: 1) are under age of 65; 2) do not have access to affordable employer sponsored coverage that meets minimum creditable coverage standards; 3) are residents of an area served by the plan; 4) have gross family income above 133 percent of the federal poverty level and below 200 percent of federal poverty level; 5) choose to obtain basic health care coverage from a participating health care plan; and 6) remain current in payment of their share of the premiums. **[Page 16]**	**[Page 73]**
B. Enrollment	• Personal Responsibility Requirement, Open Enrollment in the Individual Market: An initial open-enrollment period for eligible individuals in the individual and small-group market would be from March 1, 2013 through May 31, 2013. For every year thereafter, the open enrollment periods would be from October 15 through November 30. Special enrollment periods would be allowed for qualifying events, consistent with those included in the Public Health Service Act. **[Page 35]**	**[Page 94]**
	• Personal Responsibility Requirement, Auto Enrollment: Employers with 200 or more employees must automatically enroll employees into health insurance plans offered by the employer. Employees may opt out of employer coverage, however, if they are able to demonstrate that they have coverage from another source. Additionally, states will have the option to establish a process for auto-enrollment of individuals and families into policies offered in the individual and group markets. State programs for auto enrollment must be approved by the Secretary of Health and Human Services (HHS). **[Page 36]**	**[Page 56]**

	• Personal Responsibility Requirement: Beginning in 2013, all U.S. citizens and legal residents would be required to obtain coverage through: 1) the individual market, a public program such as Medicare, Medicaid, the Children's Health Insurance Program (CHIP), Veteran's Health Care Program, or TRICARE or through an employer (as a dependent of a covered employee) in the small group market, meeting at least the requirements of a bronze plan; or 2) in the large group market, in a plan with first dollar coverage for prevention-related services, except in cases where value-based insurance design is used and cannot have an unreasonable annual or lifetime limit coverage or a maximum out-of-pocket limit greater than that provided by the standards established for health savings accounts current law limit in order to meet minimum creditable coverage. **[Page 34]**	**[Page 204]**
	• Personal Responsibility Requirement: Exemptions from the requirement to have health coverage would be allowed for religious objections that are consistent with those allowed under Medicare, and for undocumented aliens. **[Page 34]**	**[Page 103]**
	• Personal Responsibility Requirement: An individual enrolled in a grandfathered plan would be deemed to have met the responsibility requirement. **[Page 34]**	**[Page 48]**
	• Personal Responsibility Requirement, Ensuring Compliance: To ensure compliance with the personal responsibility requirement, individuals would be required to report on their federal income tax return the months for which they maintain the required minimum health coverage for themselves and all dependants under age 18. Furthermore, insurers must report information on health insurance coverage information. **[Page 34]**	**[Page 194]**
	• Personal Responsibility Requirement, Ensuring Compliance: The consequence of not maintaining insurance would be an excise tax of $750 per adult in the household, which would be phased in over time: for 2013, $0; for 2014, $200; for 2015, $400; for 2016, $500; for 2017, $750. **[Page 34]**	**[Page 197]**
	• Personal Responsibility Requirement, Ensuring Compliance: No interest will accrue on these sums and there shall be no criminal penalty. **[Page 34]**	**[Page 207]**
	• Personal Responsibility Requirement, Ensuring Compliance: Exemptions from the excise tax will be made for individuals where the full premium of the lowest cost option available to them exceeds eight percent of their adjusted gross income, and for individuals: below 100 percent of the federal poverty level, with religious objections, experiencing hardship situations, or who are Indians. There shall be no criminal penalty. **[Page 34]**	**[Page 199]**
C. Enrollment Process and Marketing	• Informed Consumer Choices: In implementing the state exchanges, the Secretary would be required to do the following: 1) develop standard definitions for common insurance terms; 2) develop standard definitions for medical terms; 3) develop several scenarios (for example, breast cancer) which include information that must be provided by every insurance carrier offering coverage in the individual and small group markets in describing their plans to consumers; and 4) develop standards for an annual personalized statement that summarizes an individuals' use of health care services and claims paid in the previous year. **[Page 47]**	**[Page 256]**
	• Standardization: In order to provide uniform, meaningful and actionable information to consumers concerning health insurance coverage, this provision mandates the development and utilization of uniform outline of coverage documents. The Secretary shall request the National Association of Insurance Commissioners (NAIC) to develop, and submit to the Secretary not later than 12 months after the date of enactment of this Act, standards for use by health insurance issuers in compiling and providing to enrollees an outline of coverage that accurately describes the coverage under the applicable health insurance plan. **[Pages 47-48]**	**[Page 251]**
D. Safeguards Against Involuntary Loss of Enrollment	• Insurance Market Reforms, Rating Rules in the Individual Market: Requires issuers in the individual market to offer coverage on a guaranteed issue and guaranteed renewability basis. **[Page 2]**	**[Page 19]**
3. Health Insurance Coverage and Access to High Quality Covered Treatments and Services		
A. Benefits	• Making Coverage Affordable, Benefit Options: In defining minimum benefit requirements, some flexibility in plan design is allowed, but the Secretary must ensure that plan design does not encourage adverse selection. **[Page 22]**	**[Page 134]**

	• Making Coverage Affordable, Benefit Options, Definition of Four Benefit Categories: Four benefit categories would be available: bronze, silver, gold and platinum. The Secretary is required to define the categories of benefits annually; however, the benefits cannot exceed those of a typical employer-based plan. **[Page 22]**	**[Page 135]**
	• Making Coverage Affordable, Benefit Options, Definition of Four Benefit Categories, Minimum Required Benefits: All health insurance plans in the individual and small group market would be required, at a minimum, to offer coverage in the silver and gold categories. **[Page 22]**	**[Page 135]**
	• Making Coverage Affordable, Benefit Options, Definition of Four Benefit Categories, Minimum Required Benefits: All plans in the individual and small group market must provide preventive and primary care, emergency services, hospitalization, physician services, outpatient services, day surgery and related anesthesia, diagnostic imaging and screenings (including x-rays), maternity and newborn care, pediatric services (including dental and vision), medical/surgical care, prescription drugs, radiation and chemotherapy that at least meet minimum standards set by federal and state laws. **[Page 22]**	**[Page 125]**
	• Making Coverage Affordable, Benefit Options, Definition of Four Benefit Categories, Minimum Required Benefits: All plans in the individual and small group market must provide mental health and substance abuse services that at least meet minimum standards set by federal and state laws. **[Page 22]**	**[Page 131]**
	• Making Coverage Affordable, Benefit Options, Definition of Four Benefit Categories: A separate "young invincible" policy is available for those aged 25 and younger, which is a catastrophic-only plan. **[Page 22]**	**[Page 136]**
	• Insurance Market Reforms, National Plans: National plans must be compliant with the benefit levels and categories detailed in the Mark, but would preempt state benefit mandates – thereby allowing these national plans to offer a single, uniform benefit package. **[Page 14]**	**[Page 62]**
	• State Exchanges and Marketing Requirements, Child-Only and Dental Plans: Provides for the availability of child-only health insurance coverage through the Exchange. Stand-alone dental plans also would be permitted to offer pediatric dental benefits directly and to offer coverage through the exchange. **[Page 18]**	**[Page 132]**
	• Making Coverage Affordable, Benefit Options, Stand-Alone Dental Plans: Stand-alone dental plans must be allowed to offer the required pediatric dental benefits directly and to offer coverage through the exchange and must comply with any relevant consumer protections required for participation in the exchange. **[Page 24]**	**[Page 82]**
	• State Exchanges and Marketing Requirements, Benefit Options: State insurance commissioners are permitted to allow *de minimus* variation around the benefit target valuations to account for differences in actuarial estimates to encourage widely agreed upon cost and quality effective services. **[Pages 23-24]**	**[Page 62]**
	• Making Coverage Affordable, Benefit Options, Definition of Four Benefit Categories: Each plan design in the exchange is required to meet the class and category of drug coverage requirements specified in Medicare Part D. **[Page 23]**	**[Page 131]**
	• Making Coverage Affordable, Benefit Options, Definition of Four Benefit Categories, Minimum Required Benefits: The Secretary would ensure that in each exchange, at least one plan provides coverage of abortions beyond those for which federal funds appropriated for HHS are permitted. **[Pages 32-33]**	**[Page 141]**
	• Making Coverage Affordable, Benefit Options, Definition of Four Benefit Categories, Minimum Required Benefits: Any insurer that rates on tobacco use must also provide coverage for comprehensive tobacco cessation programs including counseling and pharmacotherapy (prescription and non-prescription). **[Page 22]**	**[Page 132]**
B. Benefit Restrictions	• Making Coverage Affordable, Benefit Options, Definition of Four Benefit Categories, Minimum Required Benefits: Abortion cannot be required as part of the minimum benefits package. **[Pages 32-33]**	**[Page 140]**
	• Making Coverage Affordable, Benefit Options, Definition of Four Benefit Categories, Minimum Required Benefits: A qualified health plan would not be prohibited, however, from providing coverage for abortions beyond those for which federal funds appropriated by HHS are permitted. **[Pages 32-33]**	**[Page 140]**
	• Making Coverage Affordable, Benefit Options, Definition of Four Benefit Categories, Minimum Required Benefits: Plans are required to segregate public funds based on an actuarial value of the optional abortion service coverage. **[Pages 32-33]**	**[Page 143]**
	• Making Coverage Affordable, Benefit Options, Definition of Four Benefit Categories, Minimum Required Benefits: No tax credit or cost-sharing credits may be used to pay for abortions beyond those permitted by the most recent appropriation for HHS. **[Pages 32-33]**	**[Page 142]**

	• Making Coverage Affordable, Benefit Options, Definition of Four Benefit Categories, Minimum Required Benefits: Health benefits plans participating in state exchanges would be prohibited from discriminating against any individual health care provider or health care facility because of its willingness or unwillingness to provide, pay for, provide coverage, or refer for abortions. **[Pages 32-33]**	**[Page 144]**
	• Assisted Suicide: Prohibits federal funds under Title V from being used to pay for assisted suicide and offers conscience protections to providers or plans refusing to offer assisted suicide services. **[Page 86]**	**[Page 581]**
C. Preventive Services and Wellness	*See Medicaid (6A) and Medicare (6B)*	*N/A*
D. Cost-Sharing	• Making Coverage Affordable, Benefit Options, Definition of Four Benefit Categories: Each plan design for products in the state exchanges would be required to apply parity for cost-sharing for treatment of conditions within each of the following categories of benefits: 1) inpatient hospital; 2) outpatient hospital; 3) physician services; and 4) other items and services, except in cases where value-based insurance design is used. **[Page 23]**	**[Page 130]**
	• Making Coverage Affordable, Benefit Options, Definition of Four Benefit Categories, Minimum Required Benefits: Plans could waive cost-sharing (e.g., deductibles, copayments) for preventive care services, except in cases where value-based insurance design is used. **[Page 22]**	**[Page 127]**
	• State Exchanges and Marketing Requirements, Emergency Room Protections: Enrollees may not be charged co-payments or cost-sharing for emergency room services furnished out-of-network that are higher than in-network rates. **[Page 18]**	**[Page 133]**
	• Making Coverage Affordable, Benefit Options, Definition of Four Benefit Categories, Minimum Required Benefits: Plans could also not include lifetime limits on coverage or annual limits on any benefits. **[Page 22]**	**[Page 139]**
	• Medigap: Requests that the NAIC create new standardized model plans for C and F (policy issuers are required to offer at least policies with benefit packages A, and if they are to offer others, they must offer at least C or F) that include nominal cost sharing to encourage the use of appropriate Medicare Part B physician services. The nominal cost sharing must be based on evidence either published or from integrated delivery systems, of how cost sharing affects utilization of appropriate physician care. The new models C and F would be available in 2015. **[Page 175]**	**[Page 1011]**
E. Provider Networks and Access to Out-of-Network Care	• Emergency Room Protections: Requires that health plans and health insurers offering coverage in the exchange would be required to provide enrolled individuals coverage for emergency room services without regard to prior authorization or the emergency care provider's contractual relationship with the health plan. **[Page 18]**	**[Page 133]**
F. Actuarial Tests of Reasonableness	• Making Coverage Affordable, Benefit Options, Definition of Four Benefit Categories: No policies could be issued in the individual or small group market (other than grandfathered plans) that do not meet specified actuarial standards. **[Page 22]**	**[Page 733]**
G. Paying for Health Care Coverage	• Making Coverage Affordable, Benefit Options, Definition of Four Benefit Categories: Insurers participating in the state exchanges would be required to provide payments for services furnished to enrollees of the insurer by any electing federally-qualified health center at levels no less than the center would receive under Section 1902(bb) of the Social Security Act (regarding Medicaid payment for services provided by federally qualified health centers and rural clinics) for such services. **[Page 23]**	**[Page 135]**

	• Linking Payment to Quality Outcomes in the Medicare Program, Expanding the Physician Feedback Program: Beginning in 2014, payment would be reduced by five percent if an aggregation of the physician's resource use is at or above the 90th percentile of national utilization. **[Page 102]**	**[Page 676]**
	• Linking Payment to Quality Outcomes in the Medicare Program, Gainsharing Pilot Program: The Secretary's authority to conduct the gainsharing demonstration would be extended until September 30, 2011. **[Page 124]**	**[Page 805]**
	• Pooling Requirements for Individual and Small Group Markets, Reinsurance: As a condition of issuing commercial, major medical health insurance policies or administering benefit plans for major medical coverage in years 2013, 2014, and 2015, all health insurance issuers would be required to contribute to a reinsurance program for individual policies that is administered by a non-profit reinsurance entity. In order to meet this requirement, insurers must contribute to a non-profit to help stabilize premiums for individual coverage during the first few years of operation of the state exchanges when the risk of adverse selection related to new rating rules and market changes is greatest. The non-profit must use funds collected to support a reinsurance mechanism applied to individuals enrolled in plans offered within the state exchange. **[Page 9]**	**[Page 27]**
	• Pooling Requirements for Individual and Small Group Markets, Risk Corridors: After reinsurance is applied, in the case of a plan that offers coverage in the individual and small group market in years 2013, 2014, and 2015, risk corridors modeled after that applied to a regional participating provider organizations in Medicare Part D will be provided if a plan chooses to participate. **[Page 10]**	**[Page 35]**
4. Consumer Protections		
A. Information About Plan Performance	• Information Provided to the Exchange: All personal information submitted to the state exchange can only be used for purposes of providing insurance coverage through the state exchange, eligibility for and determination of the amount of the health care tax credit, or other administrative functions related to the efficient operation of the state exchange. Appropriate penalties will apply to the use of fraudulent information or stolen identity information in the state exchange. **[Page 28]**	**[Page 114]**
	• Informed Consumer Choices: Beginning in 2010, to ensure transparency and accountability, health plans would be required to report the proportion of premium dollars that are spent on items other than medical care. Also, beginning in 2010, hospitals would be required to list standard charges for all services and Medicare diagnosis related groups. **[Page 47]**	**[Page 250]**
B. Utilization Management, Grievances, and Appeals	• State Exchanges and Marketing Requirements, Internal Appeals Process: Plans and health insurance carriers offering coverage in the exchange would be required to have an internal claims appeal process. **[Page 18]**	**[Page 248]**
	• State Insurance Commissioners: State Insurance Commissioners are responsible for protecting the interests of insurance consumers by performing efforts such as anti-fraud efforts, addressing consumer complaints, market analysis, producer licensing, and regulatory interventions. They are responsible for enforcing the general rules governing insurance. State insurance commissioners would continue to provide oversight of plans with regard to consumer protections, rate reviews, solvency, reserve requirements, premium taxes, and all requirements imposed on insured plans as specified in this Mark. They would provide oversight of plans with regard to federal rating rules and any additional state rating rules, facilitate risk adjustment within service areas, and establish rate schedules for broker commissions in the state exchanges. **[Page 11]**	**[Page 55]**
	• Transparency and Accountability, Ombudsman Program: In 2010, states would be required to establish an ombudsman office to act as a consumer advocate for those with private coverage in the individual and small group markets. Policyholders whose health insurers have rejected claims and who have exhausted internal appeals, whose internal appeal process has exceeded nine months, and whose appeal involves a life-threatening issues, would be able to access the ombudsman office for assistance. Policyholders would also be able to access ombudsman services for assistance in resolving problems with premium credits and cost-sharing subsidies and with assistance in filing appeals as needed once the state exchanges are implemented. **[Page 46]**	**[Page 247]**

	• Transparency and Accountability, Health Insurance Consumer Assistance Grants: Authorizes $30 million (and such sums as necessary after these dollars are expended) to establish a new competitive grant program to support consumer assistance organizations in each state. Grantee organizations would assist consumers in solving problems and navigating health insurance coverage transitions, as well as collect data on consumer encounters and report to HHS on types of problems and inquiries. Grantee organizations may include small business development centers as well as commercial fishing organizations, ranching and farming organizations, and other organizations capable of conducting community-based health care outreach and enrollment assistance for hard to reach and rural workers. **[Page 46]**	**[Page 248]**
	• State Exchanges and Marketing Requirements, Child-Only and Dental Plans: These plans must comply with all consumer protection requirements in order to participate in the exchange. **[Page 18]**	**[Page 132]**
C. Choice of Provider	*Not Addressed*	*N/A*
D. Remedies for Injuries	*Not Addressed*	*N/A*
E. Medical Malpractice	• Sense of the Senate Regarding Medical Malpractice: It is the sense of the Senate that health care reform presents an opportunity to address issues related to medical malpractice and medical liability insurance. It is also the sense of the Senate that states should be encouraged to develop and test alternatives to the current civil litigation system as a way of improving patient safety, reducing medical errors, encouraging the efficient resolution of disputes, increasing the availability of prompt and fair resolution of disputes, and improving access to liability insurance, while preserving an individual's right to seek redress in court. Finally, it is the sense of the Senate that Congress should consider establishing a state demonstration program to evaluate alternatives to the current civil litigation system. **[Pages 207-08]**	**[Page 1211]**
5. Treatment of Populations and Communities at Risk of Disparities in Care		
A. Investments in Primary Care for Medically Underserved Populations and Communities	• Strengthened Primary Care and Other Workforce Improvements, Proposal on Development of a National Workforce Strategy: Several studies and policy experts have called for a renewed effort to develop a comprehensive and coordinated national strategy to address workforce shortages and encourage training in key focus areas that support delivery system reform goals, such as improving care coordination, health provider use of health information technology and increasing access to primary care services. To achieve these goals, the Secretary would create a Workforce Advisory Committee. These stakeholders would develop and present a national workforce strategy to the Secretary and the Congress that will set the nation on a path towards recruiting, training and retaining a health workforce that meets the nation's current and future health care needs. **[Page 132]**	**[Page 843]**
	• Strengthening Primary Care and Other Workforce Improvements, Demonstration Project to Address Health Professions Workforce Needs: To address needs in the health professions workforce, establishes grants to provide aid and supportive services to low-income individuals with the opportunity to obtain education and training for occupations in the health care field that pay well and are expected to experience labor shortages or be in high demand. **[Page 132]**	**[Page 847]**
	• Strengthening Primary Care and Other Workforce Improvements, Teaching Health Centers: To increase training and improve access to primary care services, qualified teaching health centers would be eligible for payments for direct graduate medical residency training programs. **[Page 134]**	**[Page 863]**

	• Strengthening Primary Care and Other Workforce Improvements, Extension of Family-to-Family Health Information Centers: The Deficit Reduction Act of 2005 (DRA) provided dedicated funding for the development and support of family-to-family health information centers. The centers: 1) assist families of children with disabilities or special health care needs make informed choices about health care to promote good treatment decisions, cost effectiveness, and improved health outcomes for such children; 2) provide information regarding the health care needs of children with disabilities or special health care needs; 3) identify successful health delivery models for such children; 4) develop models of collaboration between families of such children and health professionals; 5) provide training and guidance with regard to the care of such children; and 6) conduct outreach activities to families of such children, health care providers, schools, and other appropriate entities and individuals. Funding for family-to-family health information centers is extended at $5 million for 2010 through 2012. **[Page 134]**	**[Page 847]**
	• Maternal, Infant, and Early Childhood Visitation: States, as a condition for receiving the maternal and child health (MCH) block grant, will be required to conduct a needs assessment to identify communities that are at risk for poor maternal and child health and have few quality home visitation programs. A new state grant program will be established for early childhood home visitation. Grantees in this new program would be required to establish appropriate process and three and five year outcome benchmarks to measure improvement in maternal and child health, childhood injury prevention, school readiness, juvenile delinquency, family economic factors, and coordination with community resources. **[Page 84]**	**[Page 453]**
	• Extend Medicare Rural Hospital Flexibility Program: The Balanced Budget Act of 1997 established the Medicare Rural Hospital Flexibility Program, which created the critical access hospital designation under Medicare and authorized a grant program (FLEX grants) that is administered by the Health Resources and Services Administration. Under this program, FLEX grants may be awarded to states to develop and implement rural health care plans and rural health networks, to designate critical access hospitals, to upgrade data systems and to improve the provision of rural emergency medical services. The FLEX grant program would be extended two years until 2012. The proposed change would allow Small Rural Hospital Improvement Program funding to also be used to support small rural hospitals' participation in the delivery system reform programs outlined in this legislation, such as value-based purchasing programs, Accountable Care Organizations, bundling, and other programs deemed appropriate by the Secretary. **[Page 146]**	**[Page 914]**
	• Revisions to Demonstration Project: The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) authorized a demonstration project to allow eligible entities to develop and test new models for the delivery of health care services in eligible counties for the purpose of improving access to, and better integrating delivery of, acute care, extended care, and other essential health care services to Medicare beneficiaries. The limitation on the number of eligible counties that may participate in the demonstration project within the qualifying states is stricken. The proposed change would also delete references to rural health clinic services and replace these with a requirement that physician services may also be included within the scope of the demonstration project. **[Page 150]**	**[Page 911]**
	• Strengthening Primary Care and Other Workforce Improvements, Primary Care/General Surgery Bonus: Establishes a new ten percent bonus on select evaluation and management codes under the Medicare fee schedule for five years, beginning January 1, 2011. The groups of codes to which this bonus would apply includes: office visits, home visits, nursing facility visits, and domiciliary, rest home (e.g. boarding home), and custodial care services. The bonus would be available to primary care practitioners who: 1) have a specialty designation of family medicine, internal medicine, geriatric medicine, or pediatric medicine (or are an advanced practice nurse or physician assistant); and 2) furnish 60 percent of their services in the select codes. Services provided to both established patients and new patients would qualify. Qualifying practitioners providing care in a health professional shortage area would also receive the ten percent bonus on hospital visit codes that are typical of primary care medicine (as determined by the Secretary), though only ten percent of these visits would count toward the 60 percent threshold. In addition, general surgeons providing care in a health professional shortage area would also be eligible for a ten percent bonus on major procedure codes for five years, beginning January 1, 2011. Half (50 percent) of the cost of the bonuses would be offset through an across-the-board reduction to all other codes, except for physicians who primarily provide services in a health professional shortage area zip code. **[Page 125]**	**[Page 806]**

	• Rural Protections, Extend Hospital Outpatient Hold Harmless: Small rural hospitals (with no more than 100 beds) that are not sole community hospitals can receive additional Medicare payments if their outpatient payments under the prospective payment system are less than under the prior reimbursement system. For calendar year (CY) 2006, these hospitals would receive 95 percent of the difference between payments under the prospective payment system and those that would have been made under the prior reimbursement system. The hospitals would receive 90 percent of the difference in CY2007 and 85 percent of the difference in CY2008 and CY2009. Sole community hospitals with not more than 100 beds would receive 85 percent of the payment difference for covered hospital outpatient department services furnished on or after January 1, 2009, and before January 1, 2010. The provision would establish that small rural hospitals would receive 85 percent of the payment difference in CY2010 and CY2011. Sole community hospitals with not more than 100 would receive 85 percent of the payment difference in CY2010 and CY2011. Sole community hospitals with more than 100 beds would receive 85 percent of the payment difference in CY2010 and CY2011. **[Pages 147-48]**	**[Page 905]**
	• Rural Protections, Extend Rural Hospital Demonstration Program: As required by Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA), the Centers for Medicare and Medicaid Services (CMS) is conducting a five-year Rural Community Hospital Demonstration Program to test the feasibility and advisability of reasonable cost reimbursement for small rural hospitals (those with fewer than 51 beds). Currently, there are ten hospitals participating in the program. This provision would extend the demonstration program for an additional two years, expand the maximum number of participating hospitals to 30, and expand eligible sites to rural areas in all states until January 1, 2012. **[Pages 147-48]**	**[Page 906]**
	• Rural Protections, Extend Medicare Dependant Hospital Program and Study on Applying the MDH Program to Urban Hospitals: Medicare dependent hospitals are small rural hospitals with a high proportion of patients who are Medicare beneficiaries. Specifically, the hospitals have at least 60 percent of acute inpatient days or discharges attributable to Medicare in 1987 or in two of the three most recently audited cost reporting periods. As specified in regulation, they cannot be an sole community hospitals and must have 100 or fewer beds. Medicare dependant hospitals receive special treatment, including higher payments under Medicare's inpatient prospective payment system. The sunset date for the Medicare dependant hospitals classification has been periodically extended by legislation. DRA, had established that the Medicare dependent hospital classification would expire September 30, 2011. This provision extends the Medicare dependant hospital classification for two years, until September 30, 2013. **[Page 148]**	**[Page 909]**
	• Rural Protections, Extend Medicare Dependant Hospital Program and Study on Applying the MDH Program to Urban Hospitals: The Secretary must conduct a study on the need for an additional Medicare inpatient payment for urban Medicare dependant hospitals paid under the prospective payment system which receive no additional payments or adjustments under the prospective payment system, such as indirect medical education, disproportionate share hospital, rural referral center, critical access hospital, sole community hospital, or Medicare dependant hospital payments. **[Page 148]**	**[Page 955]**
	• Temporary Improvements to the Medicare Inpatient Hospital Payment Adjustment for Low-Volume Hospitals: Under Medicare's inpatient prospective payment system, certain low-volume hospitals receive a payment adjustment to account for their higher costs per discharge. A temporary adjustment that would increase payment in 2011 and 2012 for certain low-volume hospitals would be created. A low-volume hospital could be located more than 15 road miles from another comparable hospital and have 1,500 discharges of individuals entitled to or enrolled for Medicare Part A benefits. The Secretary would 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 1,500 discharges of individuals with Medicare Part A benefits. **[Page 149]**	**[Page 910]**
	• Technical Correction Related to Critical Access Hospital Services: Clarifies that critical access hospitals are eligible to receive 101 percent of reasonable costs for providing outpatient services regardless of billing method and for providing qualifying ambulance services. **[Page 153]**	**[Page 913]**
B. Language Access	*Not Addressed*	*N/A*

C. Provider Obligations to Treat Members who are Residents of Medically Underserved Communities	*Not Addressed*	*N/A*
D. Data Collection and Reporting on Health Care Access and Quality by Race, Ethnicity, and Language and Other Factors Such as Health Status or Disability	• Addressing Health Disparities, Standardized Collection of Data: Establishes uniform categories for collecting data on race and ethnicity, sex, and primary language and requires CMS to collect data on individuals with disabilities. **[Page 81]**	**[Page 444]**
	• Addressing Health Disparities, Sufficient Disparities Data: Requires that federally-funded population surveys collect sufficient data on racial and ethnic subgroups to generate statistically reliable results in studies comparing health disparities populations. **[Page 81]**	**[Page 446]**
	• Addressing Health Disparities, Data Sharing: Requires HHS to share health disparities data, measures, and analyses with other relevant agencies. **[Page 82]**	**[Page 450]**
	• Addressing Health Disparities, Privacy and Security: Requires the Secretary to ensure all appropriate privacy and security safeguards are followed for activities relating to health disparities data collection, analysis, and sharing. **[Page 83]**	**[Page 451]**
	• Patient-Centered Outcomes Research, Patient-Centered Outcomes Research Institute, Addressing Subpopulations: The Patient-Centered Outcomes Research Institute would design research to take into account potential differences in outcomes among different subpopulations, such as racial and ethnic minorities, women, age, and groups of individuals with different co-morbidities, genetic and molecular subtypes, or quality of life preferences. Members of such subpopulations would be included in the research as feasible and appropriate. **[Page 198]**	**[Page 1139]**
E. Civil Rights Laws	*Not Addressed*	*N/A*
6. Treatment of Other Forms of Health Insurance and Health Care Arrangements		
A. Medicaid and Children's Health Insurance Program (CHIP)	• Medicaid Coverage for the Lowest Income Populations, Eligibility Standards and Methodologies: Creates a new eligibility category for all non-elderly non-pregnant individuals (childless adults) otherwise ineligible for Medicaid. In 2011, states would have the option to cover childless adults through a state plan amendment. Establishes 133 percent of the federal poverty level as the new mandatory minimum Medicaid income eligibility level for all non-elderly individuals – parents, children, and childless adults – beginning on January 1, 2014. Existing law would not change for pregnant women. During 2013, individuals at or below 133 percent of federal poverty level would not be subject to the requirement to obtain health insurance, nor would they be eligible for tax credits in the state exchanges. **[Page 50]**	**[Page 258]**
	• Medicaid Coverage for the Lowest Income Populations, Eligibility Standards and Methodologies, Maintenance of Effort: States would be required to maintain existing income eligibility levels for all Medicaid populations upon enactment. This "maintenance of effort" provision would expire when the state exchange becomes fully operational (expected July 1, 2013), except as it applies to coverage at income levels of 133 percent of federal poverty level and below, for which it would continue through January 1, 2014 (unless the state certifies that it has a budget deficit). **[Page 50]**	**[Page 269]**

	• Medicaid Coverage for the Lowest Income Populations, Eligibility Standards and Methodologies: All newly-eligible, non-pregnant adults would receive a benchmark benefit package consistent with Section 1937 of the Social Security Act (regarding state flexibility in benefit packages). The benchmark and benchmark-equivalent packages would have to meet the requirements for minimum creditable coverage. For benchmark-equivalent plans, prescription drugs would be added to the list of benefits that must have the same actuarial value as the benchmark. Populations currently exempted from mandatory enrollment in Section 1937 plans would remain exempted. **[Page 51]**	**[Page 259]**
	• Medicaid Coverage for the Lowest Income Populations, Medicaid Program Payments, Newly Eligible Beneficiaries: States would continue to receive federal financial assistance as determined by federal medical assistance percentages. Beginning in 2014, additional federal financial assistance would be provided to all states to defray the costs of covering newly-eligible beneficiaries. The federal government would pay a greater share of the costs for individuals "newly eligible" for Medicaid based on the proposed eligibility changes. Those states that offer minimal or no coverage of the newly-eligible population currently would receive more assistance initially than those states that currently cover at least some non-elderly, non-pregnant individuals. Between 2014 and 2018, the additional assistance to expansion states and other states would be adjusted downward and upward, respectively, so that, in 2019, all states would receive the same level of additional assistance for covering newly eligibles. **[Page 51-52]**	**[Page 260]**
	• Medicaid Coverage for the Lowest Income Populations, Eligibility Standards and Methodologies, Measurement of Income: Other than for the elderly and groups eligible for Medicaid through another program, effective January 1, 2014, income disregards would no longer apply, and income would be measured based on modified gross income as defined in the state exchanges. **[Page 50]**	**[Page 260]**
	• Medicaid Coverage for the Lowest Income Populations, Medicaid and Employer-Sponsored Coverage: Effective July 1, 2013, states will be required to offer premium assistance and wrap-around benefits to Medicaid beneficiaries who are offered employer-sponsored insurance if it is cost-effective to do so, consistent with current law requirements. **[Page 53]**	**[Page 287]**
	• Medicaid Coverage for the Lowest Income Populations, Medicaid Program Payments, High Needs States: Provides additional assistance to "high-need states," which are defined as states that: 1) have total Medicaid enrollment that is below the national average for Medicaid enrollment as a percent of state population as of the date of enactment; and 2) had seasonally-adjusted unemployment rates of 12 percent or higher for August 2009. The additional assistance provided to such states would be full federal funding for the cost of providing medical assistance to newly eligible beneficiaries for the five-year period of 2014 through 2018. **[Page 52]**	**[Page 263]**
	• Medicaid Coverage for the Lowest Income Populations, Treatment of the Territories: Increases spending caps for the territories by 30 percent and the applicable federal medical assistance percentages by five percentage points – to 55 percent – beginning on January 1, 2011. The cost of covering "newly eligibles" would not count towards the spending caps. **[Page 54]**	**[Page 264]**
	• Improvements to Medicaid, Presumptive Eligibility: Effective January 1, 2014, all hospitals that participate in Medicaid will be permitted to make presumptive eligibility determinations, in addition to providers currently eligible to do so. In addition, hospitals and other providers are allowed to make such determinations for all Medicaid-eligible populations, as long as the state agency verifies the hospital or provider is capable of doing so. The time period of presumptive eligibility would be consistent with current law. Current notification procedures would apply to all presumptive eligibility determinations. **[Page 58-59]**	**[Page 307]**
	• American Indians and Alaska Natives, Eligiblity Determination: Indian tribes, tribal organizations, and urban Indian organizations would be added to the definition of an Express Lane Agency. Tribes would also be allowed to accept applications for public programs and state exchange plans. **[Page 78]**	**[Page 442]**

	• Improvements to Medicaid, Enrollment Coordination with the State Exchange: Requires the Secretary to issue guidance to states regarding standards and best practices to help improve enrollment of vulnerable populations in Medicaid and CHIP. Vulnerable populations include: children, unaccompanied homeless youth, children and youth with special health care 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. **[Page 57]**	**[Page 331]**
	• Improvements to Medicaid, Enrollment Coordination with State Exchange: Requires states to establish a Medicaid enrollment website to promote seamless enrollment in Medicaid should a Medicaid-eligible individual apply for tax credits through a state exchange website or vice versa. A single, streamlined form can be used to apply for all three subsidy programs (Medicaid, CHIP, and tax credits) with one exception: the Secretary may allow use of a supplemental or alternative form when individuals apply for a category of Medicaid eligibility that is not determined based on modified adjusted gross income. **[Pages 57-58]**	**[Page 115]**
	• Improvements to Medicaid, Enrollment Coordination with State Exchange: Exchanges and state Medicaid and CHIP agencies operate satisfactory systems to ensure a secure electronic interface sufficient to allow a determination of eligibility for all three programs based on the single, streamlined form or reliable third-party data. To safeguard program integrity, the state exchanges will regularly engage in data matches with the Internal Revenue Service, the Social Security Administration, the National Directory of New Hires, the applicable State Workforce Agency, or any other source of data that, under current law, may be used to verify eligibility for Medicaid or CHIP. To accomplish these goals, the Secretary may promulgate model agreements and enter into interagency agreements concerning data-sharing, consistent with safeguards of privacy and data integrity. **[Pages 57-58]**	**[Page 117]**
	• American Indians and Alaska Natives, Premiums and Cost-Sharing: Prohibits cost-sharing (including premiums, deductibles, copayments, co-insurance, etc.) for all AI/ANs with incomes at or below 300 percent of the federal poverty level for state exchange plans and public programs. **[Page 77]**	**[Page 441]**
	• Medicaid Services, Free Standing Birth Centers: Identifies free-standing birthing centers as Medicaid providers. **[Page 61]**	**[Page 333]**
	• Medicaid Services, Curative and Palliative Care for Children in Medicaid: Allows children, as defined by the state, who are eligible for Medicaid, to receive hospice services without foregoing any other service to which the child is entitled under Medicaid. **[Page 61]**	**[Page 336]**
	• Medicaid Services, ADRC Funding: Allocates $10 million each fiscal year, beginning in 2010 for five years to continue funding Aging Disability Resource Centers. **[Page 62]**	**[Page 337]**
	• Medicaid Services, Community First Choice Option: Establishes the Community First Choice Option, which would create a state plan option under Section 1915 of the Social Security Act (regarding the inapplicability and waiver of certain provisions of the Medicaid Title) to provide community-based attendant supports and services to individuals with disabilities who are Medicaid-eligible and who require an institutional level of care. States who choose this option would be eligible for enhanced federal match rate of an additional six percentage points for reimbursable expenses in the program. This option would also modify the Money Follows the Person Rebalancing Demonstration to reduce the amount of time required for individuals to qualify for that program for 90 days. **[Page 62]**	**[Page 337]**
	• Spousal Impoverishment: Protects against spousal impoverishment in all Medicaid home and community based services programs by requiring states to apply the same spousal impoverishment rules currently provided to the spouses of nursing home residents in Medicaid. This provision would sunset after five years. **[Page 62]**	**[Page 350]**
	• Medicaid Services, Home and Community Based Services: Provides a targeted increase in the federal medical assistance percentage to states that undertake structural reforms proven to increase nursing home diversions and access to home and community based services in their Medicaid programs. **[Page 62]**	**[Page 351]**
	• Removal of Barriers to Providing Home and Community-Based Services: States would be able to offer home and community-based services through a waiver or through a state plan amendment. States that choose a state plan amendment would be able to include individuals with incomes up to 300 percent of the maximum Supplemental Security Income payment. Funding for the nursing home diversion program would be available for five years beginning in 2011. **[Page 62]**	**[Page 361]**

	• Medicaid Services, Family Planning Services: Adds a new optional categorically-needy eligibility group to Medicaid. This new group would be comprised of: 1) non-pregnant individuals with income up to the highest level applicable to pregnant women covered under the Medicaid or CHIP state plan; and 2) at state option, individuals eligible under the standards and processes of existing Section 1115 waivers that provide family planning services and supplies. Benefits would be limited to family planning services and supplies (as per Section 1905(a)(4)(C) of the Social Security Act regarding the definition of "medical assistance" for purposes of family planning services and services provided to individuals of child-bearing age) and would also include related medical diagnosis and treatment services. States are also allowed to make a "presumptive eligibility" determination for individuals eligible for such services through the new optional eligibility group. [Page 63]	[Page 371]
	• Medicaid Services, School-Based Clinics: Establishes a grant program to be used to fund operating expenses for school-based health centers (as defined in the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA)). [Page 64]	[Page 380]
	• Medicaid Services, Definition of Medical Assistance: Clarifies the original intent of Congress that the term "medical assistance" as used in various sections of the Social Security Act encompasses both payment for services provided and the services themselves. [Page 64]	[Page 371]
	• Medicaid Services, Money Follows the Person Demonstration: Extends the Money Follows the Person Rebalancing Demonstration through September 30, 2016. [Page 63]	[Page 369]
	• Addressing Health Disparities: Adds a rule of construction that nothing in Section 1905(a) of the Social Security Act (regarding the definition of "medical assistance") shall be construed as limiting a state from covering therapeutic foster care for eligible children in out-of-home placements. [Page 83]	[Page 381]
	• Addressing Health Disparities: Ensures that children aging out of the foster care system have the opportunity to designate a medical power of attorney prior to emancipation from foster care. States must supply information and an opportunity for the child to designate another individual to make medical decisions on their behalf should they be unable to participate in such decision making process as part of the transition process for children expected to age out of the foster care system. The opportunity to designate an individual to make such decisions must be made in compliance with state law in the form of a health care power of attorney, health care proxy, or other similar document recognized by state law. The importance of designating another individual to make medical treatment decisions shall be incorporated into the curriculum of Independent Living Education programs for adolescents preparing to age out of the foster system. [Page 83]	[Page 451]
	• Sense of the Senate Regarding Long-Term Care: The sense of the Senate is that this Congress should address long-term services and supports in a comprehensive way that guarantees elderly and disabled individuals the care they need. It is also the sense of the Senate that long term services and supports should be made available in the community in addition to in institutions. [Page 62]	[Page 382]
	• Medicaid Prescription Drug Coverage: Removes smoking cessation drugs, barbiturates, and benzodiazepines from Medicaid's excluded drug list, effective January 1, 2014. [Page 65]	[Page 391]
	• Promoting Disease Prevention and Wellness, Medicaid, Improving Access to Preventive Services for Eligible Adults: Encourages states to improve coverage of and access to recommended preventive services and immunizations. [Page 91]	[Page 615]
	• Promoting Disease Prevention and Wellness, Medicaid, Improving Access to Preventive Services for Eligible Adults: Encourages states to improve coverage of and access to recommended preventive services and immunizations. At a minimum, states would be required to provide Medicaid coverage for comprehensive tobacco cessation services for pregnant women without cost-sharing for such services. Additionally, a state that opts to provide Medicaid coverage for all U.S. Preventive Services Task Force-recommended services and immunizations recommended by the Advisory Committee on Immunization Practices as well as removes cost-sharing for those services would receive a one percentage point increase in the federal share of its federal medical assistance percentage for those services, and for the required comprehensive tobacco cessation services for pregnant women. [Page 91]	[Page 617]

	• Promoting Disease Prevention and Wellness, Medicaid, Incentives for Healthy Lifestyles: The Secretary would develop criteria for healthy lifestyle programs using relevant, evidence-based resources. These programs must be comprehensive and uniquely suited to address the needs of Medicaid-eligible beneficiaries and have demonstrated success in helping individuals lower or control cholesterol and/or blood pressure, lose weight, quit smoking and/or manage or prevent diabetes, and may address co-morbidities, such as depression, associated with these conditions. **[Page 91]**	**[Page 620]**
	• Promoting Disease Prevention and Wellness, Medicaid, Medicaid State Plan Option Promoting Health Homes and Integrated Care: Creates a new Medicaid state plan option under which Medicaid enrollees with at least two chronic conditions or with one chronic condition and at risk of developing another chronic condition, could designate a provider as their health home. The designated provider or a team of health professionals would offer the following services: 1) comprehensive care management; 2) care coordination and health promotion; 3) comprehensive transitional care, including appropriate follow-up, from inpatient to other settings; 4) patient and family support; and 5) referral to community and social support services, if relevant, and, as feasible, use health information technology to link such services. **[Page 95]**	**[Page 627]**
	• Promoting Disease Prevention and Wellness, Medicaid, Appropriations for a Childhood Obesity Demonstration Project: Appropriates $25 million for the Secretary to carry out the childhood obesity demonstration project. Also, the Secretary is required to issue guidance to states and health care providers regarding Medicaid's coverage of obesity-related services and preventive services. **[Page 93]**	**[Page 638]**
	• Promoting Disease Prevention and Wellness, Medicaid, Public Awareness of Preventive and Obesity-Related Services: Requires the Secretary to issue guidance to states and health care providers regarding Medicaid's coverage of obesity-related services and preventive services. The Secretary would be required to increase public awareness of and education regarding coverage of obesity-related benefits such as obesity screening and counseling for both children and adults. The Secretary must report to Congress on its public awareness efforts as well as the guidance provided to states and health care providers every three years starting in 2011 and ending in 2017. **[Page 96]**	**[Page 638]**
	• Medicaid Quality, Medicaid Quality Measures: Directs the Secretary, in consultation with the states, to develop an initial set of care quality measures specific to adults who are eligible for Medicaid, similar to the quality provisions enacted under CHIPRA. Also establishes the Medicaid Quality Measurement Program, which would expand upon existing quality measures, identify gaps in current quality measurement, establish priorities for the development and advancement of quality measures, and consult with relevant stakeholders. **[Page 73]**	**[Page 410]**
	• Medicaid Quality, Medicaid Emergency Psychiatric Care Demonstration Project: Establishes a three-year, $75 million demonstration project for up to eight states to expand the number of emergency inpatient psychiatric care beds available in communities. This project – the Medicaid Emergency Psychiatric Care Demonstration Project – would allow states to cover patients in non-governmental free standing psychiatric hospitals and receive federal Medicaid matching payments to demonstrate that covering patients in these hospitals will improve timely access to emergency psychiatric care, reduce the burden on overcrowded emergency rooms, and improve the efficiency and cost-effectiveness of inpatient psychiatric care. **[Page 76]**	**[Page 424]**
	• Medicaid Prescription Drug Coverage, Increase the Brand-Name Drug Rebate Amount: Increases the flat rebate percentage used to calculate Medicaid's basic rebate for outpatient brand name prescription drugs from 15.1 percent to 23.1 percent, except for clotting factors that receive a furnishing fee under Section 1842(o)(5) of the Social Security Act (regarding separate payment for blood clotting factors) and outpatient drugs that are approved by the Food and Drug Administration exclusively for pediatric indications, for which the basic rebate would increase to 17.1 percent. Also limits the total rebate liability on an individual single source or innovator multiple source drug to 100 percent of average manufacturer price for that drug product. Other features of the drug rebate program, such as Medicaid's best price provision, would remain unchanged. **[Page 66]**	**[Page 384]**

	• Medicaid Prescription Drug Coverage, Increase the Generic Drug Rebate Amount: Increases the rebate for non-innovator, multiple-source drugs to 13 percent of the average manufacturer price. Also requires the Comptroller General to review state laws that have a negative impact on generic drug utilization in federal programs due to restrictions such as but not limited to limits on pharmacists' ability substitute a generic drug or carve-outs of certain classes of drugs from generic substitution. **[Page 67]**	**[Page 386]**
	• Medicaid Prescription Drug Coverage, Extend to and Collect Rebates on Behalf of Managed Care Organizations: Brand name and generic prescription drug manufacturers would be required to pay rebates for beneficiaries who receive care under risk-based agreements similar to the way rebates are now required for fee-for-service beneficiaries. Drug manufacturers would be required to pay the managed care organization rebates directly to states, as they do under fee-for-service. But managed care organizations would not be prohibited from negotiating with manufacturers and wholesalers for rebates above Medicaid's statutory rebates. **[Page 67]**	**[Page 386]**
	• Medicaid Prescription Drug Coverage, Application of Rebates to New Formulations of Existing Drugs: Treats new formulations of existing brand name drugs as if they were the original product for purposes of calculating Medicaid's additional drug rebate. **[Page 68]**	**[Page 389]**
	• Medicaid Prescription Drug Coverage, Changes to Medicaid Payment for Prescription Drugs: Changes the federal upper limit to no less than 175 percent of the weighted average (determined on the basis of utilization) of the most recent average manufacturer prices for pharmaceutically and therapeutically equivalent multiple source drugs available nationally through commercial pharmacies. Also would clarifies what transactions, discounts, and other price adjustments were included in the definition of the average manufacturer price. Additionally, clarifies that retail survey prices do not include mail order and long term care pharmacies. In addition, the disclosure requirement is expanded to include monthly weighted average manufacturer prices and retail survey prices. **[Page 69]**	**[Page 392]**
	• Medicaid Disproportionate Share Payments, Coordination of Dual Eligibles: State disproportionate share hospital allotments would remain intact as under current law until a state trigger is tripped. The trigger would be tripped once a state's uninsured rate, as measured by the Census Bureau's American Community Survey, decreases by at least 50 percent, compared to an initial uninsured rate on the date of enactment. Once the trigger is tripped, state disproportionate share hospital allotments would be decreased by 50 percent. Low disproportionate share hospital state allotments would be decreased by 25 percent. As the rate of uninsurance drops further, the disproportionate share hospital payment rate will drop further as well. **[Page 70]**	**[Page 404]**
	• Medicaid and Children's Health Insurance Program Payment and Access Commission: The Medicaid and Children's Health Insurance Program Payment and Access Commission (MACPAC) was created under CHIPRA, in order to review program policies under both Medicaid and CHIP affecting children's access to benefits, including: 1) payment policies, such as the process for updating fees for different types of providers, payment methodologies, and the impact of these factors on access and quality of care; 2) the interaction of Medicaid and CHIP payment policies with health care delivery generally; and 3) other policies, including those relating to transportation and language barriers. The commission is also charged with making recommendations concerning such policies. $11 million is authorized for MACPAC for 2010. Of this total, $9 million would come from Medicaid funds, and $2 million would come from CHIP funds. Funding in subsequent years would be subject to appropriation of such sums as are necessary. MACPAC's mission is also expanded to include assessment of adult services in Medicaid, including for dual eligbles, and more detailed reporting requirements to states and Congress. **[Page 76]**	**[Page 430]**
	• Children's Health Insurance Program: Maintains the current CHIP structure. The CHIP benefit package and cost-sharing rules would continue as under current law. **[Page 56]**	**[Page 292]**
	• Children's Health Insurance Program: Calls for the reauthorization of CHIP by September 30, 2013. **[Page 56]**	**[Page 292]**

	• Children's Health Insurance Program: Upon enactment, states would be required to maintain income eligibility levels for currently eligible children in Medicaid (up to the Children's Health Insurance Program eligibility level) and CHIP. This requirement would expire as of December 31, 2019. States would be able to expand their current income eligibility levels at any time. Children's Health Insurance Program-eligible children who cannot enroll in CHIP due to federal allotment caps would be eligible for tax credits in the state exchange. **[Page 56]**	**[Page 292]**
	• Children's Health Insurance Program: The Medicaid and CHIP enrollment bonuses included in CHIPRA would not apply beyond the current reauthorization period. **[Page 56]**	**[Page 293]**
	• Children's Health Insurance Program: States would receive the current law enhanced CHIP match rate for federal fiscal years 2010-2013. Beginning in 2014, states would receive a 23 percentage point increase in the CHIP match rate, subject to a cap of 100 percent. This 23 percentage point increase would continue through federal fiscal year 2019. States would also receive an increase of 0.15 percentage points in their Medicaid match rate to offset the additional state costs due to the Medicaid maintenance of effort provision. **[Pages 56-57]**	**[Page 291]**
B. Medicare	• American Indians and Alaska Natives, American Indian and Alaska Native Providers and Medicare Part B: Removes the sunset in current law to allow Indian tribes, tribal organizations, and urban Indian organizations to continue to receive payment for certain Medicare-covered items and services. **[Page 79]**	**[Page 443]**
	• Medicare Part B Special Enrollment for Disabled TRICARE Beneficiaries: Creates a twelve-month special enrollment period for military retirees, their spouses (including widows/widowers) and dependent children, who are otherwise eligible for TRICARE and entitled to Medicare Part A based on disability or end-stage renal disease, but who have declined participation in Medicare Part B. **[Pages 143-44]**	**[Page 893]**
	• Promoting Disease Prevention and Wellness, Medicare, Annual Wellness Visit: Beginning in 2011, Medicare beneficiaries would have access to a comprehensive health risk assessment based on guidelines developed by the Secretary in consultation with relevant groups and entities. The assessment would identify chronic diseases, modifiable risk factors, and emergency or urgent health needs. The assessment could be provided through an interactive telephonic or web-based program or during an encounter with a health professional. The Secretary would also set standards for the electronic tools that could be used to deliver the assessment. A comprehensive health risk assessment will be completed prior to or as part of the wellness visit. Medicare payment would also be authorized for a visit to a primary care provider to create a personalized prevention plan. The administration of the health risk assessment will be taken into account as part of this determination. **[Page 87]**	**[Page 585]**
	• Promoting Disease Prevention and Wellness, Medicare, Removing Barriers to Preventive Services: Encourages beneficiaries to receive preventive screenings by removing cost-sharing (co-payment and deductible) for services covered by Medicare and recommended (rated "A" and "B") by the U.S. Preventive Services Task Force for any indication or population. **[Page 88]**	**[Page 595]**
	• Promoting Disease Prevention and Wellness, Medicare, Evidence-Based Coverage of Preventive Services: Encourages evidence-based coverage of preventive services by giving the Secretary the authority to use the same standards of evidence that apply to any new preventive services to existing preventive services. The Secretary could modify coverage of existing preventive services to the extent that the modification is consistent with U.S. Preventive Services Task Force recommendations. The Secretary would also be allowed, but not required, to withdraw Medicare coverage for services rated "D" or harmful by U.S. Preventive Services Task Force. Funding would also be provided for CMS to improve provider education and patient awareness of covered preventive services. Finally, a Government Accountability Office study is required to determine if any barriers exist that prevent the optimal utilization of covered primary, secondary and tertiary preventive services. **[Page 89]**	**[Page 600]**

	• Promoting Disease Prevention and Wellness, Medicare, Study on Beneficiary Access to Immunizations: Requires a Government Accountability Office study and report to Congress on the impact of the coverage of adult immunizations under Medicare Part D on access to those immunizations by Medicare beneficiaries. **[Page 90]**	**[Page 606]**
	• Promoting Disease Prevention and Wellness, Medicare, Incentives for Healthy Lifestyles: Authorizes and appropriates $100 million over five years for the Secretary to establish an initiative to provide incentives to Medicare beneficiaries who successfully participate in certain healthy lifestyle programs. **[Page 90]**	**[Page 607]**
	• Encouraging Development of the New Patient Care Models, Reducing Avoidable Hospital Readmissions: Starting in 2013, hospitals with readmission rates above a certain threshold would have payments for the original hospitalization reduced by 20 percent if a patient with a selected condition is re-hospitalized with a preventable readmission within seven days and by ten percent if a patient with a selected condition is re-hospitalized with a preventable readmission within 15 days. **[Page 111]**	**[Page 798]**
	• Strengthening Primary Care and Other Workforce Improvements, Redistribution of GME slots to Increase Access to Primary Care and General Physicians: Establishes a policy to redistribute currently unused residency training slots as a way to encourage increased training, particularly in the areas of primary care and general surgery, similar to the proposal set forth in MMA. The Secretary would distribute the increase in otherwise applicable resident limit based on the following factors: 1) to hospitals in states with resident to population ratios in the lowest quartile; and 2) to hospitals located in a state that is among the top ten states in terms of the ratio of the total population living in a health professional shortage area determined by HHS as of the date of enactment compared to total population of the state based on the most recent state population projections of the U.S. Census Bureau. **[Page 126]**	**[Page 819]**
	• Federally Qualified Health Centers: Directs the Secretary to establish a prospective payment system for Medicare-covered services furnished by federally qualified health centers. The prospective payment system payment rate would be extended to health plans and health insurers participating in the state exchanges. Insurers participating in the state exchanges would be required to provide payment for services furnished to enrollees by federally qualified health care centers must pay these providers at the prospective payment system rate. **[Page 144]**	**[Page 812]**
	• Access to Critical Lab Tests: Provides that, for a two-year period, in cases when a laboratory test is ordered less than 14 days after a beneficiary leaves a hospital, the laboratory furnishing the test could bill for tests that meet certain criteria. **[Page 145]**	**[Page 898]**
	• Public Meeting and Report to Congress on Payment for New Clinical Lab Tests: Directs the Secretary to convene a public meeting on payment systems for new clinical laboratory diagnostic tests and to submit a report to Congress summarizing the meeting and providing recommendations for legislative and administrative actions to reform the reimbursement mechanisms for new clinical laboratory diagnostics. **[Page 145]**	**[Page 952]**
	• Medicare Payment for Biosimilar 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 average sales price of the biosimilar plus six percent of the average sales price of the reference product. **[Page 145]**	**[Page 950]**
	• Nurse Midwifery Access and Reimbursement Equity: Increases the Medicare payment rate for nurse-midwives for covered services from 65 percent to 100 percent of the physician fee schedule rate. **[Page 186]**	**[Page 901]**
	• Improving Medicare for Patients and Providers, Ensuring Beneficiary Access to Physician Care and Other Services, Sustainable Growth Rate: The annual update to the conversion factor used in the determination of the Medicare fee schedule would be a 0.5 percent increase in 2010. The conversion factor for 2011 and subsequent years would be computed as if the increase in 2010 had never applied. **[Page 136]**	**[Page 878]**

	• Improving Medicare for Patients and Providers, Ensuring Beneficiary Access to Physician Care and Other Services, Extension of Floor on Medicare Work Geographic Adjustment: Extends the 1.00 floor for the geographic index for physician work for an additional two years through December, 2012. Also directs the Secretary to adjust the practice expense geographic practice cost increases for 2010 to reflect three-quarters of the difference between the relative costs of employee wages and rents in each of the different fee schedule areas and the national averages (i.e. a blend of three-quarters local and one-quarter national) instead of the full difference under current law. For 2011, the adjustment would reflect one-half of the difference between the relative costs of employee wages and rents in each of the different fee schedule areas and the national averages (i.e. a blend of one-half local and one-half national). Relief would apply only to areas with a practice expense geographic practice cost increases less than 1.0. Introduces a clause to hold-harmless any areas negatively impacted by the adjustment. Directs the Secretary to analyze current methods of establishing practice expense geographic practice cost increases under the physician fee schedule and evaluate data that fairly and reliably establishes distinctions in the costs of operating a medical practice in the different Medicare payment localities. Based on the analysis and evaluation, the Secretary shall, no later than January 1, 2012, make appropriate adjustments to the practice expense geographic practice cost increases to ensure accurate geographic adjustments across payment areas. **[Page 137]**	**[Page 879]**
	• Improving Medicare for Patients and Providers, Ensuring Beneficiary Access to Physician Care and Other Services, Misvalued Relative Value Units (RVUs): The Secretary must periodically identify physician services as being potentially misvalued, and make appropriate adjustments to the relative values of such services under the Medicare physician fee schedule. For purposes of identifying potentially misvalued services, the Secretary shall examine: 1) codes for which there has been the fastest growth; 2) codes that have experienced substantial changes in practice expenses; 3) codes for new technologies or services after the relative values are initially established for such codes; 4) multiple codes that are frequently billed in conjunction with furnishing a single service; 5) codes with low relative values, particularly those that are often billed multiple times for a single treatment; 6) codes which have not been subject to review since the implementation of the Resource-Based relative value scale; and 7) such other codes determined to be appropriate by the Secretary. Adjustments to misvalued procedures would be subject to budget neutrality requirements. **[Page 138]**	**[Page 936]**
	• Improving Medicare for Patients and Providers, Ensuring Beneficiary Access to Physician Care and Other Services, Therapy Caps: Extends the exceptions process for therapy caps for two years, through December 31, 2011. **[Page 139]**	**[Page 883]**
	• Improving Medicare for Patients and Providers, Ensuring Beneficiary Access to Physician Care and Other Services, Extension of Treatment of Certain Physician Pathology Services under Medicare: Extends the provision of MMA that permits independent laboratories to receive direct payments for the technical component of certain pathology services until January 1, 2012. **[Page 139]**	**[Page 883]**
	• Improving Medicare for Patients and Providers, Ensuring Beneficiary Access to Physician Care and Other Services, Extension of Increased Payments for Ambulance Services Under Medicare: Extends, until January 1, 2012, the provision of MIPPA that provided that the Medicare rate for ground ambulance services otherwise established for the year would be increased an additional three percent for rural ambulance services and two percent for other areas and areas designated as rural on December 31, 2006, are treated as rural for purposes of payments for air ambulance services during this period. **[Page 139]**	**[Page 884]**
	• Improving Medicare for Patients and Providers, Ensuring Beneficiary Access to Physician Care and Other Services, Extension of Long Term Care Hospital Provisions: Extends the Medicare, Medicaid and Children's Health Insurance Program Extension Act of 2007 (MMSEA), Section 114(c) and (d) (regarding the moratorium the establishment of new Long Term Care Hospitals) by two years. **[Page 140]**	**[Page 885]**
	• Improving Medicare for Patients and Providers, Ensuring Beneficiary Access to Physician Care and Other Services, Extension of Payment Adjustment for Medicare Mental Health Services: Extends the provision of MIPPA that increased payments for certain Medicare mental health services by five percent until January 1, 2012. **[Page 141]**	**[Page 885]**

	• Improving Medicare for Patients and Providers, Ensuring Beneficiary Access to Physician Care and Other Services, Permitting Physician Assistants to Order Post-Hospital Extended Care Services: Allows a physician assistant who does not have a direct or indirect employment relationship with a skilled nursing facility, but who is working in collaboration with a physician, to certify the need for post-hospital extended care services for Medicare payment purposes. Applies to items and services furnished on or after January 1, 2010. **[Page 141]**	**[Page 886]**
	• Improving Medicare for Patients and Providers, Ensuring Beneficiary Access to Physician Care and Other Services, Recognizing Attending Physician Assistants as Attending Physicians to Serve Hospice Patients: For purposes of a hospice written plan of care, a physician assistant is included in the definition of an attending physician. But physician assistants continue to be excluded from the authority to certify an individual as terminally ill. This applies to items and services furnished on or after January 1, 2010. **[Page 142]**	**[Page 886]**
	• Improving Medicare for Patients and Providers, Ensuring Beneficiary Access to Physician Care and Other Services, Medicare Diabetes Self-Management Training: Provides for the recognition of state-licensed or registered health care professionals who are certified diabetes educators as Medicare providers of diabetes outpatient self-management training services. Certified diabetes educators would still provide diabetes self-management treatment services according to physician referral, but they would be able to provide such services in appropriate, non-hospital locations to meet current needs. **[Page 142]**	**[Page 887]**
	• MedPAC Study on Adequacy of Medicare Payments for Health Care Providers Serving Rural Areas: Requires the Medicare Payment Advisory Committee (MedPAC) to review payment adequacy for rural health care providers serving the Medicare program and provide a report to Congress by January 1, 2011. In this report, MedPAC shall provide an analysis of the rural payment adjustments outlined in this section and an analysis of beneficiaries' access to care in rural communities, adequacy of Medicare payments to rural providers and quality of care. Based on this analysis, MedPAC shall provide recommendations on appropriate modifications to the rural payment adjustments outlined in this section. **[Page 150]**	**[Page 912]**
	• Reimbursement for DXA Services: Reinstates reimbursement for dual energy x-ray absorptiometry services to 70 percent of the 2006 payment rates for 2010 and 2011. Also authorizes the Institute of Medicine to study the effect of Medicare reimbursement reductions for dual energy x-ray absorptiometry on beneficiary access to bone density tests. **[Page 150]**	**[Page 896]**
	• Super Rural Ambulance Payments: The provision extends until January 1, 2012 the bonus payments under Medicare to ambulance service providers which serve the most rural quartile of counties ("super rural" areas as originally defined in Section 414(c) of MMA). **[Page 150]**	**[Page 884]**
	• Improving Payment Accuracy, Home Health Payment Changes, Updating Home Health Payments Through Rebasing: Starting in CY2013, the Secretary must rebase payments to reflect the number and mix of Home Health services, level of intensity of services, and the average cost of providing care. As part of the rebasing proposal, the Secretary must ensure adjustments in home health spending as a result of this policy will be no greater than 3.5 percent per year during the four year transition relative to home health payment levels at the date of enactment of this legislation. **[Page 176]**	**[Page 915]**
	• Improving Payment Accuracy, Home Health Payment Changes, Provider-Specific Cap on Home Health Outlier Payments: Starting in CY2011, the Secretary would be directed to establish a provider-specific annual cap of ten percent of revenues that a home health agency may be reimbursed in a given year from outlier payments. Provider-specific outlier payments would be calculated using provider cost reports. To ensure that providers would not be paid in excess of the ten percent cap, CMS would be directed to update its claims processing system to ensure the outlier cap is not exceeded. **[Pages 176-77]**	**[Page 918]**
	• Improving Payment Accuracy, Home Health Payment Changes, Reinstatement on Rural Home Health Payment Adjustment: Between CY2010 to CY2015, the Secretary would be directed to provide for a three percent add-on payment for home health providers serving rural areas. **[Page 177]**	**[Page 920]**

	• Improving Payment Accuracy, Home Health Payment Changes, Study Regarding the Development of Home Health Payment Reforms to Ensure Access to Care and Quality Services: The Secretary shall conduct a study to evaluate the costs and quality of care among efficient home health providers relative to their peers in providing ongoing access to care and in treating beneficiaries with varying severity levels of illness and develop recommendations on ways to reform home health payments and case mix adjustments based on this analysis. In conducting the study, the Secretary shall consider whether certain factors should be used to measure patient severity of illness and access to care. The study may include a number of recommendations and in conducting the study, the Secretary shall seek input from stakeholders representing home health providers and beneficiaries. The Secretary shall issue a report on its findings and recommendations to the Congress by no later than March 1, 2011. Based on the findings of this report, the Secretary shall establish a temporary Medicare payment adjustment targeted towards ensuring access to care for beneficiaries with a high severity of illness or to improve access to care for low-income or underserved beneficiaries. **[Page 177-78]**	**[Page 920]**
	• Improving Payment Accuracy, Study Regarding the Development of Home Health Payment Reforms to Ensure Access to Care and Quality Services: The Secretary shall conduct a study to evaluate the costs and quality of care among efficient home health providers relative to their peers in providing ongoing access to care and in treating beneficiaries with varying severity levels of illness and develop recommendations on ways to reform home health payments and case mix adjustments based on this analysis. In conducting the study, the Secretary shall consider whether certain factors should be used to measure patient severity of illness and access to care. The study may include recommendations on: 1) methods to revise home health payment system to more accurately account for the costs related to patient severity of illness or to improving beneficiary access to care; and 2) an assessment of the validity and reliability of responses on the OASIS instrument with particular emphasis on questions that relate to higher prospective payment system payment and higher outcome scores under "Home Care Compare;" 3) additional research or payment modifications that may be necessary to set home health rates based on costs of high-quality and efficient home health providers or improve beneficiary access to care; and 4) other areas deemed appropriate by the Secretary. **[Page 178]**	**[Page 920]**
	• Improving Payment Accuracy, Hospice Payment Reforms, Payment Reforms: The Secretary would be required to collect additional data and information in order to revise payments for hospice care after consulting with hospice providers and MedPAC. The Secretary would be required to implement changes to the payment methodology for hospice care as appropriate based on the additional data and information collected. These changes may include per diem payments to hospices that reflect changes in resource intensity in providing hospice services during the course of the entire episode or additional payments (end-of-episode payment) reflecting resource intensity of services provided at the end of episode if the patient is not transferred to another hospice or revokes election of the hospice benefit. **[Page 179-80]**	**[Page 926]**
	• Improving Payment Accuracy, Hospice Payment Reforms, Accountability: The Secretary would impose certain requirements on hospice providers as follows: 1) that a hospice physician or advanced practice nurse visit the patient to determine continued eligibility prior to the 180th day recertification and each subsequent recertification, and attest that such visits took place; and 2) that all stays in excess of 180 days be medically reviewed by CMS or its contractors for hospices for which stays exceeding 180 days make up a certain level of their total cases, as determined appropriate by the Secretary. **[Page 180]**	**[Page 930]**
	• Improving Payment Accuracy, Hospice Payment Reforms, Medicare Hospice Concurrent Care (HCC) Demonstration: Requires the Secretary to conduct a three-year demonstration program that would allow patients who are eligible for hospice care to also receive all other Medicare-covered services during the same period of time. The Secretary would establish 26 sites across the country in both urban and rural areas to examine improvement in patient care, quality of life, and cost-effectiveness that results from the demonstration project. An independent evaluation of this delivery model would be conducted with reports submitted to the Secretary and Congress. This demonstration would be required to be budget neutral. **[Page 180]**	**[Page 953]**

	• Improving Payment Accuracy, Medicare DSH Changes: Starting no later than 2015 and continuing on an annual basis, the Secretary would make disproportionate share payments equal to 25 percent of the disproportionate share payments that would otherwise be made, a payment that represents the empirically justified amount as determined by MedPAC in its March 2007 Report to Congress. In addition to this amount, an additional payment would be made to reflect hospitals' continued uncompensated care costs. Given a lag in accurate data to measure the change in the level of insurance in 2015, the Secretary will be directed to calculate insurance coverage levels relative to the projected impact of the coverage expansion in 2015, 2016, and 2017 compared to the last year before coverage expansion (2012). Starting in 2018, the Secretary will use the most recent Census Bureau data for purposes of the adjustment. **[Page 181]**	**[Page 931]**
	• Improving Payment Accuracy, Plan to Reform Medicare Hospital Wage Index: 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. The Secretary would also be required to restore the ratios used in determining geographic hospital wage index reclassification to pre-October 1, 2008 levels until the first fiscal year one year after the Secretary submits the Plan to Reform the Medicare Hospital Wage Index to Congress as required in the Mark. Any applications for reclassification for fiscal year 2011 and subsequent years denied on the basis of the changed ratios must be reconsidered using the pre-existing ratios, and approved, if the applicant meets the pre-existing ratios. **[Page 182]**	**[Page 946]**
	• Improving Payment Accuracy, Plan to Reform Medicare Hospital Wage Index: Budget neutrality must be applied on a national basis in the calculation of the Medicare hospital wage index floor for each all-urban and rural state. **[Page 182]**	**[Page 955]**
	• Improving Payment Accuracy, Extend Section 508 Reclassifications: Section 508 of the MMA provided $900 million for a one-time, three year geographic reclassification of certain hospital who were otherwise unable to qualify for administrative reclassification to areas with higher wage index values. The Section 508 reclassifications would be extended until September 30, 2011. **[Page 183]**	**[Page 946]**
	• Improving Payment Accuracy, Advanced Diagnostic Imaging Services: Increases the utilization rate assumption for calculating the payment for advanced imaging equipment from 50 percent to 65 percent for 2010 through 2013. The rate would be further increased to 75 percent beginning in 2014. The Secretary would be required to conduct a study by January 1, 2013 on the estimated impact of the utilization rate change on the following: 1) beneficiary access, including in rural areas; 2) utilization of advanced diagnostic imaging services; and 3) the estimated savings to the Medicare program over the period of 2010 through 2019. In addition, the technical component payment reduction for sequential imaging services on contiguous body parts during the same visit would be increased from 25 percent to 50 percent. **[Page 184]**	**[Page 941]**
	• Improving Payment Accuracy, Durable Medical Equipment, Elimination of Additional Payment in 2014: Payments to durable medical equipment suppliers are based on fee schedules. The fee schedules are generally updated yearly to reflect a measure of health care inflation. MIPPA required the 2014 update to durable medical equipment suppliers to be two percentage points above the otherwise scheduled amount. This 2014 add-on payment is eliminated. **[Page 185]**	**[Page 945]**
	• Improving Payment Accuracy, Durable Medical Equipment, Power Wheelchairs: Starting in 2011, the option to purchase a power-driven wheelchair with a lump-sum payment is limited to complex, rehabilitative power wheelchairs. The lump-sum payment option would be eliminated for all other wheelchairs as would the lump-sum purchase option for replacing a wheelchair for all chairs except complex, rehabilitative power wheelchairs. **[Page 185]**	**[Page 945]**
	• Improving Payment Accuracy, Durable Medical Equipment, Accreditation Exemption For Certain Pharmacies: Makes pharmacies eligible for an exemption from the accreditation requirements under the following circumstances: 1) the pharmacy has had no adverse determination against it for the last five years due to fraud; 2) the pharmacy submits an attestation that its total Medicare durable medical equipment, prosthetics and supplies billings are and continue to be less than a rolling three year average of five percent of total pharmacy sales; and 3) the pharmacy is willing to submit documentation to the Secretary (based on a random sample of pharmacies) that would allow the Secretary to verify the information in (2). The documentation submitted for (3) could consist of an accountant certification or filing of tax returns by the pharmacy. **[Page 185]**	**[Page 890]**

	• Improving Payment Accuracy, Treatment of Certain Cancer Hospitals: The Secretary would be required to conduct a study determine if the outpatient costs incurred by prospective payment system exempt cancer hospitals with respect to Medicare's Ambulatory Payment Classifications exceed those costs incurred by other hospitals reimbursed under outpatient prospective payment system. If the costs in the prospective payment system-exempt cancer hospitals are excessive, the Secretary would be required to provide for an appropriate adjustment for services furnished starting January 1, 2011 under Section 1833(t) of the Social Security Act (regarding the prospective payment system for hospital outpatient department services). In making this adjustment, the Secretary would be directed to ensure no prospective payment system-exempt cancer hospital receives outpatient prospective payment system payments that are lesser than their payment level as a result of this provision. **[Pages 185-86]**	**[Page 949]**
	• Ensuring Medicare Sustainability, Market Basket Cuts, Home Health Providers: Reduces market basket updates for home health providers by one percent in 2011 and 2012, and by 0.5 percent in 2013-2019 in addition to productivity adjustments referenced in the bill. In addition to the productivity adjustment, if in any year from 2014-2019, the previous year's total percentage of insured population (as reflected in the share of the total, non-elderly population) is more than five percentage points below projections at time of bill enactment, then the Secretary shall "give back" this payment reduction via an adjustment to the otherwise applicable market basket increase in the current year. **[Pages 186-87]**	**[Page 1073]**
	• Ensuring Medicare Sustainability, Market Basket Cuts, Inpatient and Outpatient Hospitals: For hospitals, the provision would require a market basket minus 0.25 percent reduction in 2010 and 2011 for inpatient and outpatient hospitals, inpatient psychiatric facilities, inpatient rehabilitation and long term care hospitals. The provision would also implement an additional 0.2 percent market basket reduction for inpatient and outpatient hospitals, inpatient psychiatric facilities, inpatient rehabilitation facilities and long term care hospitals from 2012-2019 in addition to the productivity adjustments described in the next section, and, with regards to the 0.2 percent reduction, if in any year from 2014-2019, the previous year's total percentage of insured population (as reflected in the share of the total, non-elderly population) is more than five percentage points below projections at time of bill enactment, then the Secretary shall "give back" this payment reduction via an adjustment to the otherwise applicable market basket increase in the current year. **[Pages 186-87]**	**[Page 1066]**
	• Ensuring Medicare Sustainability, Productivity: Provides for updates based on the market basket or consumer price index, minus full productivity estimates for all Parts A and B providers who are subject to a market basket or consumer price index update. **[Page 187]**	**[Page 1068]**
	• Ensuring Medicare Sustainability, Temporary Adjustment to the Income-Related Premium for Part B of Medicare: Medicare Part B finances coverage for physicians' and other outpatient services, in part through premiums paid by beneficiaries who enroll in the voluntary program. Under a provision of the MMA, approximately 1.7 million higher-income beneficiaries have faced progressively greater shares of those costs, depending on income. Freezes the current income thresholds for the period of 2011 through 2019. **[Page 188]**	**[Page 1086]**

	• Ensuring Medicare Sustainability, Medicare Commission: Establishes an independent Medicare Commission that would develop and submit proposals to Congress aimed at extending the solvency of Medicare, slowing Medicare cost-growth, and improving the quality of care delivered to Medicare beneficiaries. The Commission would be tasked with presenting proposals to Congress that would reduce Medicare spending by targeted amounts compared to the trajectory of Medicare spending under current law. The scope of proposals presented to Congress should: 1) to the extent feasible, target reductions to sources of excess cost growth; 2) to the extent feasible, improve the health care delivery system, including the promotion of integrated care, care coordination, prevention and wellness and quality improvement; 3) to the extent feasible, protect beneficiary access to care, including in rural and frontier areas; 4) to the extent feasible, consider the effects of provider payment changes on beneficiaries; 5) to the extent feasible, consider the effects of proposals on any provider who has, or is projected to have, negative profit margins or payment updates; 6) to the extent feasible, improve the quality of care delivered to Medicare beneficiaries; 7) to the extent feasible, consider the unique needs of individuals dually eligible for Medicare and Medicaid; and 8) prior to December 31, 2019 not impact providers scheduled to receive a reduction to their inflationary payment updates in excess of a reduction due to productivity in a year in which the Commission's proposals would take effect. The Commission would be prohibited from presenting proposals that would ration care, increase revenues, or otherwise change Medicare beneficiary cost-sharing (including premiums under Sections 1818, 1818A, and 1839 of the Social Security Act), benefits, or eligibility standards. **[Page 189]**	**[Page 1087]**
	• Ensuring Medicare Sustainability, MedPAC Review and Report on Medicaid and Commercial Payments to Congress: In 2012 and thereafter, to the extent feasible, MedPAC shall report aggregate Medicaid and commercial trends in spending, utilization and financial performance for providers where, on an aggregate national basis, a significant portion of revenue and/or services is associated with Medicaid. Where appropriate, this review shall be done in consultation with MACPAC. **[Page 192]**	**[Page 440]**
	• Medicare Advantage Payment, MA Benchmarks and Rebates: Bases the calculation of Medicare Advantage (MA) benchmarks on actual plan costs as reflected in plan bids rather than statutorily set rates. Using plan bids to set MA benchmarks would encourage plans to compete more directly on the basis of price and quality rather than on the level of extra benefits offered to enrollees. It also provides cost savings to Medicare because in nearly all areas of the country plan bids are lower than the current benchmark rates. Also, total payments to plans are risk-adjusted as under current law. **[Pages 164-65]**	**[Page 957]**
	• Medicare Advantage Payment, MA Benchmarks and Rebates: MA plans would be required to use 100 percent of any rebate amount to provide additional benefits to their enrollees. Plans would still be allowed to offer supplemental benefits for which they would charge beneficiaries an added premium, as under current law. **[Pages 164-65]**	**[Page 994]**
	• Medicare Advantage Payment, MA Benchmarks and Rebates: The Program of All-Inclusive Care for the Elderly plans would be exempt from changes to the MA benchmarks beginning with the transition to competitive bidding in 2012. **[Pages 164-65]**	**[Page 990]**
	• Medicare Advantage Payment, Bidding Rules: Requires bid information submitted by Medicare Advantage plans 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 with respect to the actuarial standards that bids must meet. Also requires the Secretary to deny bids that do not meet the actuarial standards and guidelines or abide by the rules established with respect to the competitive bid process. **[Page 165]**	**[Page 965]**

	• Medicare Advantage Payment, Payment Areas: Requires the Secretary to establish new MA payment areas for urban areas for plan years beginning in 2012. In urban areas, payment areas would be based on the definition of metropolitan statistical areas as determined by the Office of Management and Budget. The Secretary would be required to divide metropolitan statistical areas that cover more than one state, and would be allowed to adjust metropolitan statistical area-based payment areas to reflect patterns of actual health care use. The Secretary would be required to base the adjustments on recent analyses of the patterns of care. The Secretary would also be required to combine one or more rural counties in a state into a single service area beginning in 2015. In addition, these new payment areas must reflect recent research on actual patterns of care. The Secretary will also have 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 in their structural capacity to offer benefits throughout an entire payment area. **[Pages 165-66]**	**[Page 968]**
	• Medicare Advantage Payment, Grandfather Policy: 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 fee-for-service costs. **[Page 168]**	**[Page 983]**
	• Medicare Advantage Payment, Transitional Benefits: The Secretary would be required 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. The Secretary would 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; 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. **[Page 168]**	**[Page 987]**
	• Medicare Advantage Payment, CMS Actuary Certification: Strikes the (MA provisions of the Chairman's Mark related to competitive benchmarks and bonus payments if the Chief Actuary of CMS certifies that beneficiaries currently participating in MA would lose Medicare-covered benefits when such provisions are implemented. **[Page 168]**	**[Page 991]**
	• Medicare Advantage, Benefit Protection and Simplification: Includes several protections for beneficiary with respect to the cost sharing amounts charged by MA plans. Also makes additional benefits that are offered by MA plans and paid for by rebates and bonus payments more consistent across plans. **[Page 169]**	**[Page 992]**
	• Medicare Advantage, Benefit Protection and Simplification, Uniform Exceptions and Appeals: Requires sponsors of prescription drug plans and MA prescription drug plans to develop a uniform exceptions and appeals process by 2012. **[Page 170]**	**[Page 1057]**
	• Medicare Advantage, Benefit Protection and Simplification, Medicare Complaint System: Requires the Secretary to develop and maintain a complaint tracking system capable of: 1) tracking complaints made by a MA eligible individual or a Medicare Part D-eligible individual through resolution; and 2) producing reports. **[Page 170]**	**[Page 1055]**
	• Medicare Advantage, Simplification of Annual Beneficiary Election Periods: Shifts the annual enrollment period dates for MA and Medicare Part D from October 15 to December 7. The change would be effective beginning in 2011. Also eliminates the annual open enrollment period (January 1 through March 31) for MA plans. These changes are intended to simplify the time frames under which beneficiaries would need to make enrollment decisions. Also 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 could disenroll and return to traditional fee-for-service. **[Page 171]**	**[Page 1000]**
	• Medicare Advantage, Extension for Specialized MA Plans for Special Need Individuals: Extends Special Needs Plan (SNP) authority through December 31, 2013. In addition, by January 1, 2013, SNPs would need to have beneficiaries enrolled in their plans that meet the definitions for each type of SNP. Also requires the Secretary to transition beneficiaries enrolled in SNPs to other Medicare Advantage plans or original Medicare if they do not meet the definitions established for such plans by 2013. The Secretary would be allowed to make exceptions to the transition requirements for dual-eligible beneficiaries who lost their Medicaid status in order to give them time to reapply for Medicaid benefits. **[Page 172]**	**[Page 1001]**

	• Medicare Advantage, Extension for Specialized MA Plans for Special Need Individuals, Payment: Makes all changes related to payment, rebates and bonuses, as well as payment and service areas apply to Special Needs Plans (SNPs) in the same manner as they apply to MA plans through 2013. Creates a new payment adjustment for fully-integrated dual-eligible SNPs. **[Page 172]**	**[Page 1002]**
	• Medicare Advantage, Extension for Specialized MA Plans for Special Need Individuals, Certification of SNPs: Gives the Secretary discretion to require SNPs to be certified or otherwise approved by National Committee for Quality Assurance in order to participate in the MA program. **[Page 172]**	**[Page 1005]**
	• Medicare Advantage, Extension for Specialized MA Plans for Special Need Individuals, Risk Score for SNP Enrollees: Beginning in 2011, the Secretary would use a risk score for new enrollees in SNPs that reflects the known underlying risk profile and chronic health status of each enrollee. The new risk score would be budget-neutral and applied in lieu of the default risk score for new enrollees of non-SNP MA plans. **[Page 173]**	**[Page 1006]**
	• Medicare Advantage, Extension of Reasonable Cost MA plans serving the area. **[Page 174]**	**[Page 1008]**
	• Medicare Advantage, MA Private Fee-for-Service Plans: Clarifies that in defining areas in which private fee-for-service plans (not sponsored by employers) must establish contracted networks of providers, a network area would be defined as an area served by two or more MA organizations. Also allows the Secretary to grant employer-based private fee-for-service plans a waiver from the network requirements in a manner similar to the Secretary's authority to waive or modify other MA requirements for employer-based coordinated care plans. **[Page 174]**	**[Page 1008]**
	• Medicare Advantage, Erickson Demonstrations: Allows Erickson demonstrations to be a type of MA SNP, beginning in 2011, if they serve beneficiaries who reside in continuous care environments, have sufficient number of on-site primary care providers as determined by the Secretary, supply transportation benefits to other providers, and were in existence under a demonstration for at least one year. **[Page 175]**	**[Page 1010]**
	• Medicare Part D Improvements, Improving Coverage in the Part D Coverage Gap, Discount Program: Establishes a discount program for beneficiaries who enroll in Medicare Part D and have drug spending that falls into the coverage gap. Provides for manufacturer discounts on brand-name drugs that are covered under Part D and are on plan formularies or treated as being on plan formularies through exceptions and appeals processes. The discount would be available during the entire coverage gap—that is, at the point when total prescription costs of a beneficiary exceeds the initial coverage limit ($2,700 in 2009) and reaches the catastrophic coverage limit ($6,153 in 2009) each year. Once the prescription costs of a beneficiary exceed the catastrophic limit, the discount would end and the catastrophic portion of the drug benefit would apply as under current law. **[Page 151]**	**[Page 1013]**
	• Medicare Part D Improvements, Improving Coverage in the Part D Coverage Gap, Agreement with Manufacturers: Stipulates that drugs sold and marketed in the United States by a manufacturer would not be covered under Medicare Part D unless the manufacturer agrees to participate in the discount program. The agreement would require manufacturers to discount drug prices at the pharmacy or through a mail order service. Also requires manufacturers who participate in the Part D drug discount program to be audited for compliance with the discount program by the third-party administrator. Manufacturers that do not comply with the discount would be subject to fines assessed by the Secretary. **[Page 152]**	**[Page 1013]**
	• Medicare Part D Improvements, Improving the Determination of Part D Low-Income Benchmarks: Requires the Secretary to exclude MA rebates and bonus payments from the MA Prescription Drug Plan premium amount when calculating the regional low-income subsidy (LIS) benchmark amounts. This provision would take effect in 2011. It would have the effect of increasing the number of plans that can serve LIS beneficiaries at fully subsidized or $0 premiums. **[Page 153]**	**[Page 1030]**

	• Medicare Part D Improvements, Voluntary *De Minimus* Policy for Low-Income Subsidy Plans: Authorizes a policy, beginning in 2011, through which plans that bid a nominal amount above the regional 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. The Secretary would be given discretion to auto-enroll LIS beneficiaries into these plans in order to maintain an adequate LIS plan choices. The *de minimus* threshold amount would be established by the Secretary. This provision would help maintain plans that wish to serve LIS beneficiaries at fully subsidized or $0 premiums. **[Page 154]**	**[Page 1030]**
	• Medicare Part D Improvements, Special Rule for Widows and Widowers Regarding Eligibility for Low-Income Assistance: Requires that, beginning in 2011, the surviving spouse of an LIS-eligible couple 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. Subsequently, the LIS widow/widower would be determined or re-determined, as appropriate, for LIS on the same basis as other LIS-eligible beneficiaries. **[Page 155]**	**[Page 1032]**
	• Medicare Part D Improvements, Facilitation of Reassignments of Beneficiaries in Low-Income Subsidy Plans: 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 30 days of notification of the reassignment. Within 30 days of receiving the drug utilization information, plans that are reassigned LIS beneficiaries would be required to provide these beneficiaries with information about formulary differences between the old and new plan 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. The Secretary would be required to develop a standard format for plans to provide this information to beneficiaries. **[Page 156]**	**[Page 1033]**
	• Medicare Part D Improvements, Funding Outreach and Education of Low-Income Programs: Extends MIPPA Section 119 (regarding beneficiary outreach and education) and provides $45 million for outreach and education activities related to Medicare low-income assistance programs, including the Part D low-income subsidy program and the Medicare Savings Program. Funds would be allocated to State Health Insurance Programs, the Administration on Aging for Area Agencies on Aging, Aging Disability Resource Centers and for the contract for the National Center for Benefits Outreach and Enrollment in the same proportion as required by MIPPA. Funds would be available for obligation through 2012. The Secretary would have authority to enlist the support of these entities to conduct outreach activities aimed at preventing disease and promoting wellness as an additional use of these funds. **[Page 156-57]**	**[Page 1034]**
	• Medicare Part D Improvements, Strengthening Formularies with Respect to Certain Categories or Classes of Drugs: Removes the criteria, specified in Section 176 of MIPPA, that would have been used by the Secretary to identify protected classes of drugs. Gives the Secretary authority to identify classes of clinical concern, as defined by the Secretary. Codifies the current 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. **[Page 157]**	**[Page 1037]**
	• Medicare Part D Improvements, Reducing the Part B Premium Subsidy for High-Income Beneficiaries: Reduces, beginning in 2011, the Medicare premium subsidy amount for beneficiaries whose modified adjusted gross income exceeded the thresholds used under Part B. Also inflates the income thresholds by the consumer price index, except for the period between 2010 and 2019 when the income thresholds would not be updated. Also, expands the current authority for Internal Revenue Service to disclose income information to Social Security Administration for purposes of adjusting the Part B subsidy to include the Part D subsidy adjustments and related appeals. **[Page 158]**	**[Page 1039]**

	• Medicare Part D Improvements, Simplifying Plan D Information: Requires the Secretary to establish, beginning in 2011, two or more categories of prescription drug plans offered by Medicare Part D sponsors based on ranges of the actuarial values of the prescription drug benefits provided under the plans. The Secretary would also be required to develop standardized nomenclature, definitions, and language to describe and present the benefit categories on the Part D plan finder and in other relevant beneficiary communications. For example, the Secretary could establish three categories of benefit levels—Bronze, Silver, and Gold. Plans would be required to indicate the benefit category of each plan in the name of the product. The Secretary would also be required to ensure that there are meaningful differences between the benefit categories. **[Page 159]**	**[Page 1048]**
	• Medicare Part D Improvements, Limitation on Removal or Change of Coverage of Covered Part D Drugs Under a Formulary Under a Prescription Drug Plan or a MA-PD: Prohibits Medicare Part D sponsors, beginning in 2011, from removing a covered drug from a plan formulary, applying a cost or utilization management tool that imposes a restriction or limitation on the coverage of such a drug (such as through the application of a preferred status, usage restriction, step therapy, prior authorization, or quantity limitation), or increasing the cost sharing of such a drug (such as through the placement of a drug on a tier that would result in higher cost sharing for a beneficiary), other than the date on which Part D sponsors may begin marketing their plans with respect to the immediately succeeding plan year. Allows for exceptions if the change is in regard to a brand name drug for which a generic drug was approved during the plan year, or if the change is in regard to a safety issue determined by the plan's Pharmacy and Therapeutic Committee or by the Food and Drug Administration. **[Page 160]**	**[Page 1050]**
	• Medicare Part D Improvements, Medicare Part D Copayment Equity: Cost sharing under Part D for full-benefit, dual eligible beneficiaries receiving care under a home and community based services under Sections 1915, 1932 or 1115 waivers would be equal to the cost sharing for those who otherwise receive institutional care. This provision would be effective January 1, 2011. **[Page 161]**	**[Page 1054]**
	• Medicare Part D Improvements, Generic First Fill: Sponsors of prescription drug plans and MA prescription drug plans under Medicare Part D would be allowed to waive copayments for first fills of generic drugs as an incentive for beneficiaries to try a generic formulation of a drug. This provision would be effective January 1, 2011. **[Page 161]**	**[Page 1366]**
	• Medicare Part D Improvements, Long-Term Care Pharmacy: Requires Medicare Part D prescription drug and MA prescription drug plans to employ utilization management techniques, such as weekly, daily or automated dose dispensing to reduce the quantity dispensed per fill when dispensing medications to beneficiaries who reside in long-term care facilities in order to reduce waste associated with 30-day fills. **[Page 161]**	**[Page 3312]**
	• Medicare Part D Improvements, Pharmacy Benefit Manager Transparency: Requires pharmaceutical benefit managers (PBMs) to share information with the Secretary of HHS and with plans the PBMs contract with through Medicare Part D or the exchanges. Plans will only be given access to information on their own PBM's contracts. This information will be considered confidential and must be protected by the Secretary and the plans. The PBMs will be required to confidentially disclose information on: 1) the percent of all prescriptions that are provided through retail pharmacies compared to mail order pharmacies, and the generic dispensing and substitution rates in each location; 2) the aggregate amount and types of rebates, discounts and price concessions that the PBM negotiates on behalf of the plan and the aggregate amount of these that are passed through to the plan sponsor; and 3) the average aggregate difference between the amount the plan pays the pharmaceutical benefit managers and the amount that the pharmaceutical benefit managers pays the retail and mail order pharmacy. There are not mandates that these rebates are passed through, only that they be reported to plans. The same penalties that currently apply to the Secretary for disclosure of information will be applied under the Medicaid rebate statute. **[Page 161]**	**[Page 1329]**

	• Improved Medicare Prescription Drug Plan and MA-PD Plan Complaint System: Requires the Secretary to develop and maintain a complaint tracking system capable of: 1) tracking complaints made by a MA-eligible individual or a Part D-eligible individual through resolution; and 2) producing reports. **[Page 173]**	**[Page 1055]**
	• Medicare Part D Improvements, Office of the Inspector General: Requires the Office of the Inspector General to report annually on the inclusion of drugs commonly used by dual eligibles on Medicare Part D plan formularies. The Inspector General would also be required 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. **[Pages 161-62]**	**[Page 1058]**
	• Medicare Part D Improvements, Health and Human Services Ongoing Study on Coverage for Dual Eligibles: Requires the Secretary to monitor and track: 1) how many full benefit dual eligibles enroll in a plan under Medicare Part D and receive retroactive drug coverage; 2) the number of months of retroactive coverage provided; and 3) the amount of reimbursements paid to individuals during the retroactive period. The Secretary would also report annually on total annual expenditures for dual eligibles made under Titles XVIII (Medicare) and XIX (Medicaid) as well as an analysis of health outcomes and the extent to which these beneficiaries are able to access their benefits under both titles. **[Page 162]**	**[Page 1063]**
C. Employee Health Benefits	• Establishment of Simple Cafeteria Plans for Small Businesses: The eligibility requirement for a cafeteria plan is met only if all employees (other than excludible employees) are eligible to participate, and each employee eligible to participate is able to elect any benefit available under the plan (subject to the terms and conditions applicable to all participants). A cafeteria plan will not fail to satisfy this eligibility requirement merely because the plan excludes employees who: 1) have not attained the age of 21 (or a younger age provided in the plan) before the close of a plan year; 2) had fewer than 1,000 hours of service for the preceding plan year; 3) have less than one year of service with the employer as of any day during the plan year; 4) are covered under an agreement which the Secretary of Labor finds to be a collective bargaining agreement if there is evidence that the benefits covered under the cafeteria plan were the subject of good faith bargaining between employee representatives and the employer; or 5) are described in Section 410(b)(3)(C) of the Internal Revenue Code (relating to nonresident aliens working outside the United States). **[Page 8]**	**[Page 1481]**
	• Establishment of Simple Cafeteria Plans for Small Businesses: The minimum contribution requirement for a cafeteria plan is met if: 1) the employer provides flex-credits available for use during the plan year equal to at least two percent of each eligible employee's compensation for the plan year; or 2) the value of employer-paid benefits is at least six percent of each eligible employee's compensation for the plan year or, if less, twice the amount of the salary reduction amount for the year of each eligible employee who is not a highly compensated (within the meaning of Section 414(q) of the Internal Revenue Code) or a key employee (within the meaning of Section 416(i) of the Code) and who participates in the plan. An employer is permitted to provide flex credits under the cafeteria plan in addition to the minimum required matching or non-elective contributions. However, the contribution requirement is not satisfied if the matching contributions for any highly compensated or key employee are at a greater rate than matching contributions for any employee who is not a highly compensated or key employee, with respect to salary reduction contributions. **[Page 9]**	**[Page 1479]**
	• Establishment of Simple Cafeteria Plans for Small Businesses: An eligible small employer, with respect to any year, is an employer who employed an average of 100 or fewer employees on business days during either of the two preceding years. A year may only be taken into account if the employer was in existence throughout the year. If an employer was not in existence throughout the preceding year, the determination is based on the average number of employees that it is reasonably expected such employer will employ on business days in the current year. If an employer was an eligible employer for any year and maintained a simple cafeteria plan for its employees for such year, then, for each subsequent year during which the employer continues, without interruption, to maintain the cafeteria plan, the employer is deemed to be an eligible small employer until the employer employs an average of 200 or more employees on business days during any year preceding any such subsequent year. **[Page 9]**	**[Page 1482]**

	• Employer-Provided Health Insurance Coverage: As under current law, an employer would not be required to offer health insurance coverage. **[Page 37]**	**[Page 38]**
	• State Exchanges and Marketing Requirements, SHOP Exchange: States would assist small employers that opt to use the Small Business Health Options Program exchange as the enrollment option for their employees. **[Page 20]**	**[Page 86]**
	• State Exchanges and Marketing Requirements, SHOP Exchange: Small firms offering through the exchange could not self-insure. **[Page 20]**	**[Page 79]**
	• State Exchanges and Marketing Requirements, SHOP Exchange: Small employers that made age-adjusted contributions on behalf of their employees would be granted a safe harbor from non-discrimination rules. **[Page 20]**	
	• Making Coverage Affordable, Benefit Options, Definition of Levels: Small employers purchasing coverage through the exchange would be required to offer a plan with a deductible that does not exceed $2,000 for individuals and $4,000 for families, unless offering contributions through a health reimbursement account or some other mechanism that would offset a deductible above these limits. This deductible limit would not affect the actuarial value of the plan, including Bronze plans and does not apply to "young invincible" plans. **[Page 23]**	**[Page 128]**
	• State Exchanges and Marketing Requirements, Large Employers: Beginning in 2015, states must allow small businesses up to 100 employees purchase coverage through the Small Business Health Options Program health insurance exchange and states may allow employers with more than 100 employees into the state exchange beginning in 2017. Businesses that grow beyond the upper employee limit in the Small Business Health Options Program exchange may continue to purchase health insurance through the SHOP exchange. **[Page 20]**	**[Page 89]**
	• State Exchanges and Marketing Requirements, Enrollment by Members of Congress and Congressional Employees: Notwithstanding any other provision of law, beginning July 1, 2013, members of Congress and congressional employees would be required to use their employer contribution (adjusted for age rating) to purchase coverage through a state-based exchange, rather than using the traditional Federal Employees Health Benefits plan. **[Page 20]**	**[Page 79]**
	• Insurance Market Reforms, Cafeteria Plans for Small Employers, Non-Discrimination Requirements: Cafeteria plans and certain qualified benefits (including group term life insurance, self insured medical reimbursement plans, and dependent care assistance programs) are subject to non-discrimination requirements to prevent discrimination in favor of highly compensated individuals generally as to eligibility for benefits and as to actual contributions and benefits provided. There is a safe harbor from the non-discrimination requirements for cafeteria plans provided by eligible small employers. The safe harbor requires that the cafeteria plan satisfy minimum eligibility and participation requirements and minimum flex-credit contribution requirements. The eligibility requirement is met only if all employees (other than excludable employees) are eligible to participate, and each employee eligible to participate is able to elect any benefit available under the plan. **[Page 4]**	**[Page 1484]**
	• Workplace Wellness, Incentives for Participation in Voluntary Wellness Programs: Codifies and enhances provisions of the Health Insurance Portability and Accountability (HIPAA) non-discrimination regulations, which allow rewards to be provided to employees for participation in or for meeting certain health standards related to a wellness program. Indicates that, consistent with these requirements, wellness programs that do not require an individual to satisfy a standard related to health factor are not in violation of the HIPAA non-discrimination regulations. **[Page 93]**	**[Page 508]**
	• Workplace Wellness, Incentives for Participation in Voluntary Wellness Programs: Allows group health plans and health insurance issuers offering coverage in group markets to provide rewards, including insurance premium discounts or rebates, based on an individual or an employee's participation in wellness programs. **[Page 94-95]**	**[Page 510]**

	• Workplace Wellness, Incentives for Participation in Voluntary Wellness Programs: Programs that reward based on the attainment of certain health standards would need to meet the following criteria: 1) the reward is capped at 30 percent of the employee-only coverage under the plan, with protections for plan participants that cannot meet the applicable standard due to a medical condition or because it is medically inadvisable to do so; 3) be reasonably designed to promote health or prevent disease; 4) provide individuals eligible for the program the opportunity to qualify for the reward under the program at least once a year; 5) ensure that the reward must be available to all "similarly situated" individuals; and 6) plan materials describing the terms of the wellness program must disclose the availability of the reasonable alternative standard for similarly situated individuals, or the possibility that the standard will be waived. **[Page 95]**	**[Page 511]**
	• Workplace Wellness, Incentives for Participation in Voluntary Wellness Programs: The provisions regarding workplace wellness programs also apply to carriers providing Federal Employee Health Benefits plans. **[Page 95]**	**[Page 517]**
	• Workplace Wellness, Incentives for Participation in Voluntary Wellness Programs: Requires the Secretaries of HHS and the Department of Treasury to establish a ten-state pilot program in 2014, one year after the new insurance rating rules for the individual market take effect. States that choose to participate in the pilot program would be allowed to apply the above-described provisions to programs of health promotion and disease prevention offered in the individual market in a manner similar to the manner in which such provisions apply to group health plans and health insurance issuers offering coverage in group markets. States participating in the pilot program would be required to ensure that consumer protections are met in programs of health promotion and disease prevention in the individual market, including verification that premium discounts do not create undue burdens or lead to cost shifting and that consumer data is protected under the existing HIPAA privacy laws. **[Page 96]**	**[Page 518]**
	• Workplace Wellness, Incentives for Participation in Voluntary Wellness Programs: The Secretary of HHS, the Secretary of Treasury, and the Secretary of Labor are also required to evaluate and submit to the appropriate Committees of Congress a report examining the following issues: 1) the effectiveness of wellness and disease prevention programs in promoting health and preventing disease; 2) the impact of a wellness program on a participant's access to care and the affordability of coverage; and 3) the impact of premium-based and cost-sharing incentives on employee behavior and their role in behavior change. **[Page 96]**	**[Page 520]**
D. Indian Health Service	• American Indians and Alaska Natives, Indian Tribe Health Benefits: Provides an exclusion from gross income for the value of specified Indian tribe health benefits for purposes of determining eligibility for Medicaid. **[Page 79]**	**[Page 1477]**
	• American Indians and Alaska Natives, Payer of Last Resort: Ensures that Indian tribes, tribal organizations, and urban Indian organizations are the payers of last resort. **[Page78]**	**[Page 441]**
	• AIDS Drug Assistance Programs and Indian Health Service: Allows drugs provided to patients by AIDS Drug Assistance Programs or the Indian Health Service (HIS) to count toward the annual out of pocket threshold for Part D under Medicare. The provision would be effective on January 1, 2011. **[Page 161]**	**[Page 1065]**
E. Veterans and Military Health Care	• VA and TRICARE: Nothing in this legislation shall prohibit or penalize veterans or their eligible family members from receiving timely access to quality health care from a Veterans Affairs healthcare provider or in a Department of Veterans Affairs health care delivery facility. Further, nothing in this Act shall prohibit or penalize eligible military health care beneficiaries from receiving timely access to quality health care in a Department of Defense medical treatment facility or a contracted health care provider (TRICARE or TRICARE for Life). **[Page 86]**	**[Page 583]**
	• Study and Report of Effect on Veterans Care: The Secretary of the U.S. Department of Veterans Affairs shall review and report to Congress on the effect that the fees on branded drugs and medical devices have on: 1) the cost of medical care provided to veterans; and 2) veterans' access to medical devices and branded drugs. **[Page 255]**	**[Page 1468]**

F. Other Non-Group Arrangements (i.e. Individual Arrangements)	• Pooling Requirements for Individual and Small Group Markets: States would be required to apply the new federal rating rules to two distinct markets: 1) the individual market; and 2) the small group market, defined as groups of 1-50 or up to 100 at state option. States would have the option to merge the pooling and rating requirements for the individual and small group markets. **[Page 8]**	**[Page 25]**
	• Insurance Market Reforms, Rating Rules in the Individual Market: Premiums could also vary among, but not within, rating areas to reflect geographic differences. **[Page 2]**	**[Page 24]**
	• Insurance Market Reforms, Rating Rules in the Individual Market: Issuers would be required to offer coverage on a guaranteed issue basis. **[Page 2]**	**[Page 19]**
	• Insurance Market Reforms, Rating Rules for Small Group Market: The rules for the small group market would be the same for those in the individual market, except that they would be phased in over a period of five years. **[Page 3]**	**[Page 25]**
	• State Exchanges and Marketing Requirements, Establishment of State Exchanges: Beginning July 1, 2013, all plans offered in the individual and small group market, whether through the Exchange or outside of the Exchange, would have to comply with the rating reforms and benefit options detailed in the Chairman's Mark. **[Page 18]**	**[Page 25]**
	• Rating Areas: Rating areas would be defined by state insurance commissioners and reviewed by the Secretary for adequacy. Rating areas: 1) could allow for exceptions (e.g. a high-quality plan that does not have the capacity to serve the enter rating area could be allowed to serve less than a full rating area); 2) would be required to allow for pooling of similar cost people; and 3) would be risk-adjusted within each area and across all plans in each market (individual and small group). **[Page 12]**	**[Page 24]**
	• Risk Adjustment: All plans in the individual and small group markets would be subject to the same system of risk-adjustment. Risk-adjustment will be applied within rating areas. **[Page 11]**	**[Page 25]**
	• Making Coverage Affordable, Benefit Options, Definition of Four Benefit Categories: Insurers participating in the state exchanges would be required to charge the same price for the same products in the entire service area as defined by the state regardless of how an individual purchases the policy (i.e., whether the policy is purchased inside or outside the state exchange from the carrier or an agent). **[Page 23]**	**[Page 130]**
	• Interstate Sale of Insurance: No later than 2013, the NAIC shall develop model rules for the creation of "health care compacts." Starting in 2015, states, following action taken by the state legislature to approve participation, may form "health care choice compacts" to allow for the purchase of individual health insurance across state lines." These "health care choice compacts" may exist between two or more states and shall provide that the state where the consumer resides retains the authority to address market conduct, unfair trade practices, network adequacy, and consumer protection standards, including addressing disputes as to the performance of the contract. **[Page 13]**	**[Page 60]**
	• National Plans: Allows national plans with uniform benefit packages to be offered across state lines. These national plans must be licensed in every state in which they choose to operate, would be regulated by the states in terms of solvency and other key consumer protections, and would offer coverage through state exchanges. Premiums for national plans will be determined based on rating rules in each state and will reflect geographic variation among rating areas. **[Pages 13-14]**	**[Page 62]**

	• Creation of Health Care Cooperatives: In order to be eligible for federal funds under the CO-OP program, an organization must: 1) be organized as a non-profit, member corporation under state law; 2) not be an existing organization that provides insurance as of July 16, 2009 nor an affiliate or successor of any such organization; 3) incorporate in its governing documents ethics and conflict of interest standards protecting against insurance industry involvement and interference; 4) not be sponsored by a state, county, or local government, or any government instrumentality; 5) have substantially all of its activities consist of the issuance of qualified health benefit plans in the individual and small group markets in each state in which it is licensed to issue such plans; 6) subject the governance of the organization to a majority vote of its members (i.e. beneficiaries); 7) operate with a strong consumer focus, including timeliness, responsiveness, and accountability to members, as provided in regulations promulgated by the Secretary; and 8) use any profits made to lower premiums, improve benefits, or for other programs intended to improve the quality of health care delivered to its members. **[Pages 44-45]**	**[Page 239]**
	• Creation of Health Care Cooperatives: An organization receiving a grant or loan under the CO-OP program qualifies for a federal tax exemption with respect to periods for which the organization is in compliance with the requirements of the CO-OP program and with the terms of any CO-OP grant or loan agreement to which such organization is a party. If the CO-OP grantee violates the terms of the CO-OP program or the requirements of its grant or loan agreement and fails to correct the violation within a reasonable period of time, the organization will be forced to repay the aggregate amount of grants and loans received under the CO-OP program, plus interest. **[Pages 44-45]**	**[Page 236]**
	• Creation of Health Care Cooperatives: In making grants, the Secretary must ensure that no federal funds may be used by CO-OP program plans for marketing or to lobby Congress. **[Pages 44-45]**	**[Page 235]**
	• Creation of Health Care Cooperatives: In making awards under the CO-OP program, the Secretary shall ensure there is sufficient funding for at least one CO-OP in all 50 states and the District of Columbia. States in which CO-OP plans operate must ensure that CO-OP plans meet state solvency standards and comply with state laws impacting other health insurers. In the event that organizations participating in the CO-OP program do not form in every state, the Secretary shall be authorized to use planning grants to encourage formation of new organizations or expansion of organizations currently participating in the CO-OP program. **[Page 45]**	
7. Integration with Public Health and Public Health Investments		
A. Integration with Public Health	*Not Addressed*	*N/A*
B. Investment in Public Health	• Rural Protections, Extend Reasonable Cost Reimbursement for Laboratory Services in Small Rural Hospitals: Generally, hospitals that provide clinical diagnostic laboratory services under Part B are reimbursed using a fee schedule. Hospitals with under 50 beds in qualified rural areas (certain rural areas with low population densities) receive 100 percent of reasonable cost reimbursement for the clinical diagnostic laboratories covered under Medicare Part B that are provided as outpatient hospital services. Reasonable cost reimbursement for laboratory services provided by these hospitals ended July 1, 2008. Reasonable cost reimbursement for clinical diagnostic laboratory service for qualifying rural hospitals with under 50 beds would be reinstated from July 1, 2010 and extended for two years, ending July 1, 2012. **[Page 147]**	**[Page 906]**
	• Elder Justice Act: Creates a comprehensive approach to ensuring adequate public-private infrastructure and resolving to prevent, detect, treat, understand, intervene in, and, where appropriate, aid in the prosecution of, elder abuse, neglect, and exploitation by incorporating the Elder Justice Act (S. 795). **[Page 84]**	**[Page 521]**

	• Abstinence Education: Appropriates $50 million a year through 2014 for abstinence education. Also appropriates $75 million each year for fiscal years 2010 through 2014 for a Personal Responsibility Education for Adulthood Training. Of the annual amount, $50 million would be available to states each year on a formula basis for programs to educate adolescents on both abstinence and contraception for prevention of teenage pregnancy and sexually transmitted infections, including HIV/AIDS. Programs must be evidence-based, medically accurate, and age appropriate and must address at least three adulthood preparation subjects. **[Page 86]**	**[Page 508]**
	• Personal Responsibility Education for Adulthood Training: Appropriates $75 million each year for fiscal years 2010 through 2014 for a Personal Responsibility Education for Adulthood Training. **[Page 86]**	**[Page 491]**
C. Public Health Emergencies	*Not Addressed*	
8. Administering the New System and Assuring Accountability		
A. Administration of the System	• State Exchanges and Marketing Requirements, Establishment of State Exchanges: States would be required to establish an exchange for the individual market and a Small Business Health Options Program exchange for the small group market, with technical assistance from the Secretary, in 2010. This requirement may encompass a single exchange with separate resources for individual and small-group customers. The Secretary would be required to establish and maintain a database of plan offerings for use by state exchanges. The database would enable the review of state-specific information. The Secretary could contract out to a private entity for the operation of the plan database and can also enter into an agreement with a sub-exchange in carrying out its functions. **[Page 18]**	**[Page 85]**
	• State Exchanges and Marketing Requirements, Administrator: The Secretary would designate an office within HHS to provide technical assistance to states on incorporating small businesses into Small Business Health Options Program exchanges. **[Page 20]**	**[Page 98]**
	• State Exchanges and Marketing Requirements, Functions Performed by Secretary and/or States: The states will do the following: 1) develop a standard enrollment application; 2) provide a standardized format for presenting insurance options in the state Exchange; 3) develop standardized marketing requirements; 4) develop a rating system for plans entering the state exchange based on relative quality and price compared to comparable plans; 5) maintain a call center that provides multilingual assistance; 6) enable consumers to enroll in plans through a variety of public offices; 7) develop a model template for a web portal for use by the states that directs individuals and small businesses to available insurance options in their state, provides a tax credit calculators, and presents standardized information related to insurance options, including quality ratings; 8) conduct eligibility determinations for tax credits and subsidies; 9) establish procedures for granting annual certification that no health benefit plan meets the definition of creditable coverage was deemed affordable for that individual and maintain a list of such individuals; 10) establish procedures for appeals of eligibility decisions for subsidies; and 11) establish a plan for publicizing the existence of the state exchange. **[Pages 19-20]**	**[Page 91]**
	• State Insurance Commissioners, Enforcement Mechanism: States must establish an exchange that complies with the requirements set forth in the federal law. If a state does not establish an exchange within 24 months of enactment, the Secretary shall contract with a non-governmental entity to establish a state exchange that complies with the federal legislation. **[Page 12]**	**[Page 87]**
	• State Exchanges and Marketing Requirements, State Exchange Related Functions Performed by State Insurance Commissioners: State insurance commissioners would establish procedures for reviewing plans to be offered through the state exchanges and would develop criteria for determining whether certain health benefit plans are "qualified health plans" that can be available for sale in the market. **[Page 20]**	**[Page 14]**
	• State Exchanges and Marketing Requirements, Administrator: The Secretary would designate an office within the HHS to provide technical assistance to states on incorporating small businesses into Small Business Health Options Program exchanges. **[Page 20]**	**[Page 98]**
	• State Exchanges and Marketing Requirements, Regional Exchanges: States could, through interstate compacts, form regional exchanges, subject to approval by the Secretary. **[Page 20]**	**[Page 86]**

	• State Option for a Basic Health Plan, Contracting: States would be encouraged to include innovative features in their health plan contracting including but not limited to: 1) care coordination and care management for enrollees, especially for those with chronic health conditions; 2) incentives for use of preventive services; and 3) establishment of a patient-doctor relationships that maximize patient involvement in health care decision-making, including awareness of the incentives and disincentives in using the health care plan. State administrators would seek to contract with managed care systems, or with systems that offer as many of the attributes of managed care as are feasible in the local health care market. State administrators should seek participation by multiple health plans to allow enrollees a choice between two or more plans, whenever possible. A minimum medical loss ratio of 85 percent would be required of all participating plans. State administrators, in conjunction with HHS, would establish specific performance measures and standards for participating health care systems that focus on quality of care and improved health outcomes. **[Page 16]**	**[Page 68]**
	• State Option for a Basic Health Plan, Coordination with Medicaid Negotiations: The state administrators would be encouraged to find ways to integrate their basic health plan negotiations with any Medicaid or other state administered health care programs to maximize efficiency and improve the continuity of care between all state administered health programs. **[Page 16]**	**[Page 70]**
B. Enforcement Tools	• State Insurance Commissioners, Enforcement Mechanism: The NAIC will devise an NAIC Model Regulation within 12 months of enactment that is consistent with the new federal law with regards to federal health insurance rating, issuance, and marketing requirements. This model becomes the new federal minimum standard without any further Congressional action. Once completed, the NAIC Model is written into federal regulation. If NAIC does not act within 12 months, the Secretary of HHS must promulgate regulations within six months in a manner consistent with the federal law, and states must adopt this rule. **[Page 11]**	**[Page 50]**
C. Preemption	• State Insurance Commissioners, Enforcement Mechanism: If a state fails to adopt the changes in conformance with the new federal minimum standards either by adopting the NAIC Model or through secretarial approval, conflicting state laws would be preempted. In such a case, insurers would then offer coverage under federal law and be overseen by HHS until the state adopts the necessary changes. **[Page 11]**	**[Page 52]**
	• State Insurance Commissioners: Prohibits state law from imposing more stringent regulatory requirements on certain health issuers that are not applied to all issuers in the individual and small group markets. All entities offering health insurance would be subject to state regulatory requirements that exceed federal requirements established under this legislation. **[Page 12]**	**[Page 55]**
	• State Opt-Out: Provides an opportunity for states to apply for a waiver to opt out of certain aspects of this Act through a waiver process beginning in 2015. States may be granted a waiver if a state applies to the Secretary to provide health care coverage that is at least as comprehensive as required under the Chairman's Mark. **[Page 14]**	**[Page 58]**
D. Fraud and Abuse	• Transparency and Program Integrity, Physician Payment Sunshine: Amends Title XI of the Social Security Act to provide for transparency in the relationship between physicians and applicable manufacturers with respect to payments and other transfers of value and physician ownership or investment interests in manufacturers. Calls for annual transparency reports, penalties for noncompliance, procedures for the submission of information and public availability of this information. **[Page 210]**	**[Page 1226]**
	• Transparency and Program Integrity, Prescription Drug Samples: Requires drug manufacturers and authorized distributors to report the information required under the Prescription Drug Marketing Act of 1987 to the Secretary. **[Page 211]**	**[Page 1248]**

	• Transparency and Program Integrity, Limitation on Medicare Exception to the Prohibition on Certain Physician Referrals for Hospitals: Beginning no later than 18 months after the date of enactment, only hospitals meeting certain requirements would be exempt from the prohibition on self-referral. Hospitals that have physician ownership and a provider agreement in operation on November 1, 2009 and that met other specified requirements would be exempt from this self-referral ban. To ensure patient safety, exempt hospitals would be required to disclose to all patients prior to admission that it does not have any physician available on the premises to provide services during all hours in which the hospital is providing services. Exempt hospitals would not be permitted to increase the number of operating rooms, procedure rooms or beds for which the hospital is licensed after the date of enactment. A process would be established to allow certain hospitals to expand. **[Page 208-09]**	**[Page 1213]**
	• Transparency and Program Integrity, Nursing Home Transparency, Required Disclosure of Ownership: Skilled nursing facilities and nursing facilities would be required to make available on request by the Secretary, the HHS Office of the Inspector General, the state, and the state long term care ombudsman, information on ownership (including direct and indirect ownership) and additional disclosable parties as well as information describing the governing body and organizational structure of the facility. **[Page 212]**	**[Page 1251]**
	• Transparency and Program Integrity, Nursing Home Transparency, Required Disclosure of Ownership, Accountability Requirements: Requires skilled nursing facilities and nursing homes to develop and implement compliance and ethics programs to be followed by their employees and agents. The Secretary must develop regulations, working with the HHS Office of the Inspector General, for an ethics and compliance program, which may include a model compliance program, within two years of enactment. The Secretary may vary program requirements on the elements and formality the elements and formality of the program based on the size of the organization. The compliance program would be required to have standards and procedures designed to detect criminal, civil, and administrative violations under the Social Security Act. **[Page 213]**	**[Page 1259]**
	• Transparency and Program Integrity, Nursing Home Compare Website: Requires the Secretary to include additional information on the Medicare *Nursing Home Compare Website*. The additional information includes: 1) standardized staffing data on nursing staff and other staff providing medical and therapy services available on facilities that is submitted by facilities in a uniform format; 2) links to state internet websites regarding state survey and certification programs, and links to form 2567 (or successor form) inspection reports, links to facility plans of correction or responses to such reports and information to guide consumers in how to interpret and understand these reports; 3) a standardized complaint form including explanatory material on how to use the complaint forms, and how to file a complaint with the state survey and certification program and the state long term care ombudsman program; 4) a summary of information on enforcement action against the facility that includes substantiated complaints and remedies proposed and imposed during the preceding three years; and 5) a summary of facility expenditures for direct care staffing based on data submitted. **[Page 214]**	**[Page 1266]**
	• Transparency and Program Integrity, Nursing Home Transparency, Reporting of Expenditures: Amends the Social Security Act by adding requirements that skilled nursing facilities and nursing homes report expenditures for wages and benefits for direct care staff on facility cost reports. The reporting of expenditures on wages and benefits for direct care staff would be required to be broken out into categories including registered nurses, licensed professional nurses, certified nurse assistants, and other medical and therapy staff. The Secretary would be required to consult with government and private sector cost report experts to assist in categorizing by functional area skilled nursing facilities expenditure data, as well as in making it publicly available. **[Page 214]**	**[Page 1284]**

	• Transparency and Program Integrity, Ensuring Staffing Accountability: Requires the Secretary to establish a process to require skilled nursing facilities and nursing facilities to regularly report staffing data, including agency and contract staff, by staff position categories (based on payroll and other verifiable and auditable data). The reporting requirements would include the category of work an employee performs such as whether the employee is a registered nurse, licensed practical nurse, licensed vocational nurse, certified nursing assistant, or other medical or therapy staff providing direct resident services, resident census data, information on employee turnover and tenure, and the hours of care provided per resident per day. **[Page 215]**	**[Page 1288]**
	• Transparency and Program Integrity, Standardized Complaint Form: Requires the Secretary to develop a standardized form for skilled nursing facilities and nursing facility residents and their representatives to use in submitting quality of care complaints. **[Pages 214-15]**	**[Page 1286]**
	• Transparency and Program Integrity, Notification of Facility Closure: Requires skilled nursing facilities and nursing homes to notify in a timely fashion state, federal, and stakeholder officials, as well as residents and their representatives of an impending nursing facility closure. Facilities would be required in the notice to issue a plan for the transfer and relocation of residents. **[Page 216]**	**[Page 1306]**
	• Transparency and Program Integrity, Civil Money Penalties: In instances where deficiencies are cited at the level of actual harm and immediate jeopardy, the Secretary would have the authority to place civil monetary penalties in an escrow account following completion of the informal dispute resolution process, or the date that is 90 days after the date of the imposition of the civil monetary penalties, whichever is earlier. Monetary amounts collected and placed in escrow would be kept in an interest bearing escrow account pending the resolution of any appeals. **[Page 215]**	**[Page 1291]**
	• Transparency and Program Integrity, National Independent Monitor Pilot Program: Requires the Secretary to develop, test, and implement a two-year pilot for an independent monitor program. The independent monitor program would oversee large interstate and intrastate skilled nursing facilities and nursing home chains. The Secretary would develop protocols for addressing quality and safety problems at the corporate management level occurring in individual homes that are owned or operated by certain chains, including those with homes in the Special Focus Facility program, and those with a record of repeated serious safety and quality of care deficiencies. **[p. 216]**	**[Page 1301]**
	• Transparency and Program Integrity, Imaging Self-Referral Sunshine: Section 1877(b)(2) of the Social Security Act (regarding general exceptions to both ownership and compensation arrangement prohibitions, in-office ancillary services) states that if a physician (or an immediate family member of a physician) has a financial relationship with an entity, the physician may not make a referral to the entity for the furnishing of designated health services for which payment may be made under Medicare or Medicaid. One of the many exceptions to this prohibition is for in-office ancillary services. The in-office ancillary exception would include a requirement that with respect to magnetic resonance imaging, computed tomography, positron emission tomography, and any other designated health services as determined by the Secretary, the referring physician must inform the individual at the time of the referral that the individual may obtain the services from a person other than the referring physician, a physician who is a member of the same group practice as the referring physician, or an individual who is directly supervised by the physician or by another physician in the group practice. The individual must be provided with a written list of suppliers who furnish services in the area in which the individual resides. **[Page 219]**	**[Page 1248]**
	• Transparency and Program Integrity, Hospital Average Charge Information: Beginning in 2011, there will be a national requirement for acute care hospitals to make their charges for each Medicare diagnostic related group available to the public and upon request to any patient served by the facility. Hospitals would be required to provide the average charge and the range between the 2nd and 4th quintiles of charges across all commercial payers and for self-pay patients for each diagnosis related group. Hospitals would update their information on an annual basis. If the hospital does not comply with the requirement, the Secretary of HHS would be authorized to impose a civil monetary penalty on the facility in the amount of $50,000. **[Page 219]**	**[Page 251]**

	• Fraud Waste and Abuse, Consolidate and Expand Provider Databases: The existing provider databases (Healthcare Integrity and Protection Data Bank, National Practitioner Data Bank, and List of Excluded Individuals/Entities) would be expanded and consolidated with a national patient abuse/neglect registry into a centralized sanctions data system. This data system would include information on providers in Medicare and all state Medicaid programs, including provider ownership and business relationships, history of adverse actions, and results of site visits or other monitoring by any program. Data on the fraud settlements that occur during the year would be reported to the consolidated database. State licensure boards and federal and state law enforcement agencies would be able to access the data. The Medicare and Medicaid programs would be required to verify any applicant's status in the provider database prior to issuing provider/supplier numbers. Also requires states to report to CMS information from their Medicaid Management Information Systems databases on a regular basis, as determined by the Secretary. States failing to report would be subject to a financial penalty through a reduction in their federal medical assistance percentages. **[Page 223]**	**[Page 1376]**
	• Fraud Waste and Abuse, Provider Compliance and Penalties, Conditions on Participation and Coverage: Medicare and Medicaid providers and suppliers would be required to implement compliance programs as a condition of participation. **[Page 225]**	**[Page 1342]**
	• Fraud Waste and Abuse, Provider Compliance and Penalties, Conditions on Participation and Coverage: Physicians and other suppliers would be required to keep documentation on referrals to programs at high risk of fraud and abuse and provide access to such documentation upon request of the Secretary. If a physician or supplier is not able to provide documentation of such referrals, the Secretary may disenroll the physician or supplier for a period of not more than one year. **[Page 225]**	**[Page 1393]**
	• Fraud Waste and Abuse, Provider Compliance and Penalties, Conditions on Participation and Coverage: As a condition of payment, physicians must have a face-to-face encounter with the patient before making a referral for home health or durable medical equipment. **[Page 225]**	**[Page 1394]**
	• Fraud Waste and Abuse, Provider Compliance and Penalties, Program Sanctions: Intermediate sanctions and program safeguards would be established to provide greater flexibility to CMS and law enforcement to address problems. **[Pages 225-26]**	**[Page 1375]**
	• Fraud Waste and Abuse, Provider Compliance and Penalties, Deterrence/Civil and Criminal Penalties: The civil monetary penalty law would be amended in several instances to increase penalties and extend use of civil monetary penalties. A civil monetary penalty would be established for each instance of a hospital's failure to report an adverse action affecting the clinical privileges of a physician. The civil monetary penalty law (in Section 1128A(a)(5) relating to beneficiary inducements), would be amended to tailor the prohibition to address harmful conduct and relieve the burden on certain charitable and other innocuous programs currently covered by the broad reach of the statute. The imposition of a civil monetary penalty would be authorized on an excluded person who orders or prescribes (rather than directly furnishes) items or services reimbursed by federal health care programs. Penalties for submitting false claims and for submitting false statements material to a false claim would be increased. Penalties would also be enhanced for delaying inspections and for the obstruction of program audits. For MA and Medicare Part D plans, penalties would be enhanced for misrepresentation or submission of falsified information as well as for marketing violations. The testimonial subpoena authority to program exclusion investigations would be extended. The provision would also amend the anti-kickback statute to add language defining "willfully" as "a person acted voluntarily and purposefully to do what the law forbids and the person need not have actual knowledge of the law or specific intent to violate that law." **[Page 226]**	**[Page 1397]**
	• Fraud Waste and Abuse, Provider Compliance and Penalties, Provider Self-Disclosure Protocol: The Secretary would be required to establish, within 180 days, a mechanism for providers to voluntarily disclose specific information regarding actual and potential violations of the physician self-referral law. **[Page 226]**	**[Page 1401]**
	• Termination of Provider Participation Under Medicaid if Terminated Under Medicare or other State Plan: States would be required to initiate termination proceedings for any provider or supplier excluded from Medicare or any other state's Medicaid program. **[Page 221]**	**[Page 1411]**

	• Medicaid Exclusion From Participation Relating to Certain Ownership, Control, and Management Affiliations: Applicants would be required to disclose affiliations with any enrolled entity that has uncollected Medicare or Medicaid debt. The Secretary would be authorized to deny enrollment in Medicare if these affiliations pose an undue risk to the program. The Secretary would also be authorized to require surety bonds up to $500,000 (the amount of the surety bond would be commensurate with the volume of billing) and, if necessary, impose moratoria on the enrollment of certain groups of new providers or suppliers to prevent fraud. **[Page 221]**	**[Page 1412]**
	• Fraud Waste and Abuse, Recovery Audit Contractors: Recovery Audit Contractors are private organizations that contract with CMS to identify and collect improper payments made in Medicare's fee-for-service program. The Recovery Audit Contractor program is extended to Medicare Parts C and D and Medicaid. **[Page 228]**	**[Page 1405]**
	• Fraud Waste and Abuse, Program Integrity and Reporting Requirements: Health Care Fraud and Abuse Control program funding would be increased by $10 million each year for ten years, and would remain available until expended. The provision would also permanently apply the consumer price index adjustment to Health Care Fraud and Abuse Control program funding. The Medicare and Medicaid Integrity Programs (MIP) evaluation requirements would be amended. Reporting requirements would be established for Medicare MIP contractors, modeled on those established for the Medicaid MIP. **[Page 229]**	**[Page 1349]**
	• Fraud Waste and Abuse, Program Integrity and Reporting Requirements, National Correct Coding Initiative: Requires states to use of the National Correct Coding Initiative in Medicaid. Amends Section 1903(r) of the Social Security Act (regarding the requirements to receive reimbursement for the use of automated data under a state plan) to require states to have an Medicaid Management Information Systems that, effective for claims filed on or after October 1, 2010, incorporates compatible elements of the National Correct Coding Initiative (or any successor initiative) and such other elements of that Initiative (or such other national correct coding methodologies) as the Secretary identifies in accordance with specified requirements. **[Page 229]**	**[Page 1416]**
	• Fraud Waste and Abuse, Adjustments to the Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies Competitive Acquisition Program: Requires the Secretary to expand the number of areas to be included in Round Two of the program from 79 of the largest medical savings accounts to 100 of the largest medical savings accounts by including the next 21 largest medical savings accounts by population. The provision would also require that the Secretary extend the competitive acquisition program, or apply competitively-bid rates, to the remaining areas by 2016. All other provisions in current law would remain in place, such as the Secretary's discretion to exempt rural areas and areas with low population density within an medical savings accounts. **[Page 231]**	**[Page 1404]**
	• Fraud Waste and Abuse, Provider Screening: Requires that the Secretary screen all providers and suppliers before granting Medicare billing privileges. An application fee of $350 would be imposed on providers and suppliers to cover the costs of screening. All providers, including physicians who order items or services, would be required to be Medicare-enrolled physicians or eligible professionals before they would be allowed to order or prescribe services that would incur any cost to the Medicare program. Some new providers or suppliers could also be subjected to enhanced oversight, such as prepayment review and payment caps, for a provisional period of six to 12 months. **[Pages 220-21]**	**[Page 1391]**
	• Fraud Waste and Abuse, Provider Screening: 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. **[Pages 220-21]**	**[Page 1333]**
	• Fraud Waste and Abuse, Program Exclusions: Section 1128(c)(3)(B) (regarding the waiver of the exclusion from federal health programs in the case of an individual or entity that is the sole community physician or sole source of essential specialized services in a community) of the Social Security Act would be amended to clarify that hardship waivers of an HHS Office of the Inspector General exclusion can be based on hardship imposed on beneficiaries of any federal health care program. **[Page 228]**	**[Page 1336]**

	• Fraud Waste and Abuse, Data Matching, Complete "One PI" Integrated Data Repository: Requires CMS to complete development of the comprehensive "One PI" Integrated Data Repository. The "One PI" Integrated Data Repository would expand existing program integrity data sources and expand data sharing and data matching across federal health care claims and payment data (including the Department of HHS, the Social Security Administration, the Departments of Veterans Affairs, Defense, and Justice). **[Page 221]**	**[Page 1350]**
	• Fraud Waste and Abuse, Provider Compliance and Penalties, Payment: The maximum period for submission of Medicare claims would be reduced to not more than 12 months. Also, the Secretary, in consultation with the Department of HHS Office of the Inspector General and CMS, could suspend payments to providers and suppliers pending an investigation of credible allegations of fraud. **[p. 226]**	**[Page 1389]**
	• Fraud Waste and Abuse, Provider Compliance and Penalties, Overpayments: The 60 days 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. Providers and suppliers would be required to repay any Medicare or Medicaid overpayment identified through an internal compliance audit. Additionally, any person who knows of an overpayment would be required to return the overpayment to the Secretary, the state, or a Medicare contractor and notify the aforementioned party in writing to whom the overpayment was returned. **[Page 226]**	**[Page 1355]**
	• Improvements to Medicaid, Waiver Transparency: Imposes statutory requirements regarding transparency in the development, implementation, and evaluation of Medicaid and CHIP Section 1115 demonstration programs that impact eligibility, enrollment, benefits, cost-sharing, or financing. Requirements would be imposed on states and the Secretary of HHS. Additional transparency requirements will be imposed on the state plan amendment approval process. **[Page 60]**	**[Page 309]**
	• Medicaid Services, Repayment of Medicaid Overpayment: Extends the 60 days that states have to repay the federal share of a Medicaid overpayment to one year. In any case due to fraud, where the state is unable to recover within the allotted time because the amount has not been finally determined through the judicial process or the final judgment is under appeal, the state must repay the federal share within 30 days after the final judgment is made. **[Page 64]**	**[Page 1415]**
9. Improving Quality and Efficiency of the Health Care System		
A. Efficiency and Quality Investments	• Strengthening the Quality Infrastructure: Building on the provision set forth in MIPPA, provides additional resources to the Department of HHS to strengthen and improve quality measure development processes for purposes of improving quality, informing patients and purchasers and guiding payment under federal health programs. **[Page 107]**	**[Page 709]**
	• Strengthening the Quality Infrastructure, National Strategy to Improve Health Care Quality: Directs the Secretary to establish a national quality improvement strategy that includes priorities to improve the delivery of health care services, patient health outcomes, and population health, through a transparent, collaborative process. The national strategy would also include a comprehensive strategic plan to achieve the priorities. In developing the national strategy and priorities, the Secretary would take into consideration recommendations submitted by a qualified consensus-based entity as set forth in MIPPA. The Secretary would update the national strategy not less than triennially and the first report would be due to Congress on December 31, 2010. **[Page 108]**	**[Page 709]**
	• Strengthening the Quality Infrastructure, Quality Measure Development: The Secretary would identify, not less than triennially, gaps where no quality measures exist, or where existing quality measures need improvement, updating or expansion, consistent with the national strategy and priorities. The Secretary would then be required to develop measures that would fill identified gaps. Measures developed under this section would be applicable to all age groups, where appropriate, and focus on a minimum of the following areas: 1) patient outcomes and functional status; 2) coordination of care across episodes of care and care transitions; 3) meaningful use of health information technology; 4) safety, effectiveness, patient centeredness, appropriateness, and timeliness of care; 5) efficiency of care; 6) equity of health services and health disparities; 7) patient experience and satisfaction; and 8) other areas deemed appropriate by the Secretary. **[Page 109]**	**[Page 717]**

	• Strengthening the Quality Infrastructure, Consultation for Selection of Endorsed Quality Measures for Use in Reporting and Payment Programs: The Secretary would also develop a process for consultation with the qualified consensus-based entity identified in MIPPA and with the multi-stakeholder group referenced above related to the selection of measures for use in reporting to and payment under federal health programs. **[Pages 109-10]**	**[Page 721]**
	• Strengthening the Quality Infrastructure, Use and Review of Quality Measures: The Secretary would also set forth a process to disseminate measures and incorporate measures, where applicable, in workforce programs, training curricula, federal health programs, and other areas deemed appropriate by the Secretary. **[Page 110]**	**[Page 730]**
	• Strengthening the Quality Infrastructure, Funding: For purposes of carrying out the required activities to strengthen the quality infrastructure, the Secretary would provide for the transfer of $50 million for each of the fiscal years 2010 through 2014 from the Federal Hospital Insurance Trust Fund and the Federal Supplemental Medical Insurance Trust Fund, to CMS Program Management Account. **[Page 110]**	**[Page 732]**
	• Revisions on the Demonstration Project on Community Health Integration Models in Certain Rural Counties: MIPPA authorized a demonstration project to allow eligible entities to develop and test new models for the delivery of health care services in eligible counties for the purpose of improving access to, and better integrating delivery of, acute care, extended care, and other essential health care services to Medicare beneficiaries. Eligibility to participate in the demonstration project under this section is limited to eligible entities that include a Rural Hospital Flexibility Program grantee under Section 1820(g) of the Social Security Act (regarding grants under the Medicare Rural Hospital Flexibility Program) and entities located in a state in which at least 65 percent of the counties in the State are counties that have six or less residents per square mile. Strikes the limitation on the number of eligible counties that may participate in the demonstration project within the qualifying states. Also deletes references to rural health clinic services and replace these with a requirement that physician services may also be included within the scope of the demonstration project. **[Pages 149-50]**	**[Page 911]**
	• State Exchanges and Marketing Requirements, Study on Use of Electronic Health Records: The Secretary or his/her designate is instructed to conduct a study on methods that entities offering insurance plans through the Exchange can use to encourage increased meaningful use of electronic health records by health care providers. **[Page 21]**	**[Page 122]**
	• Transparency and Program Integrity, Demonstration Projects on Culture Change and Use of Information Technology in Nursing Homes: Requires the Secretary to conduct two demonstration projects for nursing homes and skilled nursing facilities: 1) for the development of best practices for facilities involved in culture change; and 2) for the development of best practices in facilities for the use of information technology to improve resident care. The Secretary would be required to submit a report to Congress after completion of the demonstration projects that evaluates the projects and makes recommendations for legislation and administrative actions. The demonstration projects cannot exceed three years. **[Page 217]**	**[Page 1309]**
	• Administrative Simplification: Establishes a timeline for accelerating the development, adoption and implementation of a set of operating rules for each HIPAA transaction for which there is an existing standard. It would require the Secretary to first adopt a single set of operating rules for eligibility verification, claims status, claims remittance/payment, and electronic funds transfer. The goal would be to create as much uniformity in the implementation of electronic standards as possible. The Secretary would rely on recommendations for operating rules developed by a qualified non-profit entity. Also provides for a process to periodically update HIPAA standards including operating rules. **[Pages 204-06]**	**[Page 1194]**
	• Administrative Simplification: Requires the Secretary to adopt a rule to create unique health plan identifiers. **[Page 205]**	**[Page 1209]**
	• Administrative Simplification: Health plans would be required to file a certification statement with the Secretary that their data and information systems comply with the most current published standards, including the operating rules, for four transactions: eligibility verifications, claims status, claims remittance/payment, and electronic funds transfer. The Secretary would be required to conduct periodic audits of health plans to ensure that they maintain compliance with the operating rules. Creates a penalty fee for plans that do not demonstrate compliance with HIPAA operating rules as adopted by the Secretary. **[Page 205]**	**[Page 1211]**

	• Health Information Technology: Free clinics would be added to the list of providers eligible for Medicare and Medicaid health information technology incentives. **[Page 110]**	**[Page 874]**
B. Promoting Clinical Quality of Care and Efficient Resource Use	• Medicaid Quality, Medicaid Bundled Payments Demonstration Project: Establishes a bundled payment demonstration project under Medicaid in up to eight states. Under the demonstration, the unit of payment for acute care provided in hospitals would be redefined and expanded to include post-acute care provided in acute-care hospitals and nonhospital settings, and/or hospital and concurrent physicians' services. **[Page 75]**	**[Page 416]**
	• Medicaid Quality, Medicaid Global Payments Demonstration Project: Establishes a Medicaid Global Payments demonstration project available in up to five states from 2010 to 2012, under which a large, safety net hospital system participating in Medicaid would be permitted to alter its provider payment system from a fee-for-service structure to a capitated, global payment structure. The CMS Innovation Center would conduct an evaluation of each demonstration project, examining any changes in health care quality outcomes and spending. **[Page 75]**	**[Page 420]**
	• Medicaid Quality, Accountable Care Organizations Demonstration Project: Establishes a demonstration project in which a state would apply to the Secretary to participate, which would allow pediatric medical providers who meet certain criteria to be recognized as Accountable Care Organizations. Participating providers would be eligible to share in the federal and state cost savings achieved for Medicaid and CHIP. States, in consultation with the Secretary, would establish a minimum level of savings that would need to be achieved by an Accountable Care Organization in order for it to share in the savings. **[Page 75]**	**[Page 421]**
	• Medicaid Quality, Medicaid Reimbursement for Health Care Acquired Conditions: Prohibits federal payments to states for Medicaid services related to health care acquired conditions. The Secretary would define health care acquired conditions, consistent with the definition of hospital acquired conditions under Medicare, but it would not be limited to conditions acquired in hospitals. **[Page 74]**	**[Page 415]**
	• Dual Eligibles, Federal Coordinated Health Care Office: Establishes the Federal Coordinated Health Care Office within CMS no later than March 1, 2010. The Federal Coordinated Health Care Office would report directly to the Administrator of CMS. The purpose of the Federal Coordinated Health Care Office would be to bring together officials of the Medicare and Medicaid programs at CMS 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 in order to ensure that such individuals get full access to the items and services to which they are entitled. **[Page 72]**	**[Page 406]**
	• Ensuring Beneficiary Access to Physician Care and Other Services (Medicare), Guidelines to Ensure Emergency Room Access: Directs the Secretary to convene a working group that includes experts in emergency care, inpatient critical care, hospital operations management, nursing and other relevant disciplines to recommend boarding and diversion standards for hospitals and guidelines, measures and incentives for implementation, monitoring, and enforcement of such standards. **[Page 144]**	**[Page 902]**

	• Encouraging Development of the New Patient Care Models, National Pilot Program on Payment Bundling: The Secretary shall develop, test, and evaluate alternative payment methodologies through a national, voluntary pilot program that is designed to provide incentives for providers to coordinate patient care across the continuum and to be jointly accountable for the entire episode of care starting in 2013. The Secretary should select eight conditions to be included in the pilot program considering the following factors: 1) a mix of chronic and acute conditions; 2) a mix of surgical and medical conditions; 3) conditions for which there is evidence of opportunity for providers to improve quality of care while reducing total expenditures; 4) conditions with high-volume or high post acute care spending; and 5) conditions that are deemed most amenable to bundling across spectrum of care given current practice patterns. The pilot program's bundled program payment would be made to a Medicare provider or other entity comprised of multiple providers to cover the costs of acute care inpatient and outpatient hospital services, physician services and post-acute care. The comprehensive bundled payment would include the costs of any re-hospitalizations that occur during the covered period. The bundled payment for each of the eight selected conditions would be based on the average hospital physician, and post-acute care payments made over the hospitalization period for patient. If a selected condition is readmitted for a preventable readmission at a different hospital than the initial hospitalization, the Secretary would reimburse the subsequent hospital its base operating and capital Medicare Severity diagnosis related group payment amounts and the physicians at the subsequent hospital the amount that would otherwise be made if this policy did not apply. The Secretary would then adjust the bundled payments to recoup these same amounts. **[Pages 117-19]**	**[Page 760]**
	• Strengthening the Quality Infrastructure, Home-Based Chronic Care Management Program: Creates a chronic care coordination pilot project to bring primary care services to the highest cost Medicare beneficiaries with multiple chronic conditions in their home. Interdisciplinary teams of health care professionals caring for patients with multiple chronic conditions in their residences would be eligible for shared-savings if they achieve quality outcomes, patient satisfaction and cost savings. The Secretary shall limit the number of practices selected for participation under the pilot so that no more than 10,000 applicable beneficiaries are expected to participate. **[Page 124]**	**[Page 780]**
	• Encouraging Development of the New Patient Care Models, Transitional Care Program to Reduce Preventable Readmissions: Establishes a three-year Medicare pilot program, called the "Community Care Transitions Program" beginning in 2011 under which the Secretary would fund eligible hospitals and community-based partnership organizations to provide patient-centered, evidence-based transition services to Medicare beneficiaries at the highest risk of preventable re-hospitalization. **[Page 123]**	**[Page 200]**
	• Strengthening the Quality Infrastructure, Transitional Care Program to Reduce Preventable Readmissions: A hospital in collaboration with partnership organizations must identify at least one evidence-based care transition intervention to be utilized as the model of service delivery for targeted high-risk beneficiaries. Examples of core intervention elements for care transition services could include: 1) initiating care transition services for targeted high-risk beneficiaries no later than 24 hours prior to the beneficiary being discharged from the participating hospital; 2) assessment and active engagement with patient and caregiver focusing on coaching, self-management support when appropriate, and providing information specific to the patient's health, functional, social, and environmental conditions; 3) comprehensive medication review and management, including patient self-management when appropriate; 4) assisting patient and caregiver to engage in productive interactions with post-acute and outpatient providers in a timely manner; and 5) arrangement of timely follow-up in order to educate patient and/or caregiver about health symptoms that indicate a worsening condition and how to respond. **[Page 123]**	**[Page 200]**
	• Linking Payment to Quality Outcomes in the Medicare Program, Physician Value-Based Purchasing: Establishes a new Physician Quality Reporting Initiative option in addition to the options within the current program detailed above. Beginning with the 2011 reporting period, CMS would be required to make Physician Quality Reporting Initiative incentive payments available for two successive years to eligible professionals who voluntarily complete the following on a biennial basis: 1) participate in a qualified American Board of Medical Specialties Certification, known as a Maintenance of Certification, or equivalent programs; or 2) complete a qualified Maintenance of Certification practice assessment. **[p. 101]**	**[Page 667]**

	• Linking Payment to Quality Outcomes in the Medicare Program, Medicare Inpatient Rehabilitation Facility, Long Term Acute care Hospital, and Hospice Quality Reporting: The Secretary must establish quality reporting programs for inpatient rehabilitation facilities, long term care facilities, and hospices. The Secretary would select quality measures, and failure to report such measures would result in reduction of annual market basket update by two percent. [p. 104]	[Page 685]
	• Linking Payment to Quality Outcomes in the Medicare Program, Medicare IPPS Exempt Cancer Hospital Quality Reporting: The Secretary must establish quality reporting programs for inpatient prospective payment system-exempt cancer hospitals. Inpatient prospective payment system exempt cancer hospitals would be required to report these quality measures as part of Medicare provider agreements. [p. 104]	[Page 692]
	• Linking Payment to Quality Outcomes in the Medicare Program, Hospital Value-Based Purchasing: Building on the success of the Reporting Hospital Quality Data for Annual Payment Update program, establishes a hospital value-based purchasing program in Medicare that moves beyond pay-for-reporting on quality measures, to paying for hospital's actual performance on these measures. The measures would focus on the same areas that are the focus of the Reporting Hospital Quality Data for Annual Payment Update program, which include: heart attack (AMI); heart failure; pneumonia; surgical care activities; patient perception of care; and would include healthcare associated infections, as measured by the prevention metrics and targets established by the HHS Action Plan to Prevent Healthcare-Associated Infections or any successor plan. [Page 98]	[Page 639]
	• Linking Payment to Quality Outcomes in the Medicare Program, Hospital Value-Based Purchasing: Performance standards that reward hospitals based on either attaining a certain performance standard or making improvements on performance relative to a previous performance period would be established. Hospitals would be paid based on whichever level was higher: attainment or improvement. [Page 99]	[Page 644]
	• Linking Payment to Quality Outcomes in the Medicare Program, Hospital Value-Based Purchasing: Certain hospitals will be excluded from the Medicare Value-Based Purchasing program, including: 1) those that fail to report quality measures under the Reporting Hospital Quality Data for Annual Payment Update program; 2) those that have been cited by the Secretary for deficiencies that posed immediate jeopardy to the health or safety of patients during the performance period; and 3) those for which a minimum number of patients with conditions related to the quality measures or a minimum number of quality measures do not apply. [Page 99]	[Page 640]
	• Linking Payment to Quality Outcomes in the Medicare Program, Hospital Value-Based Purchasing: An appeals process would be established to contest performance score calculations and the resulting value-based incentive payments. There will be no judicial or administrative review of the following items: 1) the methodology used to determine the amount of the value-based incentive payments; 2) the determination of the amount of funding available for value-based payments; 3) the establishment of the hospital performance standards; 4) the quality measures that are selected for inclusion in Medicare's Reporting Hospital Quality Data for Annual Payment Update program or the Value-Based Payment program; 5) the methodology that is used to calculate hospital performance scores; and 6) the methodology for validating hospital performance. [Page 99]	[Page 655]
	• Linking Payment to Quality Outcomes in the Medicare Program, Hospital Value-Based Purchasing: Three-year demonstration projects would be established to test value-based purchasing models tailored towards critical access hospitals and small hospitals that otherwise would not qualify to participate in the Value-Based Purchasing program. [Page 100]	[Page 663]
	• Linking Payment to Quality Outcomes in the Medicare Program, Hospital Value-Based Purchasing: Individual hospital performance on each specific quality measure established by the Secretary for purposes of the Hospital Value-Based Purchasing Program in Medicare, on each condition or procedure, and on total performance will be publicly reported. [Page 99]	[Page 654]

	• Linking Payment to Quality Outcomes in the Medicare Program, Reducing Hospital Acquired Conditions: Applies a new payment adjustment to hospitals ranked in the top quartile of national risk-adjusted hospital acquired condition rates. CMS would calculate national and hospital-specific data on the hospital acquired condition rates of Medicare participating subsection (d) hospitals and for hospitals paid under 1814(b)(3) of the Social Security Act (regarding Medicare reimbursement for hospitals) for select conditions. Starting in 2013, the Secretary would share these data with hospitals and the data would be publicly reported on the *Hospital Compare Website*. Starting on October 1, 2014, hospitals in the top quartile of national hospital acquired condition rates would receive 99 percent of their otherwise applicable Medicare payments. **[Page 106]**	**[Page 706]**
	• Linking Payment to Quality Outcomes in the Medicare Program: CMS would be required to develop a plan to integrate the Physician Quality Reporting Initiative program with the standards for meaningful use of certified electronic health records created in American Recovery and Reinvestment Act of 2009. **[Page 98]**	**[Page 675]**
	• Linking Payment to Quality Outcomes in the Medicare Program, Value-Based Modifier for Physician Payment Formula: The Secretary would be required to apply a separate, budget-neutral payment modifier to the fee-for-service physician payment formula. The modifier will, in a budget-neutral manner, pay physicians or groups of physicians differently based upon the relative quality of care they achieve for Medicare beneficiaries relative to cost. Quality shall be based upon a composite of appropriate, risk-based measures of quality that reflect the health outcomes and health status of Medicare beneficiaries served by physicians or groups of physicians. **[Page 103]**	**[Page 699]**
	• Linking Payment to Quality Outcomes in the Medicare Program, Medicare Home Health Agency and Skilled Nursing Facility Value-Based Purchasing Implementation Plans: The Secretary must complete and submit to Congress Medicare value-based purchasing implementation plans for home health agencies and skilled nursing facilities by 2011 and 2012, respectively. Each plan would include consideration of the following issues: 1) the development, selection, and modification process of measures, to the extent feasible and practicable, of all dimensions of quality and efficiency relative to the quality measure development and endorsement procedures; 2) the reporting, collection, and validation of quality data; 3) a structure of proposed value-based payment adjustments, including recommendations on thresholds or improvements in quality that would substantiate a payment adjustment, the size of such payments, and the source of funding for value-based incentive payments; and 4) methods for publicly disclosing performance information on performance. In developing each plan. The Secretary must consult with relevant stakeholders and take into consideration experiences with demonstrations that are relevant to value-based purchasing in each setting. **[Page 105]**	**[Page 695]**
	• Encouraging Development of the New Patient Care Models, Accountable Care Organizations: The Medicare program would allow groups of providers who voluntarily meet certain statutory criteria, including quality measurements, to be recognized as Accountable Care Organization and be eligible to share in the cost-savings they achieve for the Medicare Program. Beginning on January 1, 2012, eligible Accountable Care Organizations would have the opportunity to qualify for an incentive bonus. **[Page 112]**	**[Page 748]**
	• Encouraging Development of the New Patient Care Models, Accountable Care Organizations: To qualify as an Accountable Care Organization, an organization would have to meet at least the following criteria: 1) agree to become accountable for the overall care of their Medicare fee-for-service beneficiaries; 2) agree to a minimum three-year participation; 3) have a formal legal structure that would allow the organization to receive and distribute bonuses to participating providers; 4) include the primary care physicians for at least 5,000 Medicare fee-for-service beneficiaries; 5) provide CMS with information regarding primary care and specialist physicians participating in the accountable care organization as the Secretary deems appropriate; 6) have arrangements in place with a core group of specialist physicians; 7) have in place a leadership and management structure, including with regard to clinical and administrative systems; 8) define processes to promote evidence-based medicine, report on quality and cost measures, and coordinate care, such as through the use of tele-health, remote patient monitoring, and other such enabling technologies; and 9) demonstrate to the Secretary that it meets patient-centeredness criteria determined by the Secretary, such as use of patient and caregiver assessments or the use of individualized care plans. **[Page 112]**	**[Page 750]**

	• Encouraging Development of the New Patient Care Models, Accountable Care Organizations: The Secretary would be authorized to incorporate reporting requirements and incentive payments and penalties related to the physician quality reporting initiative, electronic prescribing, electronic health records, and other similar initiatives into the reporting requirements for Accountable Care Organizations. **[Page 112]**	**[Page 752]**
	• Encouraging Development of the New Patient Care Models, Accountable Care Organizations: CMS would assign Medicare fee-for-service beneficiaries to Accountable Care Organizations based on their use of Medicare items and services in preceding periods. **[Page 112]**	**[Page 754]**
	• Encouraging Development of the New Patient Care Models, Accountable Care Organizations: Accountable Care Organizations with three-year average Medicare expenditures that are determined by CMS to be below their benchmark for the corresponding period would be eligible for shared savings at a rate determined appropriate by the Secretary. If the Secretary determines that an Accountable Care Organization has taken steps to avoid at-risk patients in order to reduce the likelihood of increasing costs, the Secretary would be authorized to impose an appropriate sanction, including terminating agreements with participating Accountable Care Organization. **[Page 112]**	**[Page 754]**
	• Medicare Advantage Payment, Bonus Payments: Establishes two new bonus payments for local and regional MA plans. These bonus payments would be available to all MA plans, beginning in 2014, regardless of plan type or service area. Unlike rebate payments, bonus payments would be available to plans that meet certain performance criteria and would not depend on benchmark rates. The first bonus payment is for care coordination and management activities that are conducted by MA plans. The second bonus payment is for prior year achievement or improvement in plan quality performance. **[Page 166]**	**[Page 972]**
	• Medicare Advantage Payment, Bonus Payments: The first bonus payment for MA plans is for care coordination and management activities that are conducted by MA plans. The second bonus payment is for prior year achievement or improvement in plan quality performance. **[Page 166]**	**[Page 972]**
	• Medicare Advantage Payment, Bonus Payments: Creates a new bonus payment for care coordination and management activities that are conducted by MA plans. Up to two percent of the U.S. Per Capital Costs of Medicare would be available to MA plans that demonstrate to the Secretary that they conduct activities in four to eight areas (half of one percent for each area). Creates a second bonus for prior year achievement or improvement in plan quality performance. Performance would be based on a ranking system that measures clinical quality and enrollee satisfaction or plan level as feasible. This provision will be stricken, however, if the Chief Actuary of CMS certifies that beneficiaries currently participating in MA would lose Medicare-covered benefits when these provisions are implemented. **[Pages 166-67]**	**[Page 976]**
	• Strengthening Primary Care and Other Workforce Improvements, Promoting Greater Flexibility for Residency Training Programs: Provides increased flexibility in laws and regulations governing graduate medical education funding in the Medicare program in order to promote training in outpatient settings and to ensure the availability of residency programs in rural and underserved areas. Specifically, effective for cost reporting periods beginning on or after July 1, 2010, all time spent by a resident would count toward Medicare direct graduate education payment, without regard to the setting where the activities are performed, if the hospital continues, or in the case of a jointly operated residency program, the involved entities continue to incur the costs of the stipends and the fringe benefits of the resident during the time the resident spends in the setting. **[Page 128]**	**[Page 828]**
	• Strengthening Primary Care and Other Workforce Improvements, Promoting Greater Flexibility for Residency Training Programs: Effective for discharges on or after July 1, 2010, all the time spent by a resident in patient care activities in a nonhospital setting would be counted towards Medicare indirect medical education payment if the hospital continues, or in the case of a jointly operating residency training program, the entities continue to incur the costs of the stipends and fringe benefits of the resident during the time spent in that setting. **[Page 128]**	**[Page 831]**

	• Strengthening Primary Care and Other Workforce Improvements, Rules for Counting Resident Time for Didactic and Scholarly Activities and Other Activities: When calculating direct graduate medical education payments, Medicare would count the time that residents in approved training programs spend in certain non-patient care activities in a nonhospital setting that is primarily engaged in furnishing patient care. Reimbursable non-patient care activities would include didactic conferences and seminars but would not include research that is not associated with the treatment or diagnosis of a particular patient. In addition, Medicare would count all the vacation, sick leave, and other appropriated leave spent by resident in an approved training program as long as the leave time does not extend the program's duration. **[Page 129]**	**[Page 834]**
	• Strengthening Primary Care and Other Workforce Improvements, Rules for Counting Resident Time for Didactic and Scholarly Activities and Other Activities: When calculating indirect medical education payments, Medicare would adopt the same rules about counting residents' leave time. Medicare would also include all the time spent by residents in approved training programs on certain non-patient care activities (including didactic conferences but not certain research) that occurs in an acute care hospital or in a provider-based hospital outpatient department. **[Page 129]**	**[Page 836]**
	• Strengthening Primary Care and Other Workforce Improvements, Preservation of Resident Cap Positions from Closed and Acquired Hospitals: The Secretary would promulgate regulations to establish a process where the residency allotments in a hospital with an approved medical residency program that closes could be used to increase the otherwise applicable residency limit for other hospitals. The increase in residency positions would be distributed in the following priority order: 1) hospitals located in the same or contiguous core-based statistical area as the hospital that closed; 2) to hospitals in the same state as the hospital that closed; 3) to hospitals located in the same region of the country of the hospital that closed; and 4) to be used only if the residents are not distributed under the other priorities, would be the priorities established for distribution of additional residency positions by the Mark. **[Page 130]**	**[Page 838]**
	• Strengthening Primary Care and Other Workforce Improvements, Teaching Health Centers: Seeks to increase training and improve access to primary care services. Qualified teaching health centers would be eligible for payments for direct graduate medical education expenses and other indirect expenses associated with operating approved graduate medical residency training programs. These programs will be in addition to existing Medicare-supported residency slots and must meet criteria for accreditation (as set forth by either the Accreditation Council for Graduate Medical Education or the American Osteopathic Association). The Secretary would determine the basis of payment and funding calculations for both the direct and indirect payments and would promulgate regulations under existing rulemaking requirements to establish this program. **[Page 134]**	**[Page 863]**
	• Strengthening Primary Care and Other Workforce Improvements, Advance Practice Nurse Training: Adds an appropriation of $50 million per year for 2012 through 2015 to establish a graduate nurse education demonstration program in Medicare. **[Page 135]**	**[Page 870]**
	• Linking Payment to Quality Outcomes in the Medicare Program, Physician Value-Based Purchasing: Improves the Physician Quality Reporting Initiative program by requiring CMS to make two additional enhancements to the program: 1) CMS would be required to provide timely feedback to eligible professionals on their performance with respect to satisfactorily submitting data on quality measures; 2) CMS would be required to establish an appeals process for providers who participate in the PQRI program but do not qualify for incentive payments during their performance period; and 3) CMS would be required to develop a plan to integrate the PQRI program with the standards for meaningful use of certified electronic health records created in the American Recovery and Reinvestment Act of 2009 (ARRA). **[p. 101-02]**	**[Page 676]**

	• CMS Innovation Center: Requires the Secretary to establish an Innovation Center within CMS, which is authorized to test, evaluate, and expand different payment structures and methodologies which aim to foster patient-centered care, improve quality, and slow the rate of Medicare cost growth. The CMS Innovation Center would be required to conduct an evaluation of each model tested, including an analysis of the extent to which the model results in: 1) coordination of health care services across treatment settings; 2) reduction of preventable hospitalizations; 3) prevention of hospital readmissions; 4) reduction of emergency room visits; 5) improvement in quality and health outcomes; 6) improvement in the efficiency of care; 7) reduction in the cost of health care services covered under this title; and 8) achievement of beneficiary and family-caregiver satisfaction. **[Page 113]**	**[Page 735]**
	• CMS Innovation Center: Exempts the CMS Innovation Center from budget-neutrality requirements for an initial testing period to facilitate the timely design, implementation, and evaluation of payment models. The Center would be given the authority to terminate or modify the design of models at any time during a testing period. **[Page 113]**	**[Page 742]**
	• CMS Innovation Center: In selecting models for testing, the Secretary shall also consider the extent to which models meet the following criteria: 1) fosters care coordination for high-cost, chronically ill Medicare beneficiaries who are at highest risk for hospitalization or readmission; 2) places the patient, including family members and other informal caregivers, at the center of the care team; 3) includes, but is not limited to, in-person contact with beneficiaries; 4) utilizes technology, such as electronic health records and patient-based remote monitoring systems, to coordinate care over time; 5) maintains a close relationship between care coordinators, primary care practitioners, specialist physicians, and other health care providers; and 6) relies on a team-based approach to interventions such as comprehensive care assessments, care planning, and self-management coaching. **[Page 116]**	**[Page 735]**
	• CMS Innovation Center: The scope of the program includes Medicare, Medicaid, and the Children's Health Insurance Program. **[Page 116]**	**[Page 746]**
	• CMS Innovation Center: Within 18 months of enactment, the CMS Innovation Center would be required to post on the CMS website a report on the Center's initial consideration of the models listed above, as well as a detailed plan for continuing work of the Center. **[Page 116]**	**[Page 743]**
	• CMS Innovation Center: Appropriates $10 billion from the Medicare Part A and Part B Trust Funds to the CMS Innovation Center over ten years. The costs of otherwise uncovered benefits delivered under this authority would be counted against the Center's overall funding level. In addition, the Center would be required to directly allocate a portion of such funding for the Center's evaluation activities. **[Page 116-17]**	**[Page 746]**
	• Transparency and Program Integrity, Nursing Home Background Checks: The Secretary would be required to establish a nationwide program for national background checks on direct patient access employees of certain long-term care facilities or providers and provide federal matching funds to states to conduct these activities. **[p. 217]**	**[Page 1313]**
	• Transparency and Program Integrity, Dementia and Prevention Training: Adds staff training requirements for skilled nursing facilities and nursing homes. The Secretary would revise initial nurse aide training, competency, and evaluation program requirements to include dementia management training and patient abuse prevention. If determined to be appropriate, the Secretary also may include dementia management training and patient abuse prevention in ongoing nurse aide training, competency, and evaluation program requirements. **[p. 217]**	**[Page 1311]**

C. **Investing in Research and Innovation**	• Patient-Centered Outcomes Research, Patient Centered Outcomes Research Act of 2009, Patient-Centered Outcome Research Institute: Authorizes the establishment of a private, non-profit corporation that would be known as the "Patient-Centered Outcomes Research Institute." The purpose of this Institute would be to assist patients, clinicians, purchasers and policy makers in making informed health decisions by advancing the quality and relevance of clinical evidence through research and evidence synthesis. The duties of the Institute would be to: 1) identify research priorities and establish a research agenda; 2) carry out the research project agenda; 3) study and report on the feasibility of conducting research in-house; 4) collect appropriate data from CMS; 5) appoint advisory panels; 6) support patient and consumer representatives; 7) establish a methodology committee; 8) provide for a peer-review process for primary research; 9) disseminate research findings; 10) adopt priorities, standards, processes and protocols; 11) coordinate research resources and build capacity for research; and 12) submit annual reports to Congress, the President, and the public. The Institute would also be charged with identifying national priorities for comparative clinical effectiveness research and establishing a research project agenda. **[Pages 192-94]**	**[Page 1131]**
	• Patient-Centered Outcomes Research, Patient Centered Outcomes Research Act of 2009, Patient-Centered Outcome Research Institute, Administration of the Institute: Establishes a Board of Governors for the Patient-Centered Outcomes Research Institute. The Board would be responsible for carrying out the duties of the Institute. The Board specifically would be prohibited from delegating the following duties to staff: 1) approving and monitoring disbursements from the Patient-Centered Outcomes Research Trust Fund; 2) identifying research priorities; and 3) adopting priorities, methodological standards, peer review processes, dissemination protocols. **[Page 193]**	**[Page 1157]**
	• Patient-Centered Outcomes Research, Patient Centered Outcomes Research Act of 2009, Patient-Centered Outcome Research Institute, Research of the Institute: Charges the Patient-Centered Outcomes Research Institute with identifying national priorities for comparative clinical effectiveness research and establishing a research project agenda. The Institute would consider the need for a systematic review of existing research before providing for the conduct of new research. In setting priorities, the Institute would consider the following: 1) disease incidence and prevalence in the United States; 2) evidence gaps, in terms of clinical outcomes; 3) practice variations; 4) the potential for new evidence to improve health and quality of care; 5) expenditures associated with a health care treatment strategy or health condition; 6) patient needs, outcomes, and preferences, including quality of life; and 7) relevance to assisting patients and clinicians in making informed health decisions. **[Page 194]**	**[Page 1132]**
	• Patient-Centered Outcomes Research, Patient Centered Outcomes Research Act of 2009, Patient-Centered Outcome Research Institute, Institute Contracts: Allows the Patient-Centered Outcomes Research Institute to enter into contracts with federal agencies as well as with appropriate private sector research or study-conducting entities for the management and conduct of research in accordance with the research agenda. To contract with federal agencies, such as the Agency for Healthcare Research and Quality, the contracts would have to be authorized under the agencies' governing statutes. Private contractors would be required to have experience in conducting comparative clinical effectiveness research. Both public and private entities would be required to have demonstrated experience and capacity to achieve the goals of comparative effectiveness research. Each entity under contract with the Institute would be required to: 1) abide by the same transparency and conflicts of interest requirements that apply to the Institute with respect to the management or conduct of research; 2) comply with the methodological standards adopted by the Board of Governors; 3) take into consideration public comments, provided for and transmitted by the Institute, on individual study designs before the finalization of such designs, and submit responses to such comments to the Institute which the Institute would publish with the comments and the finalized study design before the conduct of research; 4) consult with the rare disease advisory panel for the relevant study as appropriate; and 5) allow for a researcher(s) under contract to publish their findings so long as any research published is consistent with products disseminated by the Institute. Research entities under contract that do not meet the publishing requirements set by the Institute would not be allowed to enter into another contract with the Institute for a period of not less than five years. **[Page 195]**	**[Page 1135]**

	• Patient-Centered Outcomes Research, Patient Centered Outcomes Research Act of 2009, Patient-Centered Outcome Research Institute, Advisory Panels: Requires the Patient-Centered Outcomes Research Institute, as appropriate, to appoint expert advisory panels to assist in identifying research priorities and establishing the research project agenda. These panels would advise the Institute to ensure that information produced from the research is clinically relevant to decisions made by clinicians and patients at the point of care. **[Page 196]**	**[Page 1141]**
	• Patient-Centered Outcomes Research, Patient Centered Outcomes Research Act of 2009, Patient-Centered Outcome Research Institute, Methodology Committee: Establishes a standing methodology committee to serve the Patient-Centered Outcomes Research Institute. The committee would have responsibility for developing and improving the science and methods of comparative effectiveness research. It would consist of no more than 17 members, appointed by the Comptroller General. Members of the methodology committee would be experts in their scientific field, such as health services, clinical, and comparative effectiveness research, biostatistics, genomics, and research methodology. Stakeholders with such expertise could be appointed to the methodology committee. **[Page 197]**	**[Page 1144]**
	• Patient-Centered Outcomes Research, Patient Centered Outcomes Research Act of 2009, Patient-Centered Outcome Research Institute, Dissemination of Information: Requires the Patient-Centered Outcomes Research Institute to disseminate the findings of research to clinicians, patients, and the public in a comprehensible manner and form so that they are useful to providers and patients in making health care decisions. **[Page 198]**	**[Page 1151]**
	• Patient-Centered Outcomes Research, Patient Centered Outcomes Research Act of 2009, Patient-Centered Outcome Research Institute, Oversight: Requires the Patient-Centered Outcomes Research Institute to submit an annual report to Congress, the President, and the public. Establishes financial and governmental oversight of the Institute. The Institute would be required to undergo annual financial audits conducted by a private entity and the Comptroller General would also review the results and submit a report to Congress. The Comptroller General would have additional oversight responsibilities with respect to the Institute. **[Page 198]**	**[Page 1164]**
	• Patient-Centered Outcomes Research, Patient Centered Outcomes Research Act of 2009, Institute Transparency and Access: Directs the Patient-Centered Outcomes Research Institute to establish procedures to ensure transparency, credibility, and access through public comment periods, forums, public availability of information, and protocols for conflicts of interest. **[Page 199]**	**[Page 1167]**
	• Patient-Centered Outcomes Research, Patient Centered Outcomes Research Act of 2009, Conflicts of Interest: Directs the Comptroller General to consider and disclose any conflicts of interest of potential appointees to the Board of Governors of the Patient-Centered Outcomes Institute. **[Page 199]**	**[Page 1171]**
	• Patient-Centered Outcomes Research, Patient Centered Outcomes Research Act of 2009, Patient-Centered Outcome Research Institute, Use of Institute Findings: Establishes several limitations around the use of the Patient-Centered Outcomes Research Institute's comparative effectiveness research findings, specifically: 1) the Institute would not mandate coverage, reimbursement, or other policies for any public or private payer; 2) the Secretary would be prohibited from denying coverage based solely on a study conducted by the Institute; and 3) the Secretary would be prohibited from using the Institute's research in determining coverage, or creating reimbursement or incentive programs, for a treatment in ways that treat extending the life of an elderly, disabled, or terminally ill patient of lower value than extending the life of a person who is younger, non-disabled, or not terminally ill. **[Page 200]**	**[Page 1173]**
	• Patient-Centered Outcomes Research, Patient Centered Outcomes Research Act of 2009, Patient-Centered Outcomes Research Trust Fund: Creates a new trust fund, called the Patient-Centered Outcomes Research Trust Fund in the U.S. Treasury to fund the Patient-Centered Outcomes Research Institute and its activities. Monies would be directed to this fund from the general fund of the Treasury as well as the Medicare Trust Funds. The Secretary of Health and Humans Services would be the trustee of the Patient-Centered Outcomes Research Trust Fund. Additionally, $10 million from funds appropriated to the Secretary under title VIII of Division A of ARRA would be transferred to the Patient-Centered Outcomes Research Trust Fund. **[Page 201]**	**[Page 1179]**

	• Patient-Centered Outcomes Research, Patient Centered Outcomes Research Act of 2009, Coordination with the Federal Coordinating Council: Amends ARRA by: 1) adding a duty that the Federal Coordinating Council provide support to the Patient-Centered Outcomes Research Institute; 2) requiring the FCC to include an inventory of its activities with respect to comparative effectiveness research conducted by relevant federal departments and agencies in the FCC's annual report; and 3) requiring the FCC to coordinate its duties with the Institute. **[Page 202]**	**[Page 1192]**
	• Patient-Centered Outcomes Research, Patient Centered Outcomes Research Act of 2009, NCD Study: Requires the Comptroller General to submit a report to Congress within 18 months after the date of enactment on the process for making national coverage determinations under the Medicare program. The report would include a determination of whether the Secretary has complied with applicable law and regulations, including requirements for consultation with outside experts, providing appropriate public notice and comment opportunities, and making appropriate information and data available to the public and to non-voting members of advisory committees. **[Page 202]**	**[Page 1193]**
D. Data Collection and Reporting, Privacy, and Security	• Information Provided to the Exchange: All personal information submitted to the state exchange can only be used for purposes of providing insurance coverage through the state exchange, eligibility for and determination of the amount of the health care tax credit, or other administrative functions related to the efficient operation of the state exchange. Appropriate penalties will apply to the use of fraudulent information or stolen identity information in the state exchange. Such a penalty would apply to individuals accessing the exchange as well as at the exchange and federal entity level. The penalty may also include a penalty applicable to someone who applies on behalf of an individual and suppose false information or documentation. **[Pages 27-28]**	**[Page 113]**
E. System Performance	• Strengthening the Quality Infrastructure, Interagency Group on Health Care Quality: The President would convene a working group consisting of relevant federal departments and agencies that would collaborate and consult on fulfilling the national quality improvement strategy and priorities. **[Page 108]**	**[Page 714]**
10. Paying for Health Reform		
A. General Approach to Financing	• State Exchanges and Marketing Requirements, Funding for the Operation of Exchanges: The state exchanges would receive initial federal funding but then would be self-sustaining in future years. **[Page 21]**	**[Page 98]**
	• Creation of Health Care Cooperatives: Authorizes $6 billion in funding the CO-OP program to foster the creation of non-profit, member-run health insurance companies that serve individuals in one or more states. Federal funds would be distributed as loans and grants to assist start-up costs and meet state solvency requirements, respectively. **[Page 44]**	**[Page 244]**
	• Medicaid Improvement Fund: Rescinds funds available to the Medicaid Improvement Fund for fiscal years 2014 through 2018 (which total $700 million). **[Page 54]**	**[Page 290]**
	• Transforming the Health Care Delivery System, Linking Payment to Quality Outcomes in the Medicare Program, Hospital Value-Based Purchasing: Funding for value-based incentive payments for qualifying acute care hospitals would be generated through reducing Medicare inpatient prospective payment system payments to the hospitals. The reductions would be used to fund an incentive pool and would be phased-in as follows: 1.0 percent in 2013; 1.25 percent in 2014; 1.5 percent in 2015; 1.75 percent in 2016; and 2.0 percent in 2017 and beyond. Inpatient prospective payment system add-on payments such as disproportionate share hospital payments, indirect medical education payments for teaching hospitals, low-volume add-on payments and outlier payments would not be impacted by the payment reductions. **[Page 98]**	**[Page 639]**
	• Medicare Improvement Fund: Eliminates the funding in the Medicare Improvement Fund. Under current law, $22.29 billion is available for services furnished during 2014. **[Page 142]**	**[Page 898]**

	• Revenue Items, Annual Fee on Manufacturers and Importers of Branded Drugs: Imposes a fee on any person that manufactures or imports prescription drugs for sale in the United States. Fees collected would be credited to the Medicare Supplementary Medical Insurance trust fund. The aggregate fee on the sector would be $2.3 billion payable annually beginning in 2010. The aggregate fee would be apportioned among the covered entities each year based on each entity's relative market share of covered domestic sales for the prior year. Requires that the fee be paid on an annual basis. The fees assessed would not be deductible for U.S. income tax purposes. **[Page 250]**	**[Page 1450]**
	• Revenue Items, Annual Fee on Manufacturers and Importers of Medical Devices: Imposes a fee on any person that manufactures or imports medical devices offered for sale in the United States. The aggregate fee on the sector would be $4 billion payable annually beginning in 2010. The aggregate fee would be apportioned among the covered entities each year based on each entity's relative market share of covered domestic sales for the prior year. Requires that the fee be paid on an annual basis. The fees assessed would not be deductible for U.S. income tax purposes. **[Pages 251-52]**	**[Page 1459]**
	• Revenue Items, Annual Fee on Health Insurance Providers: An annual fee applies to any U.S. health insurance provider with respect to health insurance. A U.S. health insurance provider includes any company subject to federal income tax as an insurance company under Part I or Part II of Subchapter L of the Internal Revenue Code, as well as any organization exempt from federal income tax under Section 501(a) of the Code that provides insurance. In addition, a U.S. health insurance provider includes: 1) any insurer that sells employer-sponsored group health care coverage to employees that are either U.S. citizens or are employed in the United States; and 2) any insurer that sells health care insurance to individuals or groups of individuals (whether or not U.S. citizens) in the United States. A federal, state, or other governmental entity is not a U.S. health insurance provider. However, a company or organization that underwrites policies for government-funded insurance is a U.S. health insurance provider. An employer that self-insures its employees' health risks is not considered a U.S. health insurance provider. **[Pages 252-53]**	**[Page 1464]**
B. Pay or Play	• Employer-Provided Health Insurance Coverage: All employers with more than 50 employees that do not offer coverage would be required to pay a fee for each employee who receives a tax credit for health insurance through a state exchange. **[Pages 38]**	**[Page 220]**
C. Keeping Health Care Affordable	• Revenue Items, Failsafe: Beginning in 2012, the Director of the White House Office of Management and Budget would certify annually in the President's Budget that the provisions in this bill will not increase the budget deficit in the coming year. In the event the Office of Management and Budget Director determines that the provisions in this bill will increase the deficit, he or she would be required to notify Congress, and the aggregate amount of exchange subsidies provided would automatically be adjusted commensurate with the deficit increase. **[Pages 259]**	**[Page 179]**

D. Changes to Tax Code	• Revenue Items, Excise Tax on High Cost Insurance: Imposes an excise tax on insurers if the aggregate value of employer-sponsored health coverage for an employee exceeds a threshold amount. The tax is equal to 40 percent of the aggregate value that exceeds a threshold amount. The threshold amount is $8,000 for individual coverage and $21,000 for family coverage for 2013. The threshold amounts are indexed to the consumer price index for urban consumers as determined by the Department of Labor beginning in 2014 plus one percent. The excise tax is imposed pro rata on the issuers of the insurance. In the case of a self-insured group health plan, a health flexible spending account, a health reimbursement arrangement, the excise tax is paid by the plan administrator. Where the employer acts as plan administrator to a self-insured group health plan, a health flexible spending account, or a health reimbursement arrangement and with respect to employer contributions to a health savings account, the excise tax is paid by the employer. In determining the amount by which the value of employer sponsored health insurance coverage exceeds the threshold amount, the aggregate value of all employer-sponsored health insurance coverage is taken into account, including coverage in the form of reimbursements under a health flexible spending account or an health reimbursement arrangement, employer contributions to a health savings account, and coverage for dental, vision, and other supplementary health insurance coverage. This amount subject to the high-premium excise tax does not include fixed indemnity health coverage that is purchased by the employee with after-tax dollars. Employer-sponsored health insurance coverage is health coverage offered by an employer to an employee without regard to whether the employer pays for the coverage (and thus the coverage is excludible from the employee's gross income) or the employee pays for the coverage with after-tax dollars. In the case of a self-employed individual, employer-sponsored health insurance coverage is coverage for any portion of which the self-employed individual claims a deduction under section 162(l) of the Internal Revenue Code. **[Page 235]**	**[Page 1420]**
	• Revenue Items, Excise Tax on High Cost Insurance, Penalty for Under Reporting Liability for Tax to Insurers: If the employer reports to insurers and plan administrators (and the Internal Revenue Service) a lower amount of insurance cost subject to the excise tax than required, the employer is subject to a penalty equal to any additional excise tax that each such insurer and administrator would have owed if the employer had reported correctly, increased for interest from the date that the tax was otherwise due to the date paid by the employer. This may occur, for example, if the employer undervalues the aggregate premium and thereby lowers the amount subject to the excise tax for all insurers and plan administrators (including the employer when acting as plan administrator of a self-insured plan). This penalty may be waived if the employer can show that the failure is due to reasonable cause and not to willful neglect. The penalty is in addition to the amount of excise tax owed, which may not be waived. **[Page 237]**	**[Page 1430]**
	• Revenue Items, Excise Tax on High Cost Insurance, Certain Transition Relief and Other Rules: Under a transition rule for health insurance plans maintained in the 17 states in which health care was least affordable for the year ended December 31, 2012, as determined by the Secretary, the threshold amount is initially increased by 20 percent. The Secretary shall determine the 17 highest cost states based on data available for 2012. The transition rule applies with respect to coverage of a specific individual based on the individual's residence on the first day of a coverage period beginning during the transition period. The initial 20 percent increase is reduced by half each year thereafter (e.g., to ten percent for the first taxable year beginning after December 31, 2013 and to five percent for the first taxable year beginning after December 31, 2014) until the additional premium amount is eliminated entirely for taxable years beginning after December 31, 2015. The Secretary shall determine the 17 highest cost states based on data available for 2012. The transition rule applies on an individual basis with respect to coverage of a specific individual based on the individual's residence on the first day of a coverage period beginning during the transition period. **[Page 237]**	**[Page 1424]**
	• Revenue Items, Excise Tax on High Cost Insurance, Certain Transition Relief and Other Rules: For retired individuals over the age of 55, the threshold amount is increased by $1,850 for individual coverage and $5,000 for family coverage. The additional amounts are indexed to the consumer price index for urban consumers, as determined by the Department of Labor beginning in 2014, plus one percent. **[Page 237]**	**[Page 1422]**

	• Revenue Items, Excise Tax on High Cost Insurance, Certain Transition Relief and Other Rules: For plans that cover employees engaged in high risk professions, the threshold amount is increased by $1,850 for individual coverage and $5,000 for family coverage. The additional amounts are indexed to the consumer price index for urban consumers, as determined by the Department of Labor beginning in 2014, plus one percent. 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, and individuals engaged in the construction, mining, agriculture (but not food processing), forestry or fishing industries. **[Page 237]**	**[Page 1422]**
	• Revenue Items, Excise Tax on High Cost Insurance, Certain Transition Relief and Other Rules: Under this provision, an individual's threshold cannot be increased by more than $1,850 for individual coverage or $5,000 for family coverage, even if the individual would qualify for an increased threshold both on account of his or her status as a retiree over age 55 and as a participant in a plan that covers employees in a high risk profession. Provides that the amount of the excise tax imposed is not deductible for federal income tax purposes. **[Page 238]**	**[Page 1422]**
	• Revenue Items, Employer Health Insurance Reporting: An employer would be required to disclose the value of the benefit provided by the employer for each employee's health insurance coverage on the employee's annual Form W-2. To the extent that the employee receives health insurance coverage under multiple plans, the employer would disclose the aggregate value of all such health coverage (excluding the value of a health flexible spending arrangement). For example, an employee receiving health insurance coverage under a major medical plan, a dental plan, and a vision plan would only be required to report the total value of the combination of all of these health related insurance policies. For this purpose, employers would generally use the same value for all similarly situated employees receiving the same category of coverage (such as single or family health insurance coverage). **[Page 238]**	**[Page 1435]**
	• Revenue Items, Employer Health Insurance Reporting: The method of determining the value of employer-provided health insurance coverage would be to use the same calculation as is currently used in determining the employer-provided portion of the applicable premiums for the taxable year for the employee determined under the rules for Consolidated Omnibus Budget Reconciliation Act (COBRA) continuation coverage under Section 4980B(f)(4) of the Internal Revenue Code (and accompanying Treasury regulations), including the special rule for self-insured plans. If the plan provides for the same COBRA continuation coverage premium for both individual coverage and family coverage, the plan would be required to calculate separate individual and family premiums for this purpose. **[Pages 238-39]**	**[Page 1429]**
	• Revenue Items, Modify the Definition of Qualified Medical Expenses: With respect to medicine, the definition of medical expense for purposes of employer provided health coverage (including health reimbursement arrangements and health flexible spending accounts), health savings accounts, and Archer medical savings accounts), generally is conformed to the definition for purposes of the itemized deduction for medical expenses. However, this change does not apply to doctor prescribed over-the-counter medicine. Thus, under the provision, the cost of over-the-counter medicine (other than doctor prescribed) may not be reimbursed through a health flexible spending account or health reimbursement arrangement. In addition, the cost of over-the-counter medicines (other than doctor prescribed) may not be reimbursed on a tax-free basis through a health savings account or Archer medical savings account. **[Page 240]**	**[Page 1436]**
	• Revenue Items, Health Savings Accounts: The additional tax on distributions from a health savings account that are not used for qualified medical expenses is increased to 20 percent of the disbursed amount. **[Page 242]**	**[Page 1438]**
	• Revenue Items, Limiting Flexible Spending Arrangements Under Cafeteria Plans: Salary reductions by an employee for a taxable year for purposes of coverage under a health flexible spending account under a cafeteria plan are limited to $2,500. Thus, when an employee is given the option to reduce his or her current cash compensation and instead have the amount of the salary reduction made available for use in reimbursing the employee for his or her medical expenses, the amount of the reduction in cash compensation is limited to $2,500 for a taxable year. The exclusion for health coverage offered through a health reimbursement arrangement is not limited. **[Page 244]**	**[Page 1438]**

	• Employer-Provided Health Insurance Coverage: If an employee is offered health insurance coverage by his or her employer and chooses to enroll in the coverage, the exclusion from gross income would apply to the employer provided portion of the coverage. The tax treatment would be the same whether the employer offers coverage outside of a state exchange or the employer offers a coverage option through a state exchange. **[Page 37]**	**[Page 1427]**
	• Revenue Items, Corporate Information Reporting: Modifies the general information reporting requirement by eliminating the exception for payments to corporations. The class of payments with respect to which reporting is required would be clarified to include gross proceeds for both property and services. The present regulatory exception for payments to exempt or governmental organizations, international organizations and retirement plans is not affected by this provision. In addition, the Secretary would be authorized to promulgate regulations necessary to avoid duplicative information reporting. **[Page 245]**	**[Page 1439]**
	• Revenue Items, Requirements for Section 501(c)(3) Hospitals: Imposes additional requirements applicable to Section 501(c)(3) hospitals. First, each hospital facility would be required to conduct a community health needs assessment at least once every three years and adopt an implementation strategy to meet the community needs identified through such assessment. Second, each hospital facility would be required to adopt, implement, and widely publicize a written financial assistance policy. Third, each hospital facility would be required to bill patients who qualify for financial assistance no more than the amount generally billed to insured patients. Finally, a hospital facility (or its affiliates) generally would be required to follow current Medicare law and regulations regarding collection of debts, but may not undertake certain extraordinary collection actions (even if otherwise permitted by law) against a patient without first making reasonable attempts to inform the patient about the hospital's financial assistance policy. **[Pages 248-49]**	**[Page 1440]**
	• Revenue Items, Requirements for Section 501(c)(3) Hospitals, Reporting and Disclosure Requirements: Includes new reporting and disclosure requirements. The Internal Revenue Service would be required to review information about a hospital's community benefit activities (currently reported on Form 990, Schedule H) at least once every three years. Such review is intended to be similar to review of companies registered with the Securities and Exchange Commission. Requires each organization to which the Mark applies to make its audited financial statements widely available. If an organization or facility is included in consolidated financial statements, the consolidated entity's audited financial statements must also be widely available. Requires the Secretary of the Treasury and the Secretary to annually report to Congress the levels of charity care, bad debt expenses, unreimbursed costs of means-tested government programs, and unreimbursed costs of non- means tested government programs incurred by private tax-exempt, taxable, and governmental hospitals as well as the cost of community benefit activities incurred by private tax-exempt hospitals. In addition, the Secretary of the Treasury, in conjunction with the Secretary, must conduct a study of the trends in these amounts with to the results of the study provided to Congress five years from date of enactment. **[Pages 249-50]**	**[Page 1446]**
	• Revenue Items, Repeal Business Deduction for Federal Subsidies for Certain Retiree Prescription Drug Plans: Eliminates the rule that the exclusion for subsidy payments is not taken into account for purposes of determining whether a deduction is allowable with respect to retiree prescription drug expenses. Thus, the amount otherwise allowable as a deduction for retiree prescription drug expenses is reduced by the amount of the excludible subsidy payments received. **[Page 257]**	**[Page 1469]**
	• Revenue Items, Modify the Itemized Deduction for Medical Expenses: Increases the threshold for the deduction from 7.5 percent of adjusted gross income to ten percent of adjusted gross income 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 if their medical expenses exceed 7.5 percent of adjusted gross income. The proposal does not change the alternative minimum tax treatment of the itemized deduction for medical expenses. **[Page 257]**	**[Page 1469]**
	• Revenue Items, Credit to Encourage New Therapies: Modeled after existing tax credits for investments in qualifying advanced energy projects (Internal Revenue Code Section 48C), creates a temporary credit subject to an overall cap of $1 billion to encourage investments in new therapies to prevent, diagnose, and treat acute and chronic diseases. **[Page 258]**	**[Page 1485]**

	• Revenue Items, Executive Compensation: Creates a special rule under Section 162(m) of the Internal Revenue Code regarding the deductibility of excessive remuneration (including deferred deduction remuneration) by an insurance provider, 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 in the Mark ("covered health insurance provider"). As under Section 162(m)(5) of the Code, the exceptions under Section 162(m)(4) of the Code for performance based remuneration, commissions, or remuneration under existing binding contracts do not apply. Employers with self-insured plans are excluded from the definition of covered health insurance provider. **[Page 259]**	**[Page 1470]**