Calendar No. _____

111TH CONGRESS
1st Session

SENATE

REPORT
111-

AMERICA'S HEALTHY FUTURE ACT OF 2009

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OCTOBER 19, 2009.--Ordered to be printed

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Mr. Baucus, from the Committee on Finance,
submitted the following

R E P O R T

together with

ADDITIONAL AND MINORITY VIEWS

[To accompany ???]

[Including cost estimate of the Congressional Budget Office]

The Committee on Finance, having considered an original bill, S. ___, to provide affordable, quality health care for all Americans and reduce the growth in health care spending, and for other purposes, reports favorably thereon and recommends that the bill do pass.

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I. BACKGROUND AND NEED FOR LEGISLATION

The U.S. health system is in crisis. In 2008, over 46 million Americans were uninsured and millions more have lost their health coverage as a result of the recent economic downturn. Another 25 million people are underinsured, with coverage that is insufficient to protect against the cost of a major illness. The rising cost of health care outpaces wages by a factor of five to one, placing an ever greater strain on family, business, and government budgets.

Improving the health system is one of the most important challenges we face as a nation, and the inability to achieve comprehensive health reform will undermine any efforts to secure a full and lasting economic recovery. Health reform is an essential part of restoring America's overall economy and maintaining our global competitiveness.

Health care reform is also necessary to protect the finances of working families. Between 2000 and 2009, average family premiums for employer-sponsored health coverage increased by 93 percent – increasing from $6,772 to $13,073 – while wages increased by only 19 percent in the same period. Rising health care costs and mounting medical debt account for half of all filed bankruptcies – affecting two million people a year.

Countless studies have shown that those without health coverage generally experience worse health outcomes and poorer health compared to those who are insured. The uninsured are less likely to receive preventive care or even care for traumatic injuries, heart attacks, and chronic diseases. As a result, 23 percent forgo necessary care every year due to cost, while 22,000 uninsured adults die prematurely each year as a result of lacking access to care.

A majority of the uninsured has low or moderate incomes – with two-thirds in families with an annual income less than twice the Federal poverty level (FPL). Eight in ten of the uninsured are in working families in which workers are either not offered coverage by their employer or they do not qualify for employer-offered coverage.

Hospitals and clinics provide an estimated $56 billion annually in uncompensated care to people without health insurance, and those with health coverage pay the bill through higher health care costs and increased premiums. This so-called "hidden health tax" cost the average family over $1,000 in high premiums last year. An estimated ten percent of health care premiums in California are attributable to cost shifting due to the uninsured.

Rising health costs have taken a toll on U.S. businesses as well. An estimated 159 million Americans receive health benefits through an employer, with the average cost of this coverage reaching $4,824 for single coverage and $13,375 for family coverage in 2009. Over the last decade, employer-sponsored coverage has increased by 131 percent, forcing employers – particularly small employers – to make difficult choices among painful options to offset increasing health costs. These choices include raising workers' premiums, limiting raises or reducing bonus pay, eliminating family health benefits, or providing less-than-comprehensive health coverage.

Federal and state governments have also struggled with health care costs. The Congressional Budget Office has noted that rising health care costs represent the "single most important factor influencing the Federal Government's long-term fiscal balance." The U.S. spends more than 16 percent of our gross domestic product (GDP) on health care – a much greater share than other industrialized nations with high-quality systems and coverage for everyone. By 2017, health care expenditures are expected to consume nearly 20 percent of the GDP, or $4.3 trillion annually. Spending for Medicare and Medicaid, due to many of the same factors found in the private sector, is projected to increase by 114 percent in ten years. Over the same period, the GDP will grow by just 64 percent.

Despite high levels of spending on health care, a recent study by the Institute of Medicine concludes that the current health system is not making progress toward improving quality or containing costs for patients or providers. Research documenting poor quality of care received by patients in the U.S. is shocking. A 2003 RAND Corporation study found that adults received recommended care for many illnesses only 55 percent of the time. Needed care for diabetes was delivered only 45 percent of the time and for pneumonia 39 percent of the time. Patients with breast cancer fared better, but still did not receive recommended care one-quarter of the time.

Compared to other industrialized countries, our quality of care does not reflect the level of our investment. The U.S. ranks last out of 19 industrialized countries in unnecessary deaths and 29th out of 37 countries for infant mortality – tied with Slovakia and Poland, and below Cuba and Hungary. Our rate of infant mortality is double that of France and Germany.

In short, Americans are not getting their money's worth when patients receive services of little or no value – such as hospitalizations that could have been prevented with appropriate outpatient treatment, duplicate tests, or ineffective tests and treatments. Yet the current system does little to steer providers toward the right choices. Even though more care does not necessarily mean better care, Medicare and most other insurers continue to pay for more visits, tests, imaging services, and procedures, regardless of whether the treatment is effective or necessary, and pay even more when treatment results in subsequent injury or illness.

Providers are not consistently encouraged to coordinate patients' care or to supply preventive and primary care services, even though such actions can improve quality of care and reduce costs. Rewarding providers that furnish better quality care, coordinate care, and use resources more judiciously could reduce costs and, most importantly, better meet the health care needs of millions more American patients.

Each of the key challenges facing our health care system — lack of access to care, the cost of care, and the need for better-quality care — must be addressed together in a comprehensive approach. Covering millions of uninsured through a broken health system is fiscally unsustainable. Attempting to address the inefficiencies plaguing our system and the perverse incentives in the delivery system without covering the uninsured will not alleviate the burden of uncompensated care and cost shifting. The time for incremental improvements has passed; health care reform must be comprehensive in scope.

It is in this context that the Finance Committee developed the legislative proposal that would become the "America's Healthy Future Act." The legislation approved by the Finance Committee addresses the challenges facing our health care system by expanding health coverage to 29 million Americans, improving quality of care and transforming the health care delivery system, and reducing Federal health spending and the Federal deficit over the ten year budget window and in the long run.

As a general principle, the bill allows those who like their health insurance to keep what they have today. For the millions of Americans who don't have employer-sponsored coverage, cannot afford to purchase coverage on their own, or who are denied coverage by health insurance companies due to a pre-existing condition, the Chairman's Mark reforms the individual and small-group markets, making health coverage affordable and accessible. These market reforms would require insurance companies to issue coverage to all individuals regardless of health status, prohibit insurers from limiting coverage based on pre-existing conditions and allow only limited variation in premium rates.

The Mark would make purchasing health insurance coverage easier and more understandable by creating state-based web portals, or "exchanges" that would direct consumers to all available health plan options. The exchanges would offer standardized health insurance enrollment applications, a standard format companies would use to present their insurance plans, and standardized marketing materials. Small businesses would have access to state-based Small Business Health Options Program (SHOP) exchanges. These exchanges – like the individual market exchanges – would be web portals that make comparing and purchasing health care coverage easier for small businesses.

The Mark standardizes benefits to force insurance companies to compete on price and quality and not their ability to select the healthiest individuals and ensures that every policy offered in tbe individual and small group market provides meaningful coverage for essential services. Those age 25 or under will also have access to an affordable young invincible plan that would provide catastrophic coverage and first dollar coverage for prevention. Plans would not be allowed to set lifetime or annual coverage limits.

The Chairman's Mark would standardize Medicaid eligibility for all parents, children, pregnant women and childless adults with incomes at or below $30,000 a year for a family of four ($14,400 for an individual), beginning in 2014. Individuals between 100 percent of FPL and 133 percent of FPL would be given the choice of enrolling in either Medicaid or in a private health insurance plan offered through a health insurance exchange. The federal government would provide significant additional funding to states to cover the cost of providing services to newly eligible Medicaid beneficiaries.

To ensure that health coverage is affordable, the Mark would provide an advanceable, refundable tax credit for low and middle-income individuals (between 100-400 percent of FPL) to help offset the cost of private health insurance premiums. Undocumented immigrants are prohibited from benefiting from the credit. A cost-sharing subsidy would be provided to limit the amount of out-of-pocket costs that individuals and families between 100-200 percent of FPL have to pay.

The cost-sharing subsidy would be designed to buyout any difference in cost sharing between the insurance purchased and a higher actuarial value plan.

A tax credit would also be available to small businesses. In 2011 and 2012, eligible employers can receive a small business credit for up to 35 percent of their contribution. Once the exchanges are up and running in 2013, qualified small employers purchasing insurance through the exchange can receive a tax credit for two years that covers up to 50 percent of the employer's contribution. Small businesses with 10 or fewer employees and with average taxable wages of $20,000 or less will be able to claim the full credit amount. The credit phases out for businesses with more than 10 employees and average taxable wages over $20,000, with a complete phase-out at 25 employees or average taxable wages of $40,000. Non-profit organizations with 25 or fewer employees would also be eligible to receive tax credits if they meet the same requirements. These organizations would be eligible for a 25 percent credit from 2011-2013 and a 35 percent credit in 2013 and thereafter.

The Mark creates authority for the formation of the Consumer Owned and Oriented Plans (CO-OPs). These plans can operate at the state, regional or national level to serve as non-profit, member-run health plans to compete in the reformed non-group and small group markets. These plans will offer consumer-focused alternatives to existing insurance plans. Six billion dollars in federal seed money would be provided for start-up costs and to meet state solvency requirements.

To ensure the insurance market reforms function properly, the Mark would create a personal responsibility requirement for health care coverage, with exceptions provided for religious conscience (as defined in Medicare) and undocumented individuals. Those who fail to meet the requirement are subject to a penalty. Appropriate exemptions are made from the penalty.

The Chairman's Mark does not require employers to offer health insurance. However, effective July 1, 2013, all employers with more than 50 employees who do not offer coverage would be required to reimburse the government for each full-time employee (defined as those working 30 or more hours a week) receiving a health care affordability tax credit in the exchange equal to the average national exchange credit and subsidy up to a cap of $400 per total number of employees (whether they are receiving a tax credit and subsidy or not). A Medicaid-eligible individual can always choose to leave the employer's coverage and enroll in Medicaid. In this circumstance, the employer is not required to pay a fee.

In addition to provisions that expand health care coverage, the Chairman's Mark would make critical investments in policies to promote healthy living and help prevent costly chronic conditions like diabetes, cancer, heart disease and obesity. Preventive screenings enable doctors to detect diseases earlier, when treatment is most effective, thereby averting more serious, costly health problems later.

The Mark would provide Medicare beneficiaries with a free visit to their primary care provider every year to create and update a personalized prevention plan designed to address health risks and chronic health problems and to develop a schedule for regular recommended preventive screenings. It would eliminate out-of-pocket costs for recommended preventive services for Medicare beneficiaries and provide incentives for states to cover recommended services and immunizations in Medicaid. And finally, the Mark establishes an initiative to reward Medicare and Medicaid participants for healthier choices. Funding will be available to provide participants with incentives for completing evidence-based, healthy lifestyle programs and improving their health status. Programs will focus on lowering certain risk factors linked to chronic disease such as blood pressure, cholesterol and obesity.

The legislation makes significant steps to reform the health care delivery system. Medicare currently reimburses health care providers on the basis of the volume of care they provide – regardless of whether the treatment contributes to helping a patient recover. The Chairman's Mark includes various proposals to move the Medicare fee-for-service system towards paying for quality and value. These proposals include hospital value-based purchasing – and value-based purchasing for other Medicare providers including physicians, home health agencies, nursing homes, long-term care hospitals, inpatient rehabilitation facilities, PPS-exempt cancer hospitals and hospice providers.

To encourage greater collaboration among health care providers, the Chairman's Mark would allow high-quality providers that coordinate care across a range of health care settings to share in the savings they achieve for the Medicare program. It would create an Innovation Center at the Centers for Medicare & Medicaid Services (CMS) that would have authority to test new patient-centered payment models designed to encourage evidence-based, coordinated care for Medicare, Medicaid, and CHIP. Payment reforms that are shown to improve quality and reduce costs could be expanded throughout the Medicare program. It would also implement a national pilot program on payment bundling and start to pay hospitals less for avoidable hospital readmissions.

Efforts to reduce costs and improve quality in the health care delivery system will require an investment in the health care infrastructure necessary to support coordinated quality care and create a more effective, efficient delivery system. The legislation would provide additional resources to strengthen the quality measure development processes for purposes of improving quality, informing patients and purchasers, and updating payments under federal health programs. The Mark would also invest in research on what treatments work best for which patients and ensure that information is available and accessible to patients and doctors, such as through the establishment of an independent institute to research the effectiveness of different health care treatments and strategies. These provisions are carefully crafted so that patients would never be denied treatment based on age, disability status or other related factors as a result of the research findings.

To promote primary care and maintain adequate access to health care providers, the Chairman's Mark would provide primary care practitioners and targeted general surgeons with a Medicare payment bonus of ten percent for five years. It would strengthen the health care workforce by increasing graduate medical education (GME) training positions through a slot re-distribution program for currently unused training slots, with priority given to increasing training in primary

care and general surgery. The provision would also encourage additional training in outpatient settings, including teaching health centers, and ensure communities retain vital training slots if a hospital closes.

The Mark also improves the accuracy of Medicare payments to providers by reducing overpayments to providers. It would cancel a scheduled 21.5 percent reduction to physician payments in 2010 and replace the impending cut with a positive update. The legislation would improve the value of Medicare Advantage by reforming payments so that the program appropriately pays insurers for their costs and promotes plans that offer high quality, efficient health care for seniors. To preserve beneficiary access to certain services they now receive, the legislation would grandfather MA plans in areas where plans currently bid at or below 75 percent of traditional fee-for-service Medicare to deliver benefits, so plans will continue to offer the plans they currently offer and pay what they currently pay to deliver benefits for existing beneficiaries.

For rural providers, the Mark includes important provisions to ensure rural health care facilities and providers have the resources they need to continue delivering quality care in their communities. Specifically, the Mark would extend and improve many rural access protections.

Sharply rising costs throughout the health system threaten Medicare's sustainability in the long term. If costs are not constrained, the Medicare program will be insolvent by 2017. To ensure the fiscal solvency and sustainability of the Medicare program, the Chairman's Mark would create a new independent Medicare Commission tasked with presenting Congress with comprehensive proposals to reduce excess cost growth and improve quality of care for Medicare beneficiaries. In years when Medicare costs are projected to be unsustainable, the Commission's proposals will take effect unless Congress passes an alternative measure that achieves the same level of savings. Congress would be allowed to consider an alternative provision on a fast-track basis. The Commission would be prohibited from making proposals that ration care, raise taxes or Part B premiums, or change Medicare benefit, eligibility, or cost-sharing standards. The Mark would also reduce annual market basket updates for hospitals, home health providers, nursing homes, hospice providers, long-term care hospitals and inpatient rehabilitation facilities, including adjustments to reflect expected gains in productivity. Payment updates for Part B providers would be reduced by an estimate of increased productivity, and income-related premiums would be adopted in Part D.

To improve the transparency of insurance products so that individuals know what they are purchasing, the services which are covered and the associated out-of-pocket costs, the Mark would create standards so that individuals receive an outline of coverage presented in a uniform format. The Mark would also require insurance companies to publish the share of their premium revenue that is used for administrative expenses and would impose new requirements on insurers to meet standards for the electronic exchange of payment and other health care information with hospitals, doctors and other providers.

Reducing fraud, waste, and abuse in Medicare, Medicaid and CHIP will reduce costs and improve quality throughout the system. The Medicare improper payment rate for 2008 was 3.6 percent of payments, or $10.4 billion and the National Health Care Anti-Fraud Association

estimates that fraud amounts to at least three percent of total health care spending, or more than $60 billion per year. The Chairman's Mark includes several significant provisions to combat fraud, waste and abuse in our health care system.

The America's Healthy Future Act is fully offset and would reduce the deficit and reduce Federal health spending over the long run. In addition to the Medicare Commission, the other policy that contributes to this goal is the high cost insurance excise tax. Beginning in 2013, this provision would levy a non-deductible excise tax on insurance companies and plan administrators for any health insurance plan that is above the threshold of $8,000 for singles and $21,000 for family plans. The threshold would be higher for workers with high risk jobs or for retirees aged 55 and up. The tax would apply to self-insured plans and plans sold in the group market, but not to plans sold in the individual market. A transition rule would increase the threshold for the 17 highest cost states for the first three years.

Other revenue measures include a limit on the amount of contributions to health Flexible Spending Accounts (FSAs) beginning in 2011, a provision to conform the definition of qualified medical expenses for Health Savings Accounts (HSAs), health FSAs, and HRAs to the definition used for the itemized deduction, an increased penalty for use of HSA funds for non-qualified medical expenses, and an increase in the threshold for claiming the itemized deduction for medical expenses.

The legislation also includes an annual flat fee of $2.3 billion on the pharmaceutical manufacturing sector, an annual flat fee of $4 billion on the medical device manufacturing sector, and an annual flat fee of $6.7 billion on the health insurance sector. Each of these non-deductible fees would be allocated across the respective industry according to market share. The device fee would not apply to companies with sales of medical devices in the U.S. of $5 million or less and would not apply to sales of Class I products or Class II products that retail for less than $100 under the FDA product classification system.

Taken together, this legislation achieves the goals of expanding health care coverage to the uninsured, reducing health care costs and improving the quality of care by transforming the health care delivery system. This comprehensive legislation represents a significant milestone in our nation's pursuit of quality, affordable health care for all Americans.

LEGISLATIVE HISTORY AND COMMITTEE ACTION

The Finance Committee has spent two years working on health reform, learning about the problem and identifying solutions. In the past two years, the committee held 20 hearings on health care reform. Last June the committee hosted a day-long health care summit at the Library of Congress featuring Federal Reserve Chairman Ben Bernanke and Dr. J. Craig Venter, genomic research pioneer, as keynote speakers.

Leading up to the markup, the committee held three roundtable discussions reflecting the three major areas of reform – access, cost and quality. In connection with each roundtable – the committee hosted experts from around the country with many different perspectives. Finance Committee members asked many questions of these experts and delved into the issues. Along

with each roundtable, the committee put out a detailed policy options paper and held three closed-door walk-through sessions to discuss those options.

In sum, the hearings, summit, roundtables and walk-through sessions demonstrated an open and exhaustive consideration of this health care proposal.

In moving forward with the markup, the Finance Committee distributed the Chairman's Mark and posted it on the committee website on September 16, a full week prior to the start of the markups. Members submitted 564 amendments to the Chairman's Mark, all of which were posted on the website – a measure in the name of transparency that has never been taken by the committee before.

The markup of America's Healthy Future Act lasted for eight days. These days were long days, often running past 10:00 PM. On the last day of considering amendments, the committee worked past 2:00 AM. All in all, it has been more than 22 years since the Finance Committee met for eight days on a single bill.

During those eight days, the committee considered 135 amendments and conducted 79 roll call votes, adopting 41 amendments. A final amendment was adopted prior to the vote on October 13, 2009 to report the bill. And the final vote to report the bill was 14-9.

The legislation resulting from the committee's effort is a balanced, sensible plan that takes the best ideas from both sides of the aisle. It achieves President Obama's vision to improve America's health care system, and it is a plan designed to get the 60 votes it needs to pass. The Congressional Budget Office confirms that the legislation will reduce the deficit by $81 billion in the first 10 years, and that the legislation will reduce the deficit further in the next 10 years. Coverage is expanded to 29 million Americans, increasing the rate of insurance to 94 percent at a cost of $829 billion.

II. EXPLANATION OF THE BILL

Title I—Health Care Coverage

Subtitle A – Insurance Market Reforms

Sec. 1001. Insurance Market Reforms in the Individual and Small Group Markets.

The Committee Bill would amend the Social Security Act (42 U.S.C. 301 et seq.) by adding a new Title XXII at the end:

"TITLE XXII—HEALTH INSURANCE COVERAGE"

Sec. 2200. Ensuring Essential and Affordable Health Benefits Coverage for All Americans.

Present Law

No provision.

Committee Bill

The purpose of Title I would be to ensure that all Americans have access to affordable and essential health benefits coverage (1) by requiring that all new health benefits plans offered to individuals and employers in the individual and small group market are qualified health benefit plans (QHBPs) that meet the insurance rating reforms and essential health benefits coverage requirements under this bill, (2) by establishing State exchanges to provide greater access to and information about QHBPs, (3) by making health benefits coverage more affordable with premium credits and cost-sharing subsidies, and (4) by establishing the CO-OP program to encourage the establishment of nonprofit health care cooperatives.

PART A – INSURANCE REFORMS

"Subpart 1 – Requirements in the Individual and Small Group Markets"

Sec. 2201. General Requirements and Definitions.

Present Law

Certain commonly used terms in health insurance are defined in statute. For example, "group health plan" is defined in Sec 5000(b) of the Internal Revenue Code, as a "plan (including a self-insured plan) of, or contributed to by, an employer (including a self-employed person) or employee organization to provide health care (directly or otherwise) to the employees, former employees, the employer, others associated or formerly associated with the employer in a business relationship, or their families".

Committee Bill

The provisions would codify some new definitions in health insurance. Each state would require that each health benefits plan (other than grandfathered plans) offered in the individual or small group market within the State would be a "*qualified health benefits plan*" (QHBP). A QHBP would be defined as a plan that has a certification issued or recognized by the State that it meets the requirements relating to insurance market reforms and meets health insurance affordability requirements. Additionally, the offeror of the plan would be licensed by the State and comply with other requirements established by the Secretary or the State.

The term "*health benefits plan*" would include health insurance coverage and group health plans. Except as specified in the bill, a health benefits plan would not include a plan that is not subject to certain state law requirements (self-funded plans and multiple employer welfare arrangements – MEWAs).

The term "*health benefits offeror*" would mean the issuer offering coverage and for a group health plan, the plan sponsor or employer.

The term "*group market*" refers to a group health plan maintained by an employer. "*Individual market*" refers to the market other than in connection with a group health plan.

Present Law

Pertaining to Sec. 2202-2206:

The private health insurance market consists of three segments: large group market, small group market, and the individual (nongroup) market. A variety of Federal and state laws and regulations apply to these markets; sometimes the requirements are distinct for each market segment and other times they overlap. Regulation of the private health insurance market is primarily done at the state level. State regulatory authority is broad in scope and includes requirements related to the issuance and renewal of coverage, benefits, rating, consumer protections, and other issues. Federal regulation of the private market is more narrow in scope and applicable mostly to employer-sponsored health insurance (i.e., through the Employee Retirement Income Security Act of 1974 (ERISA)).

The Federal Health Insurance Portability and Accountability Act of 1996 (HIPAA, P.L. 104-191), which amended ERISA, established Federal rules regarding coverage for pre-existing health conditions, guaranteed issue and availability, and guaranteed renewability in the individual and small group markets for certain persons eligible for HIPAA protections. HIPAA limits the duration that coverage for pre-existing health conditions may be excluded for "HIPAA eligible" individuals with group coverage. Group plans may impose pre-existing condition exclusions for no longer than 12 months (18 months in the case of a late enrollee), and must decrease that exclusion period by the number of months an enrollee had prior "creditable coverage." HIPAA also prohibits individual issuers from excluding coverage for pre-existing health conditions for HIPAA eligibles. All States require health issuers to reduce the period of time when coverage for pre-existing health conditions may be excluded, in compliance with

HIPAA. As of January 2009 in the small group market, 21 states had pre-existing condition exclusion rules that provided consumer protection above the Federal standard. And as of December 2008 in the individual market, 42 states reduce the period of time when coverage for pre-existing health conditions may be excluded for non-HIPAA eligible enrollees.

HIPAA requires that coverage sold to firms with 2-50 employees must be sold on a guaranteed issue basis. That is, the issuer must accept every small employer that applies for coverage. Guaranteed issue does not affect (and is not affected by) rating or benefits. HIPAA also guarantees renewal of both small and large group coverage at the option of the plan sponsor (e.g., employer), with some exceptions. HIPAA guarantees that each issuer in the individual market make at least two policies available to all "HIPAA eligible" individuals, and renewal of individual coverage is at the option of such individuals, with some exceptions. In addition, a number of states have enacted guaranteed issue rules. All states require issuers to offer policies to firms with 2-50 workers on a guaranteed issue basis. As of January 2009, 13 states also require small group issuers to offer policies on a guaranteed issue basis to self-employed "groups of one." As of January 2009 in the individual market, 14 states require issuers to offer some or all of their individual insurance products on a guaranteed issue basis.

There are no Federal rating rules applicable to the private health insurance market. Most States currently impose rating rules on insurance carriers in the small group market, the individual market, or both. Existing state rating rules restrict an insurer's ability to price insurance policies according to the risk of the person or group seeking coverage, and vary from state to state. Such restrictions may specify the case characteristics (or risk factors) that may or may not be considered when setting a premium, such as gender. The spectrum of existing state rating limitations ranges from pure community rating, to adjusted (or modified) community rating, to rate bands, to no restrictions. Pure community rating means that premiums cannot vary based on any characteristic, including health. Adjusted community rating means that premiums cannot vary based on health, but may vary based on other key risk factors, such as age.

Rate bands allow premium variation based on health, but such variation is limited according to a range specified by the state. Rate bands are typically expressed as a percentage above and below the index (i.e., the rate that would be charged to a standard population if the plan is prohibited from rating based on health factors). For example, if a state establishes a rate band of +/- 25 percent, then insurance carriers can vary premiums, based on health factors, up to 25 percent above and 25 percent below the index. Both adjusted community rating and rate bands allow premium variation based on any other permitted case characteristic, such as gender. For each characteristic, the state typically specifies the amount of allowable variation, as a ratio. For example, a 5:1 ratio for age would allow insurers to charge an individual no more than five times the premium charged to any other individual, based on age differences. As of January 2009, two states have pure community rating rules, ten have adjusted community rating rules, and 35 have rate bands in the small group market. As of January 2009 in the individual market, one state has pure community rating, seven have adjusted community rating rules, and eleven have rating bands. The remaining states have no limitations on rating set in law in the individual market.

Committee Bill

Sec. 2202. Prohibition on Preexisting Condition Exclusions.

QHBPs would be prohibited from excluding coverage for preexisting conditions, or otherwise imposing limits or conditions on coverage based on any health status-related factors. Such factors would include health status, medical condition (including both physical and mental illnesses), claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of acts of domestic violence), and disability.

Sec. 2203. Guaranteed Issue and Renewal for Insured Plans.

QHBPs would be required to offer coverage in the individual and small group markets on a guaranteed issue and guaranteed renewal basis. If a plan has a capacity limit, as determined under regulations promulgated by the Secretary, the plan would be allowed to limit enrollment to that limit as long as the plan selects enrollees on the basis of order in which individuals applied for enrollment. With respect to the guaranteed renewal provision, this provision would require (1) any rescissions of coverage to be treated in the same manner as non-renewals of coverage, and (2) the premium at the time of renewal be determined using the same categories of rate adjustment factors used at the time the policy was first issued.

Sec. 2204. Premium Rating Rules.

Health benefit plans offered in a rating area would be allowed to vary premiums only according to specified ratios for the following risk factors:

- Family enrollment:
  - Individual, 1:1
  - Adult with child, 1.8:1
  - Two adults, 2:1
  - Family, 3:1
- Age, 4:1
- Tobacco Use, 1.5:1

The Secretary would establish age bands to implement the provision relating to premium variation based on age. Health benefit plans would be prohibited from rating based on health status related factors, gender, class of business, claims experience, or any other factor not specified above.

Sec. 2205. Use of Uniform Outline of Coverage Documents.

Health benefits plans would be required to provide an outline of the plan's coverage that meets the standards of uniformity adopted by the Secretary under Sec. 1002 to (1) an applicant at the time of application, (2) an enrollee at the time of enrollment, and (3) a policyholder at the time the policy is issued.

"Subpart 2—Reforms Relating to Allocation of Risks"

Present Law

Pertaining to Sec. 2211-2215:

There are no Federally-established rating areas in the private health insurance market. However, some states have enacted rating rules in the individual and small group markets that include geography as a characteristic on which premiums may vary. In these cases, the state has established rating areas. Typically, states use counties or zip codes to define those areas.

Pooling refers to the industry practice of pooling the insurance risk of individuals or groups in order to determine premiums. In the individual market premiums are typically based on the risk of the applicant, such as an individual or family. In the small group market, premiums are typically based on the collective risk of the small group. Some states have imposed requirements on health insurance issuers that limit the issuers' ability to base premiums on the risk of individuals or small groups applying for coverage—see Present Law description under Sec. 2202.

Medicare Advantage (MA) is an alternative way for Medicare beneficiaries to receive covered benefits. Under MA, private health plans are paid a per-person amount to provide all Medicare-covered benefits (except hospice) to beneficiaries who enroll in their plan. Payments to MA plans are risk adjusted to control for variations in the cost of providing health care among Medicare beneficiaries. For example, if sicker and older patients all sign up for one plan, risk adjustment is designed to compensate the plan for their above average health expenses. Medicare Advantage payments are currently risk adjusted for the health history of the enrollee, as well as for demographic variables such as age, gender, working status, Medicaid coverage, institutionalized status, and whether the beneficiary originally qualified for Medicare on the basis of disability.

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA, P.L. 108-173) established an outpatient voluntary prescription drug benefit under a new Medicare Part D, effective January 1, 2006. MMA established risk corridors to limit plans' overall risks or profits under the new program. Under risk corridors, Medicare limits a plan's potential losses, or gains, by financing some of the higher than expected costs, or recouping excessive profits. Risk corridors are defined as specified percentages above and below a target amount and are set separately for each plan. The target amount is based on the total risk-adjusted subsidy payments paid to the plan plus beneficiary premiums, reduced by the administrative expenses assumed in the bid. The target amount is then compared to the plan's actual allowable costs. If actual costs exceed the target amount, Medicare reimburses plans for a portion of their losses, and if costs are lower than the target, the sponsor may owe money to the Center for Medicare and Medicaid Services (CMS).

Committee Bill

Sec. 2211. Rating Areas; Pooling of Risks; Phase In of Rating Rules in Small Group Markets.

Each state would be required to establish one or more rating areas within the state for purposes of applying the requirements of Title I. The Secretary would review the rating areas to ensure the

adequacy of such areas in carrying out the Title I requirements. The Secretary would be allowed to establish rating areas for those states whose rating areas are determined to be inadequate.

Individual health insurance issuers offering an insured QHBP in an area covered by an exchange would be required to consider all enrollees in the plan as members of a single risk pool, including individuals who do not purchase such a plan through an exchange. Likewise, small group issuers offering a QHBP in an area covered by an exchange would be required to consider all enrollees in the plan as members of a single risk pool, including individuals who do not purchase such a plan through an exchange. States would have the option to merge the individual and small group markets for purposes of applying the pooling requirements. Upon approval by the Secretary, states would be allowed to phase in the application of the insurance reforms under Subpart 1 to the small group market over a consecutive period of plan years (not greater than 5).

Sec. 2212. Risk Adjustment.

Each state would be required to adopt a risk-adjustment model, established by the Secretary, to apply risk adjustment to QHBPs (whether or not purchased through an exchange) and grandfathered plans in the individual and small group markets. The Secretary would establish one or more risk adjustment models that take into account differences in the risk characteristics of individuals and employer enrolled under different plans to minimize the impact of adverse selection of enrollees in those plans. States have the option to establish their own risk adjustment model if the state establishes a model, to the satisfaction of the Secretary, that (1) would produce substantially similar results to the model(s) established by the Secretary and (2) would not increase Federal costs.

The Secretary would be required to pre-qualify entities capable of conducting risk-adjustment and the states would have the option to pick among those entities. The entities pre-qualified by the Secretary cannot be a plan offeror, or an entity owned or operated by a plan offeror.

Sec. 2213. Establishment of Transitional Reinsurance Program for Individual Markets in Each State.

No later than July 1, 2013, each state would be required to establish a reinsurance program based on model regulation developed by the National Association of Insurance Commissioners (NAIC). Offerors of health benefit plans that are offered in the individual market would be required to contribute to a temporary reinsurance program for individual policies that is administered by a non-profit reinsurance entity. Such contributions would begin July 1, 2013 and continue for a 36-month period.

In development of the model regulation, the NAIC would be required to include these components: the method by which individuals would be identified as high risk for purposes of the reinsurance program, the formula for determining the amounts to be paid to offerors of plans that insure high risk individuals, the method for determining the amount each plan offeror would be required to contribute under the reinsurance program. The aggregate contribution amounts for all states, without regard to administrative expenses, would be equal to the following amounts for each 12-month plan year beginning on July 1 of the following years: $10 billion in 2013, $6

billion in 2014, and $4 billion in 2015. Plan offeror contributions to the reinsurance program established under this section are in addition to contribution amounts required under Sec. 2216. The contribution amounts allocated and used in any of the three years may vary based on the reinsurance needs of a particular year or to reflect experience in the prior year. In the event that all funds are not expended in the three year period, the reinsurer may continue to make payments under a state reinsurance program in the individual market for a 24-month period beginning on July 1, 2016, but no new contributions would be collected beyond June 20, 2016.

The non-profit reinsurance entity would coordinate the funding and operation of the reinsurance program. A state may have more than one reinsurer to carry out the reinsurance program in the state, and two or more states may enter into agreements to allow a reinsurer to operate the reinsurance program in those states. Reinsurance entities under this section are tax exempt for Federal tax purposes. The state would be required to eliminate or modify a state high risk pool to the extent necessary to carry out the reinsurance program established under this section.

Sec. 2214. Establishment of Risk Corridors for Plans in Individual and Small Group Markets.

The Secretary would establish and administer risk corridors for plan years during a 36-month period beginning on July 1, 2013, under which QHBPs in the individual and small group markets would be allowed to participate in a payment adjustment system modeled after the program applied to regional Participating Provider Organizations in Medicare, Part D.

For the purpose of this provision, "allowable costs" means the total amount of costs that the plan incurred in providing benefits covered by the plan reduced by the portion of such costs attributable to administrative expenses. The term 'target amount' means an amount equal to the total annual premium amounts (including any premium subsidies) collected, reduced by the amount of administrative expenses. If the allowable costs for the plan for the year are greater than 103 percent, but not greater than 108 percent, of the target amount for the plan and year, the Secretary would make a payment to the plan equal to 50 percent of the difference between the allowable costs and 103 percent of the target amount. If the allowable costs for the plan for the year are greater than 108 percent of the target amount for the plan and year, the Secretary would make a payment to the plan equal to the sum of 2.5 percent of the target amount and 80 percent of the difference between the allowable costs and 108 percent of the target amount. If the allowable costs for the plan for the year are less than 97 percent, but greater than or equal to 92 percent, of the target amount for the plan and year, the Secretary would receive a payment from the plan equal to 50 percent of the difference between 97 percent of the target amount and the allowable costs. If the allowable costs for the plan for the year are less than 92 percent of the target amount for the plan and year, the Secretary would receive a payment from the plan equal to the sum of 2.5 percent of the target amount; and 80 percent of the difference between 92 percent of such target amount and such allowable costs. If the allowable costs for the plan for the year are at least 97 percent, but do not exceed 103 percent, of the target amount for the plan and year, there would be no payment adjustment for the plan and year.

Sec. 2215. Temporary High Risk Pools for Individuals with Preexisting Conditions.

No later than one year after enactment, the Secretary would establish one or more temporary high risk pools to provide all eligible individuals access to coverage that does not impose any coverage exclusions for preexisting health conditions. The Secretary could carry out this section directly or through agreements or contracts with states or others as appropriate.

The high risk pool(s) established under this section would provide coverage for the essential benefits package specified under Sec. 2242, and would provide the bronze level of coverage specified under Sec. 2243. The premiums charged under the high risk pool would be equal to the standard premium rate for a plan providing coverage for the essential benefits package and the bronze level of coverage. The Secretary could vary premiums in the same manner that a QHBP may vary premiums under Sec. 2204.

There would be appropriated out of the Treasury $5 billion to finance the claims and administrative expenses of the high risk pool(s) in excess of the premiums collected from enrollees. If in any fiscal year there is a shortage of aggregate amounts for payments of pool expenses, the Secretary would make adjustments to eliminate the shortage.

Coverage under a high risk pool would end as of the end of June 30, 2013, with exceptions. The Secretary could extend high risk pool coverage if the Secretary determines that such extension is necessary to avoid a lapse in coverage resulting from the transition of enrollees from the high risk pool into QHBPs offered through an exchange. Eligible individuals for high risk pool participation include individuals who: (1) have been denied coverage due to a preexisting health condition, (2) have been uninsured for a continuous period of at least six months, (3) are not eligible for essential health benefits coverage (as defined in Sec. 5000(A)(d)), and are citizens or nationals of the U.S., legal permanent residents, or lawfully present aliens.

Sec. 2216. Reinsurance for Retirees Covered by Employer-Based Plans.

Present Law

No provision.

Committee Bill

No later than 90 days after enactment, the Secretary would establish a temporary reinsurance program to provide reimbursement to assist participating employment-based plans with the cost of providing health benefits to eligible retirees who are 55 and older (and not eligible for Medicare) and their dependents, including eligible and surviving spouses. Health benefits would be required to include medical, surgical, hospital, prescription drug, and other benefits determined by the Secretary. An employment-based plan would submit an application to the Secretary, as required. A participating employment-based program would submit claims for reimbursement to the Secretary, documenting the actual cost of items and services for each claim. Each claim would be based on the actual amount expended by the participant. The participating employment-based plan would take into account any negotiated price concessions, such as discounts, subsides, and rebates. The cost of deductibles and cost-sharing would be included in the cost of the claim, along with the amounts paid by the plan. For any valid claim,

the Secretary would reimburse the plan for 80 percent of the portion of costs above $15,000 and below $90,000. This amount would be adjusted annually based on the percent increase in the medical care component of the Consumer Price Index, rounded to the nearest multiple of $1,000. Amounts paid to a participating employment-based plan would be used to lower cost directly to participants and beneficiaries in the form of premiums, co-payments, deductible, co-insurance, or other out-of-pocket costs, but would not be used to reduce the costs of an employer maintaining the employment-based plan. The Secretary would establish an appeals process for denied claims, procedures to protect against fraud, waste, and abuse, and would conduct annual audits of claims date.

The Secretary of the Treasury would establish a separate account within the Treasury of the United States for deposit of $5 billion to the Secretary of HHS which is collected through the reinsurance program established in Sec. 2213 of this bill. Amounts in the account would be appropriated for use by the Secretary to carry out reinsurance for retirees. The Secretary would have the authority to stop taking applications or take other steps to reduce expenditures to ensure that expenditures did not exceed available funds.

"Subpart 3 – Preservation of Right to Maintain Existing Coverage"

Sec. 2221. Grandfathered Health Benefit Plans.

Present Law

No provision.

Committee Bill

Plans could continue to offer coverage in a grandfathered policy in both the individual and group market. Enrollment would be limited to those who were currently enrolled, their dependents, or in the case of an employer, to new employees and their dependents. 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 the approval from the Secretary.

Health insurance coverage in the individual market (in effect before enactment) that is actuarially equivalent to a catastrophic plan for young individuals (as defined in Sec. 2243(c) of the bill), would be treated as grandfathered plans.

"Subpart 4 – Continued Role of States"

Present Law

Pertaining to Sec. 2225-2227: Regulation of the private health insurance market is primarily done at the state level. State regulatory authority is broad in scope and includes requirements related to licensing, solvency, the issuance and renewal of coverage, benefits, rating, consumer protections, and other issues. Such rules vary from state to state. An insurance carrier must be

licensed in each state in which it operates, and comply with the applicable laws and regulations of each state.

Committee Bill

Sec. 2225. Continued State Enforcement of Insurance Regulations.

No later than 12 months after enactment, the NAIC would develop a Model Regulation to implement the requirements for plans offered in the individual and small group markets within a state. The Secretary would promulgate regulations to implement the Model Regulation developed by the NAIC. If the NAIC does not establish the Model Regulation within the 12 months after enactment, the Secretary would establish Federal standards implementing the applicable requirements. States would have until July 1, 2013 to adopt and have in effect the Model Regulation or Federal standards established by the Secretary, or a state law or regulation that implements the applicable requirements.

If a state fails to adopt or substantially enforce the Model Regulation, Federal standards, or state laws or regulations, the Secretary would be required to enforce those provisions related to the issuance, sale, renewal, and offering of health benefits plans until the state adopts and enforces such provisions. The Secretary would have enforcement authority under Sec. 2722(b) of the Public Health Services Act to impose civil money penalties on plans that fail to meet such provisions. The Model Regulation, Federal standards, or state laws and regulations implemented by a state must include a requirement that adopted standards (including existing standards under state law that offer more protection to consumers than standards set forth in this title) are applied uniformly to all offerors of health benefits plans in the individual or small group market.

By no later than July 1, 2013, a state would be required to establish and have in operation one or more exchanges, including Small Business Health Options Program (SHOP) exchanges, that meet the requirements regarding the offer of QHBPs. If states do not establish these exchanges within 2 years of enactment (or if the Secretary determines the exchanges will not be operational by July 1, 2013), the Secretary would be required to contract with a nongovernmental entity to establish the exchanges within the state. States would be required to establish interim exchanges for use by state residents as soon as practicable in the period from January 1, 2010 to June 30, 2013. If these interim exchanges are not operational within a reasonable period after enactment, the Secretary would be required to contract with a nongovernmental entity to establish state exchanges during this interim period.

This title would not replace state laws that establish, implement, or continue any standards or requirements relating to health benefits plans that offer more protection to consumers than the protection offered by standards or requirements included in this title. These standards or requirements would refer to consumer protections (e.g. claims grievance procedures, external review of claims determinations, oversight of insurance agent practices, and others); premium rating reviews; solvency and reserve requirements related to health insurance issuers' licensures; and the assessment of sate-based premium taxes on health insurance issuers. The provisions in this title would not affect ERISA provisions with respect to group health plans.

States could institute programs to provide that offerors of qualified health benefit plans, small employers, and exchanges offering plans in the state's individual and small group market could automatically enroll individuals and employees in (or continue enrollment of individuals in) QHBPs. Automatic enrollment programs would be required to allow individuals or employees to opt out of any coverage in which they were automatically enrolled.

Each state would require offerors of QHBPs through an exchange to provide for a claims review process, to notify enrollees in clear language and in the enrollees' primary language of available internal and external appeals processes, and to allow enrollees to review their files, present evidence, and maintain their insurance coverage during the appeals process. States would be required to provide for an external review process that includes consumer protections set forth in the NAIC's Uniform External Review Model Act, and ensure that enrollees can seek judicial review through Federal or state procedures.

Sec. 2226. Waiver of Health Insurance Reform Requirements.

Present Law

No provision.

Committee Bill

A state could apply for a waiver of any and all requirements of Title I and the IRC for plan years beginning on or after July 1, 2015. The waiver application would have to (1) be filed at a time and manner specified by the Secretary, and (2) provide required information, including a comprehensive description of the State legislation or program for implementing a plan meeting the waiver requirements, and a 10-year budget plan that is budget neutral for the Federal Government.

In order for the Secretary to grant a request for a waiver, the Secretary would have to determine that (1) the state plan would provide coverage at least as comprehensive as that required under a QHBP offered through exchanges, (2) the State plan received input from its citizens, and (3) the State plan would not increase the Federal deficit and would lower the growth in health spending, improving delivery system performance, providing affordable choices of all citizens, expanding protection against excessive out-of-pocket spending, and providing coverage to the same number of uninsured as this title.

The Secretary would determine the scope of the waiver, including which Federal laws and requirements would not apply to the state. This determination would be made within 180 days of receiving a waiver application from the state. The Secretary would notify the state if the waiver is granted, or would notify the state and the appropriate committees of Congress the reasons that the waiver was not granted.

Sec. 2227. Provisions Relating to Offering of Plans in More Than One State.

Present Law

No provision.

Committee Bill

"Health care choice compacts" would allow for the offer of one or more QHBPs in the individual market across state lines. By July 1, 2013, the National Association of Insurance Commissioners (NAIC) would develop model rules for these compacts. The compacts would exist between two or more states, but the QHBP would only be subject to the laws and regulations of the state in which the plan was written or issued. However, the offeror of the QHBP would be subject to laws and regulations concerning provisions on market conduct, unfair trade practices, network adequacy, and consumer protections in all states that offered the plan. The offeror of the compact would also be licensed in each state in which it offered the plan, and would notify purchasers that the policy might not be subject to all the laws and regulations of the purchaser's state. States must enact a law authorizing the compacts. These compacts would not begin before January 1, 2015.

An offeror of a QHBP in the individual or small group market could sell the plan in more than one state, including all states, and not be subject to any state laws mandating benefit coverage. However, a state may pass a law opting out of this type of policy. For all participating states, the offeror would be required to (1) have a uniform benefits package for each state; (2) be licensed in each state and meet State standards and requirements as detailed in Sec. 2225 (relating to consumer protections, premium rating reviews, and solvency and reserve requirement, and state-based premium taxes); (3) meet all the requirements with respect to QHBPs, including offering a silver and gold level plan in each state; and (4) determine each state's premiums on the basis of the rating rules in that state for the rating areas in which the plan is offered. The NAIC would develop model rules for offering QHBPs on a national basis by 2012, including implementing benefit categories that take into account benefits offered in a majority of States, and harmonization between State authorities of insurance regulation. Each participating state would be required to include the NAIC Model rules for the offering of QHBPs on a national basis in the Model Regulation, Federal standard, or State law and regulation that it adopts and has it effect under Sec.2225(a)(2).

Sec. 2228. State Flexibility to Establish Basic Health Plans for Low-Income Individuals not Eligible for Medicaid.

Present Law

There is no existing Federal law providing direct on-going program financing to the States for health insurance coverage of low-income individuals not eligible for Medicaid either under standard criteria or via waivers. The Committee Bill is modeled after the Washington State Basic Health (BH) Plan program administered and financed by the Washington State Health Care Authority (HCA). BH started as a pilot program established by the Washington State "Health Care Access Act of 1987". In 1993, Washington State made the program permanent as part of the Health Services Act. Current eligibility requirements include the following: (1) Must be a Washington State resident; (2) May not be eligible for free or purchased Medicare; (3) May not

be institutionalized at the time of enrollment; (4) May not be attending school full time in the United States on a student visa; and (5) Must be within the income guidelines (gross monthly income of $1,733.41 for an individual and $3,533.50 for a family of four).

Committee Bill

The Committee Bill would require the Secretary to establish a program where a state or a regional compact of states would establish 1 or more qualified basic health plans to provide at least an essential benefits package to eligible individuals rather than offering coverage to them through an exchange established under part B. States would enroll income-eligible persons in their Basic Health Plan that meets the competitive procurement requirements and the requirements to provide premium and cost-sharing subsidies to eligible individuals. The Committee Bill would require that the Secretary certify that the state's qualified basic health plan has premiums and cost-sharing for any plan year that does not exceed the estimated average cost for a QHBP within the state and offered through the exchanges, and that the benefits provided under the qualified basic health plan covers the items and services required under an essential benefits package in the exchange.

The Committee Bill would define a qualified basic health plan in this program as a plan established and maintained by the state under which only eligible individuals enroll. The Committee Bill would further define the plan as providing at least an essential benefits package as required for the exchange, and it would require at least a medical loss ratio of 85 percent. The Committee Bill would also require meeting the competitive procurement requirements and the requirements to provide premium and cost-sharing subsidies to eligible individuals.

The Committee Bill would require states to establish a competitive process to enter into contracts with coverage providers under the plan. Contract negotiations would include payment rates, premiums, cost-sharing, and extra benefits. States would be encouraged to include innovative features in their health plan contracting, including, but not limited to care coordination and care management (emphasizing chronic conditions), incentives for use of preventive services, and establishment of 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. States would be required to consider and make suitable allowance for differences in health care needs of enrollees and differences in local availability of health care provider resources. The competitive process would also require consideration of contracting with managed care systems or with systems that offer as many of the attributes of managed care as feasible in the local health care market. The Committee Bill would also include consideration in the competitive process of establishment of specific performance measures and standards for coverage of providers that focus on quality of care and improved outcomes, in addition to requiring providers to report measures and standards. The Committee Bill would require making performance and quality information available to enrollees in a useful form.

Under the Committee Bill, states would be instructed to seek participation by multiple health plans to allow enrollees a choice between two or more plans, whenever possible. The Committee Bill would also allow states entering into health care choice compacts to form multi-state risk pools for the purposes of negotiating with health care systems. The Committee Bill

would encourage state administrators to find ways to integrate their 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. 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, 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. Participating health care systems would report to the state on the measures. Their performance and quality information would be made available to the Secretary of HHS and to the Basic Health Plan enrollees to help enrollees choose the best health care system.

Under the Committee Bill, if the Secretary determines that a state meets the requirements of the program, then the Secretary would provide funds to participating states in order to provide affordable health care coverage through private health care systems under contract. A state's Basic Health Plan funding level would be based on the Secretary's estimates of 85 percent of the value of individual tax credits and cost sharing subsidies that would otherwise have been made for a QHBP based on enrollment in that state. This amount would be calculated on a per enrollee basis. Funds distributed to the states would be provided to independent trusts and would be used by the states only to reduce the premiums and cost sharing for eligible enrolled individuals.

Under the Committee Bill an eligible individual is defined by the following (1) must be a resident of the State who is not eligible to enroll in the State's Medicaid program for benefits that, at a minimum, are consistent with the essential benefits package in section 2242; (2) must have a household income between 133 percent and 200 percent of the Federal Poverty Level (FPL) for the size of the family involved; (3) is not eligible for an employer-sponsored plan that is not affordable coverage; and (4) has not attained the age of 65 as of the beginning of the plan year. The Committee Bill would also include in the definition of the term, individuals who are eligible for enrollment by reason of their relationship to the individual meeting the eligibility criteria. The Committee Bill would stipulate that an eligible individual would not be able to use the exchange.

The Committee Bill would require the Secretary to conduct a review of each state program on an annual basis to ensure compliance with the requirements of the program. Specifically the Committee Bill would require the Secretary to ensure state programs meet (1) eligibility verification requirements; (2) the requirements for use of Federal funds received by the program; and (3) the quality and performance standards.

The Committee Bill would stipulate that a state may provide that a participating provider in a qualified basic health plan may include a licensed health maintenance organization, a licensed health insurer, or a network of health care providers. The Committee Bill would also stipulate that any term used in this section and section 36B of the Internal Revenue Code of 1986 would have the meaning established by the latter.

"Subpart 5 – Other Definitions and Rules"

Sec. 2230. Other Definitions and Rules.

Present Law

No provision.

Committee Bill

In connection with a group health plan, the term "large employer" would mean an employer who employed an average of at least 101 employees on business days during the preceding calendar year and who employs at least 1 employee on the first day of the plan year.

In connection with a group health plan, the term "small employer" would mean an employer who employed an average of at least 1 but not more than 100 employees on business days during the preceding calendar year and who employs at least 1 employee on the first day of the plan year. Employers who initially meet the definition of small employer may continue to be treated as such, even if they later employ more than 100 employees.

For plan years beginning before January 1, 2015, states have the option to change the definition of large employer to those with at least 51 employees, and limit small employers to those with 1 to 50 employees.

Employers treated as a single employer under the IRC would also be treated as a single employer for purposes of determining whether an employer was small or large. For employers not in existence throughout the preceding calendar year, the determination of whether the employer is considered small or large would be based on reasonable expectations of the average number of employees during business days in the current year.

Subtitle B—Exchanges and Consumer Assistance

Sec. 1101 Establishment of Qualified Health Benefits Plans Exchanges.

PART B – Exchange and Consumer Assistance

"Subpart 1 - Indviduals and Small Employers Offered Affordable Choices"

Present Law

Pertaining to Sec. 2231- Sec. 2239.

No specific provision exists in Federal law today regarding a health insurance exchange. At the state level, however, Massachusetts established a connector authority, which is described below for illustrative purposes.

In 2006, in tandem with substantial private health insurance market reforms, Massachusetts created the Commonwealth Health Insurance Connector Authority, governed by a Board of Directors, to serve as an intermediary that assists individuals in acquiring health insurance. In

this role, the Health Connector manages two programs. The first is Commonwealth Care, which offers a government-subsidized plan at three benefit levels from a handful of health insurers to individuals up to 300 percent of the FPL who are not otherwise eligible for traditional Medicaid or other coverage (e.g., job-based coverage). The second is Commonwealth Choice, which offers an unsubsidized selection of four benefit tiers (gold, silver, bronze, and young adult) from six insurers to individuals and small groups.

Under state law, the Board of Directors, with its 11 board members, has numerous responsibilities, including the following: determining eligibility for and administering subsidies through the Commonwealth Care program, awarding a seal of approval to qualified health plans offered through the Connector's Commonwealth Choice program, developing regulations defining what constitutes "creditable coverage," constructing an affordability schedule to determine if residents have access to "affordable" coverage and may therefore be subject to tax penalties if they are uninsured, and developing a system for processing appeals related to eligibility decisions for the Commonwealth Care program and the individual mandate.

Committee Bill

Sec. 2231. Rights and Responsibilities Regarding Choice of Coverage Through Exchange.

Qualified individuals could choose to enroll or not to enroll in a QHBP offered through an exchange in the State in which they reside. Each qualified small employer could choose to offer its employees an exchange-offered QHBP that covers the small group market for the state in which the employee resides. Each employee of a small employer could choose to enroll or not to enroll in such a plan. A qualified small employer may limit the QHBP or levels of coverage that employees may enroll in through an exchange. A qualified small employer that offers coverage under a self-insured plan may not offer plans through an exchange.

Members of Congress and Congressional employees would be treated as qualified individuals with the right to enroll in a QHBP in the individual market offered through an exchange. Any employer contribution on behalf of the Member or employee could be paid only to the offeror of a QHBP in which the Member or employee enrolled. The contribution on behalf of Member or employee would be actuarially adjusted for age and paid directly to an exchange. A Congressional employee would be one whose pay is disbursed by the Secretary of the Senate or the Clerk of the House of Representatives.

All plan offerors of a QHPB would be required to offer the plan through the exchange and may offer the plan outside of the exchange. An offeror of a QHBP in the individual or small group market within a State must offer at least one silver level and one gold level QHBP, and may offer 1 or more bronze and platinum level plans, as well as a catastrophic plan. Each exchange that offers plan in the individual or small group market must offer all QHBPs in the state that are licensed by the State.

Each exchange within a State would be required to allow an offeror that only provides oral health benefits to offer the plan through the exchange (either separately or in conjunction with a QHBP). The plan would be treated as a QHBP.

The Secretary would establish procedures requiring states to allow agents or brokers to enroll individuals in any QHBP in the individual or small group market as soon as the plan is offered through an exchange in the State and to assist individuals in applying for premium credits and cost-sharing subsides for plans sold through an exchange.

Sec. 2232. Qualified Individuals and Small Employers: Access Limited to Citizens and Lawful Residents.

The term "qualified individual" would mean an individual seeking to enroll in an exchange-offered QHBP in the individual market who resides in the State that established the exchange. This would not include an individual who is incarcerated, other than those pending the disposition of charges.

The term "qualified small employer" would mean an employer that elects to make all full-time employees eligible for 1 or more QHBPs offered through an exchange that offers QHBPs in the small group market.

If, for the entire plan year, an individual was not reasonably expected to be a citizen or national of the U.S, not lawfully admitted to the U.S. for permanent residence, or not lawfully present in the US, he or she would not be considered to be a qualified individual and could not enroll in an exchange-offered QHBP in the individual market. The individual could not enroll as an employee of (or as an individual bearing a relationship to an employee) a qualfied small employer in an exchange-offered QHBP in the small group market.

"Subpart 2 – Establishment of Exchanges"

Sec. 2235. Establishment of Exchanges by States.

No later than July 1, 2013, each state would be required to establish (1) an exchange to facilitate the enrollment of qualified individuals in QHBPs offered in the individual market, and (2) a Small Business Health Options Program ("SHOP exchange") to assist qualified small employers in facilitating the enrollment of their employees into QHBPs offered in either the individual or small group market. States could establish one exchange to serve both individuals and small businesses, so long as the exchange has separate resources to assist individuals and employers. An exchange or SHOP exchange could operate in more than one state if each state agrees to operation of the exchange in that state, and the Secretary approves.

A state could authorize an exchange to contract with an eligible entity to carry out one or more exchange responsibilities. An eligible entity would (1) be incorporated under and subject to state law, (2) have demonstrated experience administering health insurance benefits in the individual and small group markets, and (3) not be a health insurance issuer or treated under Sec. 52 of the IRC as a member of the same controlled group of corporations of such an issuer. A state could authorize an exchange to enter into an agreement with the state Medicaid agency for the purposes of establishing individual eligibility for the exchange, and for the premium credit under Sec. 36B of the Internal Revenue Code of 1986 and the cost-sharing subsidy established under

Sec. 2247, if such an agreement complies with requirements promulgated by the Secretary. Each state would provide for the establishment of rate schedules for broker commissions paid by the plans through an exchange. Beginning in 2017, each state could allow QHBP offerors in the large group market to offer plans through an exchange.

Each state, as soon as practicable after enactment, would establish an interim exchange through which enrollment in eligible health insurance coverage is offered beginning Jan. 1, 2010 through June 30, 2013. Eligible coverage would include any coverage that meets the requirements specified under Sec. 2244 (regarding cost-sharing and spending limits) which is offered by a state-licensed insurance carrier in the individual or small group market. Eligible coverage would not include limited benefit plans, as determined under regulations promulgated by the Secretary. The Secretary would provide technical assistance to each state in establishing exchanges.

Sec. 2236. Functions Performed by Secretary, States, and Exchanges.

The Secretary of HHS would enter into an agreement with each state outlining exchange-related functions that would be performed by the Secretary, the state, or the exchange. Such an agreement would provide for the state to establish certification procedures for QHBPs to participate in an exchange. Such an agreement would address the conduct for the following outreach and eligibility activities: establishment of an outreach plan, establishment and maintenance of call centers, development of a template for an Internet portal, establishment of a rating system to rate QHBPs, and determination of individuals and employers as qualified (or disqualified) to participate in an exchange. Such an agreement would provide for the establishment and implementation of an enrollment process, which would address enrollment through a variety of media and venues, establishment of open and special enrollment periods, establishment of a uniform enrollment form and standardized marketing requirements, development of a standardized format for presenting health benefit options in the exchange, and dissemination of information regarding eligibility requirements for Medicaid and the Children's Health Insurance Program (CHIP). Such an agreement would provide for the establishment and use of a tool to determine cost of coverage after application of any premium or cost-sharing credit, and implementation of the responsibilities specified under Sec. 2248 regarding advance determinations and payments of such credits. Such an agreement would establish procedures for granting annual certification attesting that an individual is exempt from the individual mandate because there is no affordable QHBP available, and for transferring to the Treasury Secretary a list of such individuals.

Sec. 2237. Duties of the Secretary to Facilitate Exchanges.

The Secretary of HHS and the Treasury Secretary would carry out the responsibilities specified under Sec. 2248, regarding advance determinations and payments of premium and cost-sharing credits that are delegated specifically to such authorities. The Secretary would designate an office with the U.S. Department of Health and Human Services to provide technical assistance to states to facilitate the participation of qualified small businesses in SHOP exchanges. The Secretary would pay each state an amount estimated by the Secretary for the unreimbursed start-up costs for any exchange or SHOP exchange. No payments could be made for any operations costs of an exchange.

Sec. 2238. Procedures for Determining Eligibility for Exchange Participation, Premium Credits, and Cost-Sharing Subsidies.

The Secretary of HHS would establish procedures for determining whether or not individuals who want to enroll in an exchange-offered QHBP or to claim a premium credit or cost-sharing subsidy, meet the requirements regarding citizenship or immigration status. Additionally, for those individuals claiming a credit or subsidy, the Secretary would determine whether the individual meets applicable insurance and coverage requirements and if so, the amount of the credit or subsidy. The Secretary of HHS also would establish procedures for determining (1) if an individual's coverage under an employer-sponsored plan is considered unaffordable, and (2) whether or not to grant an annual certification to the individual that would provide an exemption from the individual mandate requirements because there is no affordable QHBP available.

In applying for enrollment in a QHBP offered through an exchange, the applicant would be required to provide individually-identifiable information, including name, address, date of birth, and citizenship or immigration status. In the case of an individual claiming a premium credit or cost-sharing subsidy, the individual would be required to submit to the exchange income and family size information and information regarding changes in marital or family status or income. Personal information provided to the exchange would be submitted to the Secretary of HHS. In turn, the Secretary would submit applicable information to the Social Security Commissioner, Homeland Security Secretary, and Treasury Secretary for verification purposes. The Secretary of HHS would be notified of the results following verification, and would notify the exchange of such results. The provision specifies actions to be undertaken if inconsistencies are found. The Secretary of HHS, in consultation with the Treasury Secretary, Homeland Security Secretary, and Social Security Commissioner, would establish procedures for appealing determinations resulting from the verification process, and redetermining eligibility on a periodic basis. The personal information submitted for verification would be used only to the extent necessary for verification purposes and not disclosed to anyone not identified in this provision. Any individual who submits false information due to negligence or disregard of any rules would be subject to a civil penalty of not more than $25,000. Any individual who intentionally provides false information would be guilty of a felony and, upon conviction, fined not more than $250,000, imprisonment for not more than 5 years, or both. Any person who intentionally uses the personal information in violation of this provision would be guilty of a felony and, upon conviction, fined not more than $5,000, imprisonment for not more than 5 years, or both.

Sec. 2239. Streamlining of Procedures for Enrollment through an Exchange and State Medicaid and CHIP Programs.

The Secretary would establish a process for allowing state residents to apply for and participate in applicable state health subsidy programs. In establishing this process, the Secretary would (1) develop a single, streamlined application form for all applicable state health subsidy programs that may be filed through a variety of means, and (2) provide a notice of eligibility to applicants without any need for additional information or paperwork, unless specifically required by law.

The Secretary would develop for each state a secure electronic interface that the applicable state health subsidy program may use for eligibility determination, verification, and updating of information. The Secretary, in consultation with the Treasury Secretary, Homeland Security Secretary, Social Security Commissioner, and any applicable state authorities, would require the use of the interface for purposes of determining eligibility for, and amount of, premium credits and cost-sharing subsidies. The Secretary could enter into agreements regarding the exchange of data through the interface.

An exchange could contract with an entity or state Medicaid agency for carrying out its activities under this title. Nothing in this section would change any requirement that eligibility for participation in a state's Medicaid program be determined by a public agency.

Applicable state health subsidy programs would include QHBPs offered through an exchange, including premium credits and cost-sharing subsidies, state Medicaid programs, state children's health insurance programs, and a state program establishing qualified basic health plans as specified under Sec. 2228.

Sec. 1102 Encouraging Meaningful Use of Electronic Health Records.

Present Law

Congress enacted the Health Information Technology for Economic and Clinical Health (HITECH) Act as part of the American Recovery and Reinvestment Act of 2009 (P.L. 111-5) to promote the widespread adoption of interoperable electronic health records (EHRs). Among its provisions, the HITECH Act authorized bonus payments for eligible professionals and hospitals participating in Medicare and Medicaid as an incentive for them to become meaningful users of certified EHR systems. The HITECH Act defines meaningful use to include using certified EHR technology for the purpose of exchanging clinical information to improve the coordination and quality of care, and using such technology to report clinical quality measures. Beginning in 2011, Medicare incentives will be paid to eligible professionals and hospitals that are meaningful EHR users. These incentive payments will be phased out over time and, beginning in 2015, replaced with financial penalties for providers that have not become meaningful EHR users. In addition to the Medicare incentives, the HITECH Act authorized a 100 percent Federal match for payments to qualifying Medicaid providers for the adoption and meaningful use of certified EHR technology. Medicaid incentive payments will be available for a period of up to six years.

Committee Bill

The Committee Bill would require the HHS Secretary to conduct a study on methods that can be used by QHBPs offered through an exchange to encourage meaningful use of EHRs by providers. Such methods include incentive payments and promotion of low-cost EHR software, including systems available through the Veterans Administration. Within 24 months of enactment, the Secretary would be required to submit to Congress a report containing the results of the study, together with recommendations on the feasibility and effectiveness of such payment incentives. The Secretary would be required to disseminate the report to exchanges no later than 12 months after submitting the report to Congress.

Subtitle C—Making Coverage Affordable

PART I – Essential Benefits Coverage

Sec. 1201. Provisions to ensure coverage to essential benefits.

Title XXII of the Social Security Act is amended by adding the following.

PART C – Making Coverage Affordable

"Subpart 1 – Essential Benefits Coverage"

Sec. 2241. Requirements for qualified health benefits plan.

Present Law

No provision.

Committee Bill

A health benefits plan would be a QHBP only if the plan provides an essential benefits package (Sec. 2242); the plan provides coverage at the bronze, silver, gold, or platinum level (Sec. 2243); and the plan's offeror charges the same premium whether the plan is purchased through an exchange, the offeror, or an agent.

Sec. 2242. Essential Benefits Package Defined.

Present Law

Federal law does not define an essential benefit package for the private health insurance market. States have the primary responsibility of regulating the business of insurance and may define state benefit mandates. However, Federal law requires that private health insurance include certain benefits and protections, for services covered by a plan. HIPAA and subsequent amendments require, for example, that group health plans and insurers who cover maternity care also cover minimum hospital stays for the maternity care, provide parity in annual and lifetime limits for any offered mental health benefits, and offer reconstructive breast surgery if the plan covers mastectomies.

Committee Bill

As described below, an essential benefits package would be required to (1) provide payment for a specified set of services; (2) limit-cost sharing; (3) meet requirements for specific items and services; and (4) not impose any annual or lifetime limits.

Provide payment for a specified set of services: all plans would be required to provide the following set of services:

- Hospitalization;
- Outpatient hospital and outpatient clinic services, including emergency department services;
- Professional services of physicians and other health professionals;
- Medical and surgical care;
- Services, equipment, and supplies incident to physician and health professional care in appropriate settings;
- Prescription drugs;
- Rehabilitative and habilitative services;
- Mental health and substance use disorder services, including behavioral health treatment;
- Preventive services, as specified;
- Maternity benefits; and
- Well baby and well child care and oral health, vision, and hearing services, equipment, and supplies for children under 21.

Limit cost-sharing: The essential benefits package would be subject to cost-sharing requirements, with no cost-sharing allowed for required preventive items and services.
For plan years beginning in 2013, cost-sharing under an essential benefits package could not exceed the dollar amounts for the sum of the annual deductible and out-of-pocket limits in effect for an HSA for self-only and family coverage, as appropriate. For plan years beginning in 2014, these cost sharing dollar amounts would increase by the premium adjustment percentage (PAP). The PAP is defined as the percentage (if any) by which the average per capita premium for health insurance coverage in the U.S. for the preceding calendar year exceeds the 2012 average value. These averages would be estimated by the Secretary by October 1st of the relevant preceding year. The cost-sharing dollar amount for individual coverage would be the cost-sharing amount for 2013 increased by the PAP, while the cost sharing dollar amount for family coverage would be twice that amount, rounded down to the nearest $50.

Deductibles for the essential benefits package would be limited. In the small group market, the deductible could not exceed $2,000 for an individual plan, and $4,000 for any other plan. These amounts could be increased by the amount of any mandatory employer contributions to a health benefits arrangement. The deductible limitations would be applied so as not to affect the actuarial value of any QHBP, including bronze-level plans. Catastrophic plans would be exempt from these limitations.

Cost-sharing under an essential benefits package would be the same for the treatment of conditions within each of the following four categories (1) hospitalization; (2) outpatient hospital and outpatient clinic services, including emergency department services; (3) professional services of physicians and other health professionals; and (4) services, equipment, and supplies incident to physician and health professional care in appropriate settings.

Value-based plans would be exempt from certain requirements; they could charge cost-sharing for preventive services and they could charge different cost-sharing within the four categories specified directly above. A value-based design is defined as a methodology that would reduce or

eliminate cost-sharing for the clinically beneficial preventive screenings, lifestyle interventions, medications, immunizations, diagnostic tests and other procedures and treatments to reflect their high value and effectiveness.

Meet requirements for specific items and services: Essential benefits packages would be subject to certain rules.

- At least meet the class and category of drug coverage requirements specified in Medicare Part D,
- At least meet the minimum standards required by Federal or State law for coverage of mental health and substance use disorder services;
- Any plan that varies premiums based on tobacco use must also provide coverage for comprehensive tobacco cessation programs including counseling and pharmacotherapy;
- Include coverage of day surgery and related anesthesia, diagnostic images and screening, and radiation on chemotherapy;
- If a health benefits plan offered stand-alone dental benefits through an exchange, another health benefits plan offered through the exchange would not fail to be treated as a QHBP solely because it did not cover the same dental benefits; and
- For emergency care, the plan would be required to provide coverage without prior authorization and without limitation on coverage if the provider does not have a contractual relationship with the plan. Cost-sharing for out-of-network emergency services could not exceed cost-sharing for in-network emergency services.

Beginning July 1, 2012, the Secretary of HHS would be required to define and update the categories of covered treatments, items and services within benefit classes no less than annually. The Secretary could not define a package that is more extensive than a typical employer plan as certified by the Centers for Medicare and Medicaid Services, Office of the Actuary. Some flexibility in plan design would be allowed as long as it did not encourage adverse selection. The Secretary would be required to update or modify these definitions to account for changes in medical evidence or scientific advancement or to address any gaps in access or changes in the evidence base.

Each state would be required to ensure that at least one plan offered in the exchange is at least actuarially equivalent to the standard Blue Cross Blue Shield plan offered to Federal employees.

If any item or service covered by a QHPB is provided by a Federally-qualified Health Center to an enrollee, the plan offeror would pay the center at least the amount that would have been paid to the center under Medicaid.

Sec. 2243. Levels of Coverage.

Present Law

Generally, Federal law has certain requirements regarding actuarially equivalent benefit options only in the context of private plan offerings through Federal health insurance programs (e.g., Medicare Parts C and D, the State Children's Health Insurance Program). There is no Federal

law regarding actuarially equivalent benefit options in group and individual private health insurance. However, states may have such standards.

For example, Massachusetts defines a standard gold benefit package for private health insurance available in its Connector. According to the state's 2006 guidance to health insurers, a plan with a different design could be qualified as gold if it had an actuarial value within five percent of the standard gold's value. The state permits two other benefit packages available to all individuals in the Connector: Insurers were instructed that silver benefit packages were to be 80 percent of gold (plus or minus 7.5 percent), and bronze packages were to be 60 percent of gold (plus or minus two percent). However, these amounts were not set in statute and have changed somewhat over time. An additional option is available to young adults in Massachusetts; plans may exclude prescription drugs and/or limit annual plan benefit payments.

Committee Bill

A health benefits plan would be required to provide a bronze, silver, gold or platinum benefit package. The bronze benefit package would provide benefits that are actuarially equivalent to 65 percent of the essential benefits package. The silver, gold, and platinum would provide benefits that are the actuarially equivalent to 70 percent, 80 percent, and 90 percent of the essential benefits package, respectively.

A separate catastrophic plan would be available for those who are younger than 26 before the beginning of the plan year, as well as those who have a certification in effect that they are exempt from the individual responsibility requirement because there is no affordable QHBP available to them in the exchange. The catastrophic plan would have the same deductible as required by a Health Savings Account (HSA)-eligible high deductible health plan, with no cost-sharing for required preventive services.

Plans could be offered only to children; the same QHBP offered at any level of coverage could also be offered with enrollment limited to those under the age of 21.

State insurance commissioners could allow de minimus variation around the benefit target valuations to account for differences in actuarial estimates.

Sec. 2244. Application of Certain Rules to Plans in Group Markets.

Health insurance plans offered in the large or small group market in a state could not impose unreasonable annual or lifetime limits (within the meaning of section 223 of the Internal Revenue Code (IRC)). This provision would not apply to grandfathered plans.

For plan years beginning after June 30, 2013, in the case of a health benefits plan offered in the large group market, the state would require the plan to meet the requirements relating to annual limits on cost-sharing, including not allowing cost-sharing for required preventive items and services.

Each state would require any employer with more than 200 employees that offers enrollment in one or more health benefit plans to automatically enroll new full-time employees in one of those plans and to continue the enrollment of current employees in a plan. Auto-enrollment programs would be required to include adequate notice and an opportunity for an employee to opt out.

Sec. 2245. Special Rules Relating to Coverage of Abortion Services.

Present Law

Currently, Federal funds may be used to pay for abortions only if a pregnancy is the result of an act of rape or incest, or where a woman suffers from a physical disorder, physical injury, or physical illness that would place the woman in danger of death unless an abortion is performed. Many private insurance plans, however, include coverage for abortion beyond these limited categories

In addition, Federal conscience protection laws prohibit recipients of certain Federal funds from discriminating against certain medical personnel and health care entities for engaging in, or refusing to engage in, specified activities related to abortion.

Committee Bill

Under the bill, a health benefits plan would not be required to provide coveragefor abortions. The offeror of a health benefits plan would determine whether or not the plan provides coverage of abortion as part of its essential benefits package for the plan year.

The Secretary would ensure that in any exchange, at least one qualified health benefits plan does not provide coverage of abortions beyond those for which the expenditure of Federal funds appropriated for the Department of Health and Human Services is permitted (herein called "the Hyde limitations"). A QHBP would be treated as not providing coverage of abortions beyond the Hyde limitations if it does not provide coverage for any abortions. The Secretary would also ensure that in any exchange, at least one QHBP provides coverage for abortions beyond the Hyde limitations. If a state has one exchange covering both the individual and small group markets, the Secretary would be required to provide the aforementioned assurances with respect to each market.

The offeror of a QHBP that provides coverage of abortions beyond the Hyde limitations may could not use any amount attributable to a premium assistance credit or any cost-sharing subsidy to pay for such services. In addition, the offeror would be required to segregate all premium assistance credits and cost-sharing subsidies from an amount equal to the actuarial value of providing abortions beyond the Hyde limitations for all enrollees, as estimated by the Secretary. The Secretary would be required to estimate, on an average actuarial basis, the basic per enrollee, per month cost of including coverage of abortions beyond the Hyde limitations. In making such estimate, the Secretary could take into account the impact of including such coverage on overall costs, but could not consider any cost reduction estimated to result from providing such abortions, such as prenatal care. The Secretary would be required to estimate the costs as if

coverage were included for the entire covered population, but the costs could not be estimated at less than $1 per enrollee, per month.

Qualified health benefits plans could not discriminate against any individual health care provider or health care facility because of its willingness or unwillingness to provide, pay for, provide coverage of, or refer for abortions.

Sec. 1202. Application of State and Federal Laws Regarding Abortion.

Present Law

The performance of and payment for abortions is regulated by both state and Federal laws. State law, for example, sometimes prescribes parental notification requirements, mandatory waiting periods and other procedural requirements before an abortion may be performed. Under Federal law, certain kinds of Federal funds may not be used to pay for abortions and certain recipients of Federal funds may not discriminate against specified health care entities that perform or refuse to perform, pay for, provide referrals for, or provide training for abortions.

Committee bill

This provision would ensure that state laws regarding the prohibition or requirement of coverage or funding for abortions, and state laws involving abortion-related procedural requirements are not preempted. The provision similarly provides that Federal conscience protection and abortion-related antidiscrimination laws would not be affected by the bill. The rights and obligations of employees and employers under Title VII of the Civil Rights Act of 1964 would also not be affected by the bill.

Sec. 1203. Application of Emergency Services Laws.

Present Law

As a condition of Medicare participation, the Emergency Medical Treatment and Active Labor Act (EMTALA) requires hospitals with emergency departments to provide an initial screening examination and any necessary treatment to stabilize any emergency medical conditions discovered. Care must be provided to anyone who comes to the hospital and requests emergency medical services regardless of whether an individual is insured, has the ability to pay for services, is lawfully present within the United States, or any other characteristic.

In addition to this Federal requirement, some states impose similar obligations on hospitals and other health care providers. For example, California requires all health care facilities to provide emergency medical services and care to any person if the facility has appropriate facilities and qualified personnel.

Committee Bill

This provision would prohibit any construction of the Act that would relieve health care providers of their obligations to provide emergency services as required by state or Federal law, including EMTALA.

PART II – Low Income and Small Business Credits and Subsidies

"Subpart A – Low-Income Credits and Subsidies"

Sec. 1205 Premium Tax Credits and Cost-sharing Subsidies

Present Law

Currently there is no tax credit that is generally available to low or middle income individuals or families for the purchase of health insurance. Some individuals may be eligible for health coverage through State Medicaid programs which consider income, assets, and family circumstances. However, these Medicaid programs are not in the Code.

Health coverage tax credit

Certain individuals are eligible for the health coverage tax credit (HCTC). The HCTC is a refundable tax credit equal to 80 percent of the cost of qualified health coverage paid by an eligible individual. In general, eligible individuals are individuals who receive a trade adjustment allowance (and individuals who would be eligible to receive such an allowance but for the fact that they have not exhausted their regular unemployment benefits), individuals eligible for the alternative trade adjustment assistance program, and individuals over age 55 who receive pension benefits from the Pension Benefit Guaranty Corporation. The HCTC is available for "qualified health insurance," which includes certain employer-based insurance, certain State-based insurance, and in some cases, insurance purchased in the individual market.

The credit is available on an advance basis through a program established and administered by the Treasury Department. The credit generally is delivered as follows: the eligible individual sends his or her portion of the premium to the Treasury, and the Treasury then pays the full premium (the individual's portion and the amount of the refundable tax credit) to the insurer. Alternatively, an eligible individual is also permitted to pay the entire premium during the year and claim the credit on his or her income tax return.

Individuals entitled to Medicare and certain other governmental health programs, covered under certain employer-subsidized health plans, or with certain other specified health coverage are not eligible for the credit.

COBRA continuation coverage premium reduction

The Consolidated Omnibus Reconciliation Act of 1985 (COBRA, P.L. No. 99-272) requires that a group health plan must offer continuation coverage to qualified beneficiaries in the case of a qualifying event (such as a loss of employment). A plan may require payment of a premium for any period of continuation coverage. The amount of such premium generally may not exceed 102 percent of the "applicable premium" for such period and the premium must be payable, at the election of the payor, in monthly installments.

Section 3001 of the American Recovery and Reinvestment Act of 2009 (ARRA, P.L. No. 111-5) provides that, for a period not exceeding nine months, an assistance eligible individual is treated as having paid any premium required for COBRA continuation coverage under a group health plan if the individual pays 35 percent of the premium. Thus, if the assistance eligible individual pays 35 percent of the premium, the group health plan must treat the individual as having paid the full premium required for COBRA continuation coverage, and the individual is entitled to a subsidy for 65 percent of the premium. An assistance eligible individual generally is any qualified beneficiary who elects COBRA continuation coverage and the qualifying event with respect to the covered employee for that qualified beneficiary is a loss of group health plan coverage on account of an involuntary termination of the covered employee's employment (for other than gross misconduct). In addition, the qualifying event must occur during the period beginning September 1, 2008, and ending December 31, 2009.

The COBRA continuation coverage subsidy also applies to temporary continuation coverage elected under the Federal Employees Health Benefits Program and to continuation health coverage under State programs that provide coverage comparable to continuation coverage. The subsidy is generally delivered by requiring employers to pay the subsidized portion of the premium for assistance eligible individuals. The employer then treats the payment of the subsidized portion as a payment of employment taxes and offsets its employment tax liability by the amount of the subsidy. To the extent that the aggregate amount of the subsidy for all assistance eligible individuals for which the employer is entitled to a credit for a quarter exceeds the employer's employment tax liability for the quarter, the employer can request a tax refund or can claim the credit against future employment tax liability.

There is an income limit on the entitlement to the COBRA continuation coverage subsidy. Taxpayers with modified adjusted gross income exceeding $145,000 (or $290,000 for joint filers), must repay any subsidy received by them, their spouse, or their dependant, during the taxable year. For taxpayers with modified adjusted gross incomes between $125,000 and $145,000 (or $250,000 and $290,000 for joint filers), the amount of the subsidy that must be repaid is reduced proportionately. The subsidy is also conditioned on the individual not being eligible for certain other health coverage. To the extent that an eligible individual receives a subsidy during a taxable year to which the individual was not entitled due to income or being eligible for other health coverage, the subsidy overpayment is repaid on the individual's income tax return as additional tax. However, in contrast to the HCTC, the subsidy for COBRA continuation coverage may only be claimed through the employer and cannot be claimed at the end of the year on an individual tax return.

Committee Bill

Premium tax credit

The Committee Bill provides a refundable tax credit for eligible individuals and families who purchase health insurance through the state exchanges. The premium tax credit, which is refundable and payable in advance directly to the insurer, subsidizes the purchase of certain health insurance plans through the state exchanges. The premium tax credit is available for individuals (single or joint filers) with modified gross incomes (MGI) up to 400 percent of the Federal poverty level (FPL). MGI is defined as an individual's (or couple's) total income

without regard to sections 911 (regarding the exclusion from gross income for citizen or residents living abroad), 931 (regarding the exclusion for residents of specified possessions), and 933 (regarding the exclusion for residents of Puerto Rico), plus any tax-exempt interest received during the tax year, plus the MGI of dependents listed on the return. Thus, certain deductions from gross income that are allowed in determining adjusted gross income but not total income, such as the deduction for contributions to an individual retirement arrangement, are disregarded. In order to be eligible for the premium tax credit taxpayers who are married (within the meaning of Code section 7703) must file a joint return. Individuals who are listed as dependants on a return are ineligible for the premium tax credit.

Under the Committee Bill, an eligible individual enrolls in a plan offered through a state exchange and reports his or her MGI to the exchange. States are permitted to enter into contracts with State Medicaid agencies to make eligibility determinations for the credit. Based on the information provided to the state exchange, the individual receives a premium tax credit based on income according to the schedule outlined below, and the Treasury pays the premium tax credit amount directly to the insurance plan in which the individual is enrolled. The individual then pays to the plan in which he or she is enrolled the dollar difference between the premium tax credit amount and the total premium charged for the plan.[1] Individuals who fail to pay all or part of the remaining premium amount are given a mandatory three-month grace period prior to an involuntary termination of their participation in the plan. For employed individuals who purchase health insurance through a state exchange, the premium payments are made through payroll deductions. Initial eligibility for the premium tax credit is based on the individual's MGI for the tax year ending two years prior to the enrollment period. Individuals (or couples) who experience a change in marital status or other household circumstance, experience a decrease in income of more than 20 percent, or receive unemployment insurance, may update eligibility information or request a redetermination of their tax credit eligibility.

For purposes of the premium tax credit, state exchange participants must provide information from their tax return from two years prior during the open enrollment period for coverage during the next calendar year. The IRS is authorized to disclose to HHS limited tax return information to verify a taxpayer's MGI based on the most recent return information available to establish eligibility for the premium tax credit. Existing privacy and safeguard requirements apply. As described above, individuals who do not qualify for the premium tax credit on the basis of their prior year income may apply for the premium tax credit based on specified changes in circumstances. For individuals and families who did not file a tax return in the prior tax year, the Secretary of HHS will establish alternative income documentation that may be provided to determine income eligibility for the premium tax credit.

In all cases, eligibility is reconciled annually on the individual's Federal income tax return, subject to a "safe harbor." For filers whose current income is less than 300 percent of FPL — and who received a premium tax credit in excess of the level for which they qualified — the "safe harbor" limits the amount that the taxpayer has to repay to $250 for single filers and $400 for joint filers (and for those filing as the head of household). For filers whose current income

[1] Although the credit is generally payable in advance directly to the insurer, individuals may elect to purchase health insurance out-of-pocket and apply to the IRS for the credit at the end of the taxable year.

exceeds 300 percent of FPL, however, there is no a safe harbor and they must repay any premium tax credit received. Filers who overpaid will receive the balance of their credit as a refund from the IRS.

Beginning in 2013, premium tax credits are available on a sliding scale basis for individuals and families between 134-300 percent of FPL to help offset the cost of private health insurance premiums. Beginning in 2014, the credits are also available to individuals and families between 100-133 percent of FPL. However, individuals subject to a five-year waiting period under Medicaid or CHIP are eligible for the premium tax credit beginning in 2013. The credits are based on the percentage of income the cost of premiums represents, rising from two percent of income for those at 100 percent of FPL to 12 percent of income for those at 300 percent of FPL. Individuals between 300-400 percent of FPL are eligible for a premium tax credit based on capping an individual's share of the premium at a flat 12 percent of income. The percentages of income are indexed to the excess of premium growth over income growth beginning in 2014 (in order to hold the share of premiums that enrollees at a given poverty level pay the same over time). For purposes of calculating household size, illegal immigrants are not included in FPL. The premium tax credit amount is tied to the cost of the second lowest-cost silver plan in the area where the individual resides (by age according to standard age factors defined by the Secretary of Health and Human Services), and is available for any plan purchased through the Exchange.

A credit-eligible individual enrolled in any exchange offered plan pays the lesser of the applicable percentage of income or the plan premium. If an individual purchases the second lowest cost silver plan in the area where he or she resides, or any less expensive silver or bronze plan, the individual must only pay the applicable percentage of income (e.g., 12 percent for an individual at 300 percent of FPL). If, however, an individual enrolls in a plan that is more expensive than the second lowest cost silver plan the individual is responsible for the applicable percentage of income plus the difference in premium between the second lowest cost silver plan and the premium of the chosen plan.

Employer offer of health insurance coverage

As a general matter, if an employee is offered employer-provided health insurance coverage, the individual is ineligible for the premium tax credit for health insurance purchased through a state exchange.

If an employee is offered unaffordable coverage by his or her employer or the coverage offered to the employee (and his or her dependent) has an actuarial value of less than 65 percent, or the however, the employee can be eligible for the premium tax credit, but only if the employee declines to enroll in the coverage and purchases coverage through the exchange instead. Unaffordable is defined as coverage with a premium required to be paid by the employee that is ten percent or more of the employee's income, based on the type of coverage applicable (e.g., individual or family coverage). This income limit is indexed to the per capita growth in premiums for the insured market as determined by the Secretary of HHS. If the employee seeks to receive a credit on the basis that an employer offered plan is unaffordable, the employee must seek an affordability waiver from the state exchange and provide information as to family income and the premium of the lowest cost employer option offered to them. The state exchange then provides the waiver to the employee.

For purposes of determining if coverage is unaffordable, required salary reduction contributions are treated as payments required to be made by the employee. However, if an employee is reimbursed by the employer for any portion of the premium for health insurance coverage purchased through the exchange, including any reimbursement through salary reduction contributions under a cafeteria plan, the coverage is employer-provided and the employee is not eligible for premium tax credits. Thus, an individual is not permitted to purchase coverage through the exchange, apply for the premium tax credit, and pay for the individual's portion of the premium using salary reduction contributions under the cafeteria plan of the individual's employer.

No later than five years after the date of the enactment of the provision, the Secretary of the Treasury, in consultation with the Secretary of HHS, must conduct a study of whether the percentage of household income used for purposes of determining whether coverage is affordable is the appropriate level for determining whether coverage is affordable for an employee and whether such level can be lowered without significantly increasing the costs to the Federal Government and reducing employer-provided health coverage. The Secretary of the Treasury reports the results of such study to the appropriate committees of Congress, including any recommendations for legislative changes.

Eligibility verification

In order to prevent undocumented aliens from obtaining the premium tax credits, the provision requires that an individual's personal data be verified under the procedures established by Section 2238 of the Social Security Act.

Information Used to Determine Tax Credit Eligibility

All personal information used to determine eligibility for the tax credit submitted to a state exchange shall be protected by restrictions on use and disclosure in Section 2238 of the Social Security Act and Section 6103 of the Internal Revenue Code.

Cost-sharing subsidy

A cost-sharing subsidy is provided to buyout any difference in cost sharing between the insurance purchased and the actuarial values specified below. For individuals between 100-150 percent of FPL, the subsidy brings the value of the plan to 90 percent actuarial value. For those between 150-200 percent of FPL, the subsidy brings the value of the plan to 80 percent actuarial value. For individuals above 200 percent of FPL, no subsidy for cost sharing is provided. The amount received by an insurer in a 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 tax credit, the IRS is authorized to disclose to HHS limited tax return information to verify a taxpayer's MGI based on the most recent return information available.

Effective Date

The provision is effective July 1, 2013.

Sec. 1206. Cost-sharing subsidies and advance payments of premium credits and cost-sharing subsidies.

Present Law

Currently there is no tax credit that is generally available to low or middle income individuals or families for the purchase of health insurance. Some individuals may be eligible for health coverage through state Medicaid programs which consider income, assets, and family circumstances. However, these Medicaid programs are not in the tax code.

Certain individuals are eligible for the health coverage tax credit (HCTC). The HCTC is a refundable tax credit equal to 80 percent of the cost of qualified health coverage paid by an eligible individual. In general, eligible individuals are individuals who receive a trade adjustment allowance (and individuals who would be eligible to receive such an allowance but for the fact that they have not exhausted their regular unemployment benefits), individuals eligible for the alternative trade adjustment assistance program, and individuals over age 55 who receive pension benefits from the Pension Benefit Guaranty Corporation. The credit is available for "qualified health insurance," which includes certain employer-based insurance, certain State-based insurance, and in some cases, insurance purchased in the individual market. Individuals entitled to Medicare and certain other governmental health programs, covered under certain employer-subsidized health plans, or with certain other specified health coverage are not eligible for the credit.

The credit is available on an advance basis through a program established and administered by the Treasury Department. The credit generally is delivered as follows: the eligible individual sends his or her portion of the premium to the Treasury, and the Treasury then pays the full premium (the individual's portion and the amount of the refundable tax credit) to the insurer. Alternatively, an eligible individual is also permitted to pay the entire premium during the year and claim the credit on his or her income tax return.

The Consolidated Omnibus Reconciliation Act of 1985 (COBRA, P.L. 99-272) requires that a group health plan must offer continuation coverage to qualified beneficiaries in the case of a qualifying event (such as a loss of employment). A plan may require payment of a premium for any period of continuation coverage. The amount of such premium generally may not exceed 102 percent of the "applicable premium" for such period and the premium must be payable, at the election of the payor, in monthly installments.

Section 3001 of the American Recovery and Reinvestment Act of 2009 (ARRA, P.L. 111-5) provides that, for a period not exceeding nine months, an assistance eligible individual is treated as having paid any premium required for COBRA continuation coverage under a group health plan if the individual pays 35 percent of the premium. Thus, if the assistance eligible individual pays 35 percent of the premium, the group health plan must treat the individual as having paid the full premium required for COBRA continuation coverage, and the individual is entitled to a subsidy for 65 percent of the premium. An assistance eligible individual generally is any qualified beneficiary who elects COBRA continuation coverage and the qualifying event with respect to the covered employee for that qualified beneficiary is a loss of group health plan

coverage on account of an involuntary termination of the covered employee's employment (for other than gross misconduct). In addition, the qualifying event must occur during the period beginning September 1, 2008, and ending December 31, 2009.

The low income tax credit also applies to Temporary Continuation Coverage elected under the Federal Employees Health Benefits Program (FEHBP) and to continuation health coverage under State programs that provide coverage comparable to continuation coverage. The subsidy is generally delivered by requiring employers to pay the subsidized portion of the premium for assistance eligible individuals. The employer then treats the payment of the subsidized portion as a payment of employment taxes and offsets its employment tax liability by the amount of the low-income tax credit. To the extent that the aggregate amount of the subsidy for all assistance eligible individuals for which the employer is entitled to a credit for a quarter exceeds the employer's employment tax liability for the quarter, the employer can request a tax refund or can claim the credit against future employment tax liability.

There is an income limit on entitlement to the low-income tax credit. Taxpayers with modified adjusted gross income exceeding $145,000 (or $290,000 for joint filers), must repay any subsidy received by them, their spouse, or their dependents during the taxable year. For taxpayers with modified adjusted gross incomes between $125,000 and $145,000 (or $250,000 and $290,000 for joint filers), the amount of the subsidy that must be repaid is reduced proportionately. The subsidy is also conditioned on the individual not being eligible for certain other health coverage. To the extent that an eligible individual receives a subsidy during a taxable year to which the individual was not entitled due to income or being eligible for other health coverage, the subsidy overpayment is repaid on the individual's income tax return as additional tax. However, in contrast to the HCTC, the subsidy for COBRA continuation coverage may only be claimed through the employer and cannot be claimed at the end of the year on an individual tax return.

Committee Bill

Adds to the Social Security Act as amended by the bill.

"Subpart 2 – Premium Credits And Cost-sharing Subsidies"

Sec. 2246. Premium Credits.

The Committee Bill would provide premium assistance in the form of a refundable tax credit for individuals with incomes less than 400 percent of the FPL as calculated by Sec.1205 of the bill.

Sec. 2247. Cost-sharing Subsidies for Individuals Enrolling in Qualified Health Benefit Plans.

The Committee Bill would define an eligible insured as an individual not more that 400 percent of the FPL (for the family size involved) enrolled in a QHBP at the bronze or silver level of coverage in an exchange. The Secretary would notify the plan that the individual is eligible and the plan would reduce the cost-sharing by reducing the out-of-pocket limit under the bill by the following amounts by income category (for the family size involved):

- 2/3 for household income greater than 100 percent and less than 200 percent of the FPL,
- 1/2 for household income greater than 200 percent and less than 300 percent of the FPL,
- 1/3 for household income greater than 300 percent and less than 400 percent of the FPL.

The Committee Bill would instruct the Secretary to establish procedures whereby the plan would provide additional reductions in cost-sharing. The reductions would be consistent with the plan's share of total allowable costs being 90 percent for an eligible individual whose household income is between 100 percent and 150 percent of the FPL for the family size involved and 80 percent for an eligible individual whose household-income is between 150 percent and 200 percent of the FPL for the family size involved. The proposal is part of the fail-safe mechanism to prevent an increase in Federal budget deficit under Sec.1209 and would reduce the reduction in cost-sharing by the percentage specified by that section of the proposal.

The plan would notify the Secretary of cost-sharing reductions and the Secretary would make periodic and timely payments to the plan equal to the value of the reductions in cost-sharing. The Committee Bill authorizes the Secretary to establish a capitated payment system with appropriate risk adjustments.

The Committee Bill would implement special rules for Indians (as defined by the Indian Health Care Improvement Act) and undocumented aliens. For Indians whose household income is not more than 300 percent FPL (for the family size involved) and is enrolled in a QHBP through an exchange, then the individual would be treated as an eligible and the plan would eliminate any cost-sharing. The Committee Bill would also mandate that if that Indian were to be furnished an item or service directly by the Indian Health Service, an Indian Tribe, Tribal Organization, Urban Indian Organization, or through referral under contract health services, no cost-sharing under the plan would be imposed for that item or service, and the plan would not reduce the payment to the entity. The Secretary would pay the QHBP the amount necessary to reflect the actuarial value of this proposal.

For undocumented aliens the Committee Bill would prohibit cost-sharing reductions and the individual would not be taken into account in determining the family size involved, but the individual's modified gross income would be taken into account in determining household income. The Committee Bill would treat an individual as an undocumented alien unless the information required is provided.

The Committee Bill would define any term used in this section that is also used by section 36B of the Internal Revenue Code of 1986 as having the same meaning as defined by the latter. The Committee Bill would also deny subsidies to dependents, with respect to whom a deduction under 151 of the Internal Revenue Code is allowable to another taxpayer for a taxable year beginning in the calendar year in which the individual's taxable year begins. Further the Committee Bill would not permit a subsidy for any month that is not treated as a coverage month.

Sec. 2248. Advance Determination and Payment of Premium Credits and Cost-sharing Subsides.

The Committee Bill would instruct the Secretary, in consultation with the Secretary of the Treasury, to establish a program whereupon at the request of an exchange, advance determinations are made for determining income eligibility of individuals enrolling in a QHBP through the exchange for premium credits and cost-sharing subsidies. The Committee Bill would require the Secretary to notify the exchange and the Secretary of the Treasury of the advance determinations, and the Secretary of the Treasury would make advance payments of the credit or subsidy to the QHBPs.

The Committee Bill would require the Secretary to provide, under the program, that advanced determination during the annual open enrollment period be applicable to the individual or another enrollment period that may be specified by the Secretary. The Committee Bill would require that the advance determination be made on the basis of the individual's household income for the second taxable year preceding the taxable year in which enrollment through the enrollment period first takes effect.

The Committee Bill also would require the Secretary to provide procedures for making advanced determinations in cases where information included with an application form demonstrates substantial changes in income, changes in family size, a change in filing status, the filing of an application for unemployment benefits, or other significant changes affecting eligibility including (1) allowing an individual claiming a decrease of 20 percent of more in income, or filing an application of unemployment benefits, to have eligibility for the credit determined on the basis of household income for a later period or on the basis of the individual's estimate of such income for the taxable year; and (2) the determination of household income in cases where the taxpayer was not required to file a return of tax imposed by this chapter for the second preceding taxable year.

The Committee Bill would require the Secretary to notify the Secretary of the Treasury and the exchange through which the individual is enrolling of the advanced determinations made. The Committee Bill would require the Secretary of the Treasury to make the advance payment for a premium credit to the QHBP on a monthly basis or such other periodic basis as the Secretary may provide. The Committee Bill would require the QHBP that would be receiving advanced payments to reduce the premium charged for any period by the amount of the advanced payment received for the period. The QHBP would also be required to notify the Secretary of Health and Human Services of the reduction, notify the Secretary of any cases of nonpayment of premiums by the insured, and allow a three-month grace period for nonpayment of premiums before discontinuing coverage.

The Committee Bill stipulates that no advance payment would be made unless there has been a verification of the individual's citizenship or nationality or lawful presence in the United States.

Sec. 1207. Disclosures to Carry Out Eligibility Requirements for Certain Programs

Present Law

Section 6103 provides that returns and return information are confidential and may not be disclosed by the Internal Revenue Service ("IRS"), other Federal employees, State employees, and certain others having access to such information except as provided in the Internal Revenue Code. Section 6103 contains a number of exceptions to the general rule of nondisclosure that authorize disclosure in specifically identified circumstances. For example, section 6103 provides for the disclosure of certain return information for purposes of establishing the appropriate amount of any Medicare Part B premium subsidy adjustment.

Section 6103(p)(4) requires, as a condition of receiving returns and return information, that Federal and State agencies (and certain other recipients) provide safeguards as prescribed by the Secretary of the Treasury by regulation to be necessary or appropriate to protect the confidentiality of returns or return information. Unauthorized disclosure of a return or return information is a felony punishable by a fine not exceeding $5,000 or imprisonment of not more than five years, or both, together with the costs of prosecution.[2] The unauthorized inspection of a return or return information is punishable by a fine not exceeding $1,000 or imprisonment of not more than one year, or both, together with the costs of prosecution.[3] An action for civil damages also may be brought for unauthorized disclosure or inspection.[4]

Committee Bill

Under the Committee Bill, individuals will submit income and family size information to the state exchanges as part of an application process in order to claim the cost-sharing subsidy and the tax credit on an advance basis.[5] The Department of Health and Human Services (HHS) serves as the centralized verification agency for information submitted by individuals to the state exchanges with respect to the subsidy and the tax credit to the extent provided on an advance basis. The bill permits the IRS to substantiate the accuracy of income and family size information that has been provided to HHS for eligibility determination.

Specifically, upon written request of the Secretary of HHS, the IRS is permitted to disclose the following return information of any taxpayer applying to a state exchange whose income and family size is relevant in determining the amount of the tax credit or cost-sharing subsidy or eligibility for participation in the specified State health subsidy programs (i.e., a State Medicaid program under title XIX of the Social Security Act, a State's children's health insurance program under title XXI of such Act, or a basic health program under section 2228 of such Act): (1) taxpayer identity; (2) the filing status of such taxpayer; (3) the modified gross income (as defined in new sec. 36B of the Code) of such taxpayer and of any other individual for whom a dependency deduction is allowed with respect to such taxpayer; (4) such other information as is prescribed by Treasury regulation as might indicate whether such taxpayer is eligible for the credit or subsidy (and the amount thereof); and (5) the taxable year with respect to which the preceding information relates, or if applicable, the fact that such information is not available. HHS is permitted to disclose to officers, employees and contractors of the state exchanges, or of

[2] Sec. 7213.
[3] Sec. 7213A.
[4] Sec. 7431.
[5] Under the bill, the state exchanges are permitted to contract with its state Medicaid agencies to perform certain exchange functions.

the State agency administering the programs referenced above whether there is a discrepancy between the information submitted and IRS records.

The disclosed return information may be used only for the purposes of, and only to the extent necessary in establishing eligibility for participation in the exchange, and verifying the appropriate amount of the tax credit, and cost-sharing subsidy, or eligibility for the specified State health subsidy programs.

Recipients of the confidential return information are subject to the safeguard protections and civil and criminal penalties for unauthorized disclosure and inspection. The IRS is required to make an accounting for all disclosures.

Effective Date

The Committee Bill is effective on the date of enactment.

Sec. 1208. Premium Credits and Subsidy Refunds and Payments Disregarded for Federal and Federally-Assisted Programs

Present Law

Currently there is no tax credit that is generally available to low or middle income individuals or families for the purchase of health insurance.

Committee Bill

Any premium tax credits and cost-sharing subsidies provided to an individual under the Committee Bill are disregarded for purposes of determining that individual's eligibility for benefits or assistance, or the amount or extent of benefits and assistance, under any Federal program or under and State or local program financed in whole or in part with Federal funds. Specifically, any amount of premium tax credit provided to an individual is not counted as income, and cannot be taken into account as resources for the month of receipt and the following two months. Any cost sharing subsidy provided on the individual's behalf is treated as made to the health plan in which the individual is enrolled.

Sec. 1209. Fail-safe Mechanism to Prevent Increase in Federal Budget Deficit.

Present Law

No provision.

Committee Bill

Failsafe

Beginning in 2012, the President must certify annually in the President’s Budget whether or not the provisions in this bill will increase the budget deficit in the coming fiscal year. In the event the President determines that the provisions in this bill will increase the deficit, he or she

would be required to include with the certification, the percentage by which the exchange credits and subsidies in this bill need to be reduced, such that the aggregate amount of such reductions is equal to the amount of the deficit increase. The President must then instruct the Secretary of Health and Human Services and the Secretary of the Treasury to make such reductions in these credits and subsidies.

Effective Date

The provision is effective for the President's Budget submitted in 2012.

"Subpart B – Credit for Small Employers"

Sec. 1221. Small Business Tax Credit

Present Law

The Code does not provide a tax credit for employers that provide health coverage for their employees. The cost to an employer of providing health coverage for its employees is generally deductible as an ordinary and necessary business expense for employee compensation.[6] In addition, the value of employer- provided health insurance is not subject to employer paid Federal Insurance Contributions Act (FICA) tax.

The Code generally provides that employees are not taxed on the value of employer-provided health coverage under an accident or health plan. That is, these benefits are excluded from gross income. In addition, medical care provided under an accident or health plan for employees, their spouses, and their dependents is excluded from gross income. Active employees participating in a cafeteria plan may be able to pay their share of premiums on a pre-tax basis through salary reduction.[7] Such salary reduction contributions are treated as employer contributions and thus also are excluded from gross income.

Committee Bill

<u>Small business employers eligible for the credit</u>

Under the Committee Bill, a tax credit is provided for a qualified small employer for contributions to purchase health insurance for its employees. A qualified small business employer for this purpose generally is an employer with no more than 25 full-time equivalent employees (FTEs) employed during the employer's taxable year, and whose employees have annual full-time equivalent wages that average no more than $40,000. However, the full amount of the credit is available only to an employer with ten or fewer FTEs and whose employees have average annual fulltime equivalent wages from the employer of less than $20,000. These wage limits are indexed to CPI-U for years beginning in 2014. Under the provision, an employer's FTEs are calculated by dividing the total hours worked by all employees during the employer's tax year by 2080. For this purpose, the maximum amount of hours that are counted for any

[6] Sec. 162. However see special rules in sections 419 and 419A for the deductibility of contributions to welfare benefit plans with respect to medical benefits for employees and their dependents.
[7] Sec. 125.

single employee are 2080. Wages are defined the same as for purposes of FICA and the average wage is determined by dividing the total wages paid by the small employer by the number of FTEs. Hours worked and wages earned by seasonal workers are exempt from these calculations for purposes of determining eligibility for the small business tax credit. A seasonal worker is defined as an individual who performs labor or services on a seasonal basis where, ordinarily, the employment pertains to or is the kind exclusively performed at certain seasons or periods of the year and which, by nature, may not be continuous or carried on throughout the year.

The credit is only available to offset actual tax liability and is claimed on the employer's tax return. The credit is not payable in advance to the taxpayer or refundable. Thus, the employer must pay the employees' premiums during the year and claim the credit at the end of the year on its income tax return. The credit is a general business credit, and can be carried back for one year and carried forward for 20 years. The credit is available for tax liability under the alternative minimum tax.

Years the credit is available

Phase I.

Under the provision, the credit is initially available for a maximum of two taxable years for any qualified small business employer offering health insurance. Health insurance coverage for Phase I is health insurance coverage within the meaning of Code section 9832 which is generally health insurance coverage purchased from an insurance company licensed under State law. This initial phase of the credit is available for tax years 2011 and 2012.

Phase II.

For taxable years beginning in 2013, the credit is only available for a small business employer that purchases health insurance coverage for its employees through the State exchange but only with respect to premiums for coverage after June 30, 2013. If a State has not yet adopted the reformed rating rules, qualifying small business employers in the State are not eligible to receive the credit. The credit is available for the first two years that a qualified small employer purchases health insurance coverage for its employees through the State exchange.

Calculation of credit amount

Phase I

The credit is equal to the applicable percentage of the small business employer's contribution to the health insurance premium for each covered employee. Only non-elective contributions by the employer are taken into account in calculating the credit. Therefore, any amount contributed pursuant to a salary reduction arrangement under a cafeteria plan within the meaning of section 125 is not treated as an employer contribution for purposes of this credit. The credit is equal to the dollar amount of the employer's contribution multiplied by an applicable percentage. The first step in determining the applicable percentage is to calculate the employer's contribution as a percentage of the lesser of (1) the total premium for an employee's coverage or (2) a small business bench mark premium. This tax credit is only available if this percentage is at least 50. If the employer contribution percentage is at least 50, the applicable tax credit percentage is 35.

The bench mark premium is the average total premium cost in the small group market for employer sponsored coverage in the employer's State. The premium and the benchmark premium vary based on the type of coverage being provided to the employee (i.e., single, adult with child, family or two adults).

Phase II

The credit is equal to the applicable percentage of the small business employer's contribution to the health insurance premium for each covered employee. Only non-elective contributions by the employer are taken into account in calculating the credit. Therefore, any amount contributed pursuant to a salary reduction arrangement under a cafeteria plan within the meaning of section 125 is not treated as an employer contribution for purposes of this credit. The credit is equal to the dollar amount of the employer's contribution multiplied by an applicable percentage. The first step in determining the applicable percentage is to calculate the employer's contribution as a percentage of the lesser of (1) the total premium for an employee's coverage or (2) a small business bench mark premium. This tax credit is only available if this percentage is at least 50. If the employer contribution percentage is at least 50, the applicable tax credit percentage is 50. The bench mark premium is the average total premium cost in the small group market for employer sponsored coverage in the employer's State. The premium and the benchmark premium vary based on the type of coverage being provided to the employee (i.e., single, adult with child, family or two adults).

Special rules

For both the Phase I and Phase II credits, the employer is entitled to a deduction under section 162 equal to the amount of the employer contribution minus the dollar amount of the credit. For example, if a qualified small employer pays 100 percent of the cost of its employees' health insurance coverage and the tax credit under this provision is 50 percent of that cost, the employer is able to claim a section 162 deduction for the other 50 percent of the premium cost.

The credit is phased out for employers with more than ten FTEs but not more than 25 FTEs by six percent of the base credit percentage for each employee above ten. Simultaneously, the credit phases out for an employer for whom the average wages per employee is between $20,000 and $40,000 at a rate of five percent for each $1,000 increase of average wages above $20,000.

The employer is determined by applying the employer aggregations rules in section 414(b), (c), and (m). In addition, the definition of employee includes a leased employee within the meaning of section 414(n).[8]

[8] Section 414(b) provides that, for specified employee benefit purposes, all employees of all corporations which are members of a controlled group of corporations are treated as employed by a single employer. There is a similar rule in section 414(c) under which all employees of trades or businesses (whether or not incorporated) which are under common are treated under regulations as employed by a single employer, and, in section 414(m), under which employees of an affiliated service group (as defined in that section) are treated as employed by a single employer. Section 414(n) provides that leased employees, as defined in that section, are treated as employees of the service recipient for specified purposes. Section 414(o) authorizes the Treasury to issue regulations to prevent avoidance of the certain requirement under section 414(m) and 414(n).

Organizations exempt from tax under section 501(a) by reason of being described in section 501(c)(3) (i.e., charitable organizations) that otherwise qualify for the small business tax credit are eligible to receive the credit. However, for tax-exempt organizations, the applicable percentage for the credit during Phase I is limited to 25 and the applicable percentage for the credit during Phase II is limited to 35. The small business tax credit is otherwise calculated in the same manner for tax-exempt organizations that are qualified small employers as the tax credit is calculated for all other qualified small employers. Charitable organizations are eligible to apply the tax credit against the organization's liability as an employer for payroll taxes for the taxable year to the extent of: (1) the amount of income tax withheld from its employees under section 3401(a), (2) the amount of hospital insurance tax withheld from its employees under section 3101(b), (3) and the amount of the hospital tax imposed on the organization under section 3111(b). However, the charitable organization is not eligible for a credit in excess of the amount of these payroll taxes.

Self-employed individuals, including partners and sole proprietors, two percent share-holders of an S Corporation, and five percent owners of a C Corporation are not treated as employees for purposes of this credit. There is also a special rule to prevent sole proprietorships from receiving the credit for the owner and their family members. Thus, no credit is available for contribution to the purchase of health insurance for these individuals and the individual is not taken into account in determining the number of employees or average full-time equivalent wages.

Effective Date

The Committee Bill is effective for taxable years beginning after December 31, 2010.

Subtitle D - Shared Responsibility

PART I – Individual Responsibility

Sec. 1301. Penalty on Individuals Without Essential Health Benefits Coverage

Present Law

Federal law does not require individuals to have health insurance. Only the Commonwealth of Massachusetts, through its statewide program, requires that individuals have health insurance (although this policy has been considered in other states, such as California, Maryland, Maine, and Washington). All adult residents of Massachusetts are required to have health insurance that meets “minimum creditable coverage” standards if it is deemed “affordable” at their income level under a schedule set by the board of the Commonwealth Health Insurance Connector Authority ("Connector"). Individuals report their insurance status on State income tax forms. Individuals can file hardship exemptions from the mandate; persons for whom there are no affordable insurance options available are not subject to the requirement for insurance coverage.

For taxable year 2007, an individual without insurance and who was not exempt from the requirement did not qualify under Massachusetts law for a State income tax personal exemption.

For taxable years beginning on or after January 1, 2008, a penalty is levied for each month an individual is without insurance. The penalty consists of an amount up to 50 percent of the lowest premium available to the individual through the Connector. The penalty is reported and paid by the individual with the individual's Massachusetts State income tax return at the same time and in the same manner as State income taxes. Failure to pay the penalty results in the same interest and penalties as apply to unpaid income tax.

Committee Bill

Personal responsibility requirement

Beginning July 1, 2013, all U.S. citizens and legal residents are required to maintain health insurance coverage. Coverage may be acquired through the individual market, a public program such as Medicare, Medicaid, the Children's Health Insurance Program, Veteran's Health Care Program, TRICARE, or through an employer (or as a dependent of a covered employee). If coverage is acquired through an employer in the small group market, it must meet or exceed the requirements of a bronze plan in the exchange. If the employer is in the large group market, the plan must provide first dollar coverage for prevention-related services[9], have no unreasonable annual or lifetime limits on coverage, and have a maximum out-of-pocket limit that is less than that provided by the standards established under the HSA Present Law limit in order to meet minimum creditable coverage. Exemptions from the requirement to have health coverage are allowed for religious objections that are consistent with those allowed under Medicare, and for undocumented aliens. An individual enrolled in a grandfathered plan, or individuals of any age enrolled in "young invincibles" policies in an exchange are deemed to have met the responsibility requirement.

In order to ensure compliance, individuals are required to report on their Federal income tax return the months for which they maintain the required minimum health coverage for themselves and all dependents under age 18. In addition, insurers (including employers who self-insure), must report information on health insurance coverage to both the covered individual and to the IRS. Insurers will be required to identify the primary insured individual and any other individuals covered by the policy, as well as the dates during which the individual maintained coverage during the tax year. Insurers may be required to include other relevant information as determined by the Secretary. A similar reporting requirement applies to employers with respect to individuals enrolled in public health insurance plans or group health plans if the reporting is not provided by the insurer (e.g. in the case of self-insured plans).

Open enrollment in the individual market.

The initial open-enrollment period for eligible individuals in the individual and small-group market (excluding grandfathered plans) lasts from March 1, 2013 through May 31, 2013, and during the same period in subsequent years. Special enrollment periods are allowed for qualifying events, consistent with those included in the Public Health Service Act, such as when an individual becomes a dependent through marriage or birth, or when an individual loses other health insurance coverage. There may be additional special enrollment periods allowed,

[9] Except in cases where value-based insurance design is used.

consistent with those allowed under Medicare Part D (for example, special enrollment periods may be allowed for exceptional circumstances as determined by the Secretary of Health and Human Services). During each annual open enrollment period individuals may change plans or remain in their current plan.

Penalty

Individuals who fail to maintain essential health benefits coverage are subject to a penalty of $750 per adult in the household, with a maximum of two adults per household. This per adult penalty is phased in as follows: $0 for 2013; $200 for 2014; $400 for 2015; $600 in 2016, $750 in 2017 and indexed to CPI-U beginning in 2018 and thereafter.

The penalty applies to any period during which the individual is not covered by a health insurance plan with the minimum required benefit but is prorated for partial years of noncompliance. No penalty is assessed for individuals not maintaining health insurance for a period less than or equal to three months in the tax year. However, penalties are assessed for those not insured for more than three months during the tax year.

The penalty is assessed through the Code and accounted for as an additional amount of Federal tax owed. However, it is not subject to the enforcement provisions of subtitle F of the tax code.[10] Instead, in cases in which payment is not forthcoming following the initial notice and demand for payment, collection is limited to withholding of Federal payments otherwise due to the uninsured individual. The use of liens and seizures otherwise authorized for collection of taxes does not apply to the collection of this penalty. Non-compliance with the personal responsibility requirement to have health coverage is not subject to criminal or civil penalties under the Code and interest does not accrue for failure to pay such assessments in a timely manner.

Exemptions from the penalty are allowed for individuals where the full premium of the lowest cost option available to them (net of subsidies and employer contribution, if any) exceeds eight percent of their AGI in 2013. This income limit is indexed to the excess of premium growth over income growth beginning in 2014. Exemptions from the penalty are also allowed for individuals below 100 percent of the Federal Poverty Level, individuals with sincerely held beliefs who participate in health arrangements provided by established religious organizations (e.g., those participating in Health Sharing Ministries), individuals experiencing hardship situations (as determined by the Secretary of HHS) and individuals who are Indians as defined in section 4 of the Indian Health Care Improvement Act. Determinations of an individuals' exemption, do not take into account income from individuals not subject to the requirement.

The Government Accountability Office must 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

[10] IRS authority to assess and collect taxes is generally provided in subtitle F "Procedure and Administration" in the Code. That subtitle establishes the rules governing both how taxpayers are required to report information to the IRS and pay their taxes as well as their rights. It also establishes the duties and authority of the IRS to enforce the Code, including civil and criminal penalties.

meet the personal responsibility requirement. Such report shall be made to the Congressional committees of jurisdiction no later than February 1, 2014. The committees must report legislation no later than April 1, 2014 to examine the implementation and assessment of the provision and to bring such legislation to the floor in each chamber within 15 days of reporting by such committees. In the Senate, this legislation is subject to 30 hours of debate. Once passed by both chambers, the conference report is limited to ten hours of debate in the Senate.

Automatic enrollment

Employers with 200 or more employees must automatically enroll employees into health insurance plans offered by the employer. Employees may decline employer coverage, however, if they are able to demonstrate that they have coverage from another source (e.g., through a public program such as Medicare, Medicaid or the Children's Health Insurance Program or as a dependent in a spouse or other family member's health benefits).

Additionally, States have the option to establish a process for auto-enrollment of individuals and families into policies offered in the individual and small group markets. State programs for auto enrollment must be approved by the Secretary of HHS.

Effective Date

The Committee Bill is effective for taxable years beginning after December 31, 2012.

Sec. 1302. Reporting of Health Insurance Coverage

Present Law

No provision.

Committee Bill

Under the Committee Bill, insurers (including employers who self-insure and therefore act as insurers) that provide essential health benefits coverage to an individual coverage must report certain health insurance coverage information to both the covered individual and to the Internal Revenue Service. In the case of coverage provided by a governmental unit or any agency or instrumentality of a governmental unit, the reporting requirement applies to the person or employee who enters into the agreement to provide coverage (or their designee).

The information required to be reported includes the name, address and taxpayer identification number of the primary insured and each other individual obtaining coverage under the policy, the dates during which the individual was covered under the policy during the calendar year, the amount of any premium tax credit or cost-sharing subsidy received by the individual with respect to such coverage, and such other information as the Secretary may require.

To the extent the coverage is provided through the group health plan of the individual's employer, the insurer is also required to report the name, address and employer identification number of the employer, the portion of the premium, if any, required to be paid by the employer,

and any information the Secretary may require to administer the new tax credit for qualified small employers.

The insurer is required to report the above information, along with the name, address and contact information of the reporting insurer, to the covered individual on or before the January 31 of the year following the calendar year for which the information is required to be reported to the Internal Revenue Service.

Effective Date

The Committee Bill is effective for calendar years beginning after 2012.

PART II – Employer Responsibility

Sec. 1306. Employer-Provided Health Insurance Coverage

Present Law

Currently, there is no Federal requirement that employers offer health insurance coverage to employees or their families. However, as with other compensation, the cost of employer-provided health coverage is a deductible business expense under section 162 of the Code.[11] In addition, employer-provided health insurance coverage is generally not included in an employee's gross income.[12]

Employees participating in a cafeteria plan may be able to pay the portion of premiums for health insurance coverage not otherwise paid for by their employers on a pre-tax basis through salary reduction.[13] Such salary reduction contributions are treated as employer contributions for purposes of the Code, and are thus excluded from gross income.

One way that employers can offer employer-provided health insurance coverage for purposes of the tax exclusion is to offer to reimburse employees for the premiums for health insurance purchased by employees in the individual health insurance market. The payment or reimbursement of employees' substantiated individual health insurance premiums is excludible from employees' gross income.[14] This reimbursement for individual health insurance premiums can also be paid for through salary reduction under a cafeteria plan.[15] However, this offer to reimburse individual health insurance premiums constitutes a group health plan

The Employee Retirement Income Security Act of 1974 (ERISA)[16] preempts State law relating to certain employee benefit plans, including employer-sponsored health plans. While ERISA specifically provides that its preemption rule does not exempt or relieve any person from any State law which regulates insurance, ERISA also provides that an employee benefit plan is not

[11] Sec. 162. However see special rules in sections 419 and 419A for the deductibility of contributions to welfare benefit plans with respect to medical benefits for employees and their dependents.
[12] Sec. 106.
[13] Sec. 125.
[14] Rev. Rul. 61-146 (1961-2 CB 25).
[15] Proposed Treas. Reg. sec.1.125-1(m).
[16] P.L. 93-406

deemed to be engaged in the business of insurance for purposes of any State law regulating insurance companies or insurance contracts. As a result of this ERISA preemption, self-insured employer-sponsored health plans need not provide benefits that are mandated under State insurance law.

While ERISA does not require an employer to offer health benefits, it does require compliance if an employer chooses to offer health benefits, such as compliance with plan fiduciary standards, reporting and disclosure requirements, and procedures for appealing denied benefit claims. There are other Federal requirements for health plans which include, for example, rules for health care continuation coverage.[17] The Code imposes an excise tax on group health plans that fail to meet these other requirements.[18] The excise tax generally is equal to $100 per day per failure during the period of noncompliance and is imposed on the employer sponsoring the plan.

Under Medicaid, States may establish "premium assistance" programs, which pay a Medicaid beneficiary's share of premiums for employer-sponsored health coverage. Besides being available to the beneficiary through his or her employer, the coverage must be comprehensive and cost-effective for the State. An individual's enrollment in an employer plan is considered cost-effective if paying the premiums, deductibles, coinsurance and other cost-sharing obligations of the employer plan is less expensive than the State's expected cost of directly providing Medicaid-covered services. States are also required to provide coverage for those Medicaid-covered services that are not included in the private plans. A 2007 analysis showed that 12 States had Medicaid premium assistance programs as authorized under Present Law.

Committee Bill

Penalty for employees receiving premium credits.

Any employer with more than 50 employees that does not offer coverage for all its full-time employees, does not provide coverage that is affordable, or does not provide coverage with an actuarial value of at least 65 percent, is required to pay a penalty. The penalty is an excise tax that is imposed for each employee who receives a premium tax credit for health insurance purchased through a state exchange. The number of employees is determined based on the number of full-time employees during the most recent year using the definition of employee that applies for purposes of determining if an employer is eligible for the small employer exception from COBRA continuation coverage.[19]

For each full-time employee (defined as working 30 hours or more each week) receiving a premium tax credit through a state exchange, the employer is required to pay a flat dollar amount set by the Secretary of HHS and published in a schedule each year. The flat dollar amount is equal to the national average tax credit. These payments are not linked to an individual employee, but are contributed to a general fund. The penalty for each employer is capped at an amount equal to $400 multiplied by the total number of employees of the employer (regardless

[17] These rules were added to ERISA and the Code by the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") (Pub. L. No. 99-272).
[18] Sec. 4980B.
[19] Treas. Reg. 54.4980B-3, Q&A 2.

of how many are receiving the premium tax credit). This amount is indexed to premium growth in the state exchanges beginning in 2014.

Thus, the employer must pay the lesser of the flat dollar amount multiplied by the number of full-time employees receiving a tax credit or an excise tax of $400 per employee paid on its total number of full-time employees. For example, Employer A, who does not offer health coverage, has 100 employees, 30 of whom receive a tax credit for enrolling in a state exchange offered plan. If the flat dollar amount set by the Secretary of HHS for that year is $3,000, Employer A should owe $90,000. Since the maximum amount an employer must pay per year is limited to $400 multiplied by the total number of employees (for Employer A, 100), however, Employer A must pay only $40,000 (the lesser of the $40,000 maximum and the $90,000 calculated tax).

The excise taxes imposed under this provision are payable on an annual, monthly or other periodic basis as the Secretary of Treasury may prescribe. The excise taxes imposed under this provision for employees receiving premium tax credits are not deductible under section 162 as a business expense.

Employer offer of health insurance coverage.

Under the Committee Bill, as under Present Law, an employer is not required to offer health insurance coverage. If an employee is offered health insurance coverage by his or her employer and chooses to enroll in the coverage, the employer-provided portion of the coverage is excluded from gross income. The tax treatment is the same whether the employer offers coverage outside of a state exchange or the employer offers a coverage option through a state exchange.

Definition of coverage

As a general matter, if an employee is offered affordable employer-provided health insurance coverage, the individual is ineligible for a premium tax credit for health insurance purchased through a state exchange.

Unaffordable coverage

If an employee is offered unaffordable coverage by their employer or coverage with an actuarial value of less than 65 percent, however, the employee can be eligible for the premium tax credit, but only if the employee declines to enroll in the coverage and purchases coverage through the exchange instead. Unaffordable is defined as coverage with a premium required to be paid by the employee that is more than 10 percent of the employee's household MGI (as defined for purposes of the premium tax credits provided under the bill). This percentage of the employee's income is indexed to the per capita growth in premiums for the insured market as determined by the Secretary of HHS. The employee must seek an affordability waiver from the state exchange and provide information as to family income and the premium of the lowest cost employer option offered to them. The state exchange then provides the waiver to the employee. The employer penalty applies for any employee(s) receiving an affordability waiver.

For purposes of determining if coverage is unaffordable, required salary reduction contributions are treated as payments required to be made by the employee. However, if an employee is reimbursed by the employer for any portion of the premium for health insurance coverage

purchased through the exchange, including any reimbursement through salary reduction contributions under a cafeteria plan, the coverage is employer-provided and the employee is not eligible for premium tax credits. Thus, an individual is not permitted to purchase coverage through the exchange, apply for the premium tax credit, and pay for the individual's portion of the premium using salary reduction contributions under the cafeteria plan of the individual's employer.

Within five years of implementation, the Secretary of HHS must conduct a study to determine if the definition of affordable could be lowered without significantly increasing costs or decreasing employer coverage.

Effect of Medicaid enrollment

A Medicaid-eligible individual can always choose to leave the employer's coverage and enroll in Medicaid, and an employer is not required to pay an excise tax for any employees enrolled in Medicaid.

Report on the effect of the excise taxes

The Secretary of Labor is required to review and report to Congress the effect of the excise taxes and assessments on workers' wages. In order to conduct the statistical analysis necessary to conduct this review, the secretary of Labor must use the Bureau of Labor Statistics' National Compensation Survey. The National Compensation Survey provides comprehensive measures of wages and employment costs. Earnings data is available for metropolitan and rural areas, broad geographic regions and on a national basis.[20]

Effective Date

The effective date for this provision is July 1, 2013.

Subtitle E – Federal Program for Health Care Cooperatives

Sec. 1401. Establishment of Federal Program for Health Care Cooperatives.

PART D – Federal Program for Health Care Cooperatives

Present Law

There is no Present Law facilitating the creation of non-profit, member-run health insurance companies. Furthermore, there is no Present Law authorizing the Secretary to provide grants or

[20] The Department of Labor currently administers several programs where they have an obligation to determine that an activity will not adversely affect American workers' salaries or working conditions. For example, the Department's Employment Training Administration performs that function under the foreign labor certification program.

loans to existing non-profit, member-run health insurance companies. The Committee Bill builds, in part, on existing non-profit tax law which is summarized below.

Health insurance may be provided by different types of insurance companies including mutual, stock ownership, life, and property and casualty. Present law provides special rules for determining the taxable income of insurance companies. Both mutual insurance companies (e.g. collective owned by its members) and stock insurance companies are subject to Federal income tax under these rules. Separate sets of rules apply to life insurance companies and to property and casualty insurance companies. Insurance companies are subject to Federal income tax at regular corporate income tax rates.

An insurance company that provides health insurance is subject to Federal income tax as either a life insurance company or as a property insurance company, depending on its mix of lines of business and on the resulting portion of its reserves that are treated as life insurance reserves. For Federal income tax purposes, an insurance company is treated as a life insurance company if the sum of its (1) life insurance reserves and (2) unearned premiums and unpaid losses on non-cancellable life, accident or health contracts not included in life insurance reserves, comprises more than 50 percent of its total reserves.

The IRC generally provides for exemption from Federal income tax for certain organizations. These organizations include, among other, those that engage in insurance activities including: (1) certain fraternal beneficiary societies, orders, or associations operating under the lodge system or for the exclusive benefit of their members, that provide for the payment of life, sick, accident, or other benefits to the members or their dependents; (2) certain voluntary employees' beneficiary societies that provide for the payment of life, sick, accident, or other benefits to the members of the association or their dependents or designated beneficiaries; (3) certain benevolent life insurance associations of a purely local character; (4) certain small, non-life insurance companies with annual gross receipts of no more than $600,000 ($150,000 in the case of a mutual insurance company); (5) certain membership organizations established to provide health insurance to certain high-risk individuals; (6) certain organizations established to provide workers' compensation insurance.

Certain health maintenance organizations (HMOs) have been held to qualify for tax exemption as charitable organizations. Specifically, the Tax Court held that a staff model HMO qualified as a charitable organization. A staff model HMO generally employs its own physicians and staff and serves its subscribers at its own facilities. The court concluded that the HMO satisfied the community benefit standard, as its membership was open to almost all members of the community. Although membership was limited to persons who had the money to pay the fixed premiums, the court held that this was not disqualifying because the HMO had a subsidized premium program for persons of lesser means to be funded through donations and Medicare and Medicaid payments. The HMO also operated an emergency room open to all persons regardless of income. Generally speaking, the Courts have held that a healthcare provider must make its services available to all in the community plus provide additional community or public benefits. The benefit must either further the function of government-funded institutions or provide a service that would not likely be provided within the community but for the subsidy. Further, the

additional public benefit conferred must be sufficient to give rise to a strong inference that the public benefit is the primary purpose for which the organization operates.

Tax law also provides that an organization may not be exempt from tax unless no substantial part of its activities consists of providing commercial-type insurance. For this purpose, commercial-type insurance excludes, among other things: (1) insurance provided at substantially below cost to a class of charitable recipients and (2) incidental health insurance provided by an HMO of a kind customarily provided by such organizations. At enactment of this law in 1986, the following reasons for the provision were stated: (1) concern that exempt charitable and social welfare organizations that engaged in insurance activities are engaged in an activity whose nature and scope is so inherently commercial that tax exempt status is inappropriate; (2) belief that the tax-exempt status of organizations engaged in insurance activities provides an unfair competitive advantage to these organizations; and (3) the availability of tax-exempt status provides incentive for some large insurance entities to compete directly with commercial insurance companies.

Committee Bill

PART D – Federal Program for Health Care Cooperatives

Sec. 2251. Federal Program To Assist Establishment And Operation Of Nonprofit, Member-Run Health Insurance Issuers.

The Committee Bill authorizes $6 billion in funding for, and instructs the Secretary, to establish the Consumer Operated and Oriented Plan (CO-OP) program to foster the creation of non-profit, member-run health insurance companies that offer qualified health benefits that serve eligible individuals in one or more states. CO-OP grantees would compete in the reformed individual and small group insurance markets on a level regulatory playing field. Federal funds would be distributed as loans for start-up costs and grants for meeting solvency requirements.

Under the Committee Bill, no later than January 1, 2010, the Secretary would make the grant and loan awards. The Secretary would make grant and loan awards after taking into account the recommendations of the advisory board chaired by the Secretary or a designate. The Secretary would make grant and loan awards giving priority to applicants that will offer qualified health benefits on a statewide basis, that use an integrated care model, and have significant private support. The Secretary would ensure that there is sufficient funding to establish at least one qualified non-profit health insurance issuer in each state and the District of Columbia. If no health insurance issuer applies within a state, the Secretary may use funds for the program to award grants to encourage the establishment of qualified issuers within the state or the expansion of an issuer from another state to the state with no applicants.

The Committee Bill would require that those receiving loans or grants under the CO-OP program enter into an agreement with the Secretary requiring the recipient of CO-OP funds to meet and continue to meet any requirement to be treated as a qualified nonprofit health insurance issuer, and any requirements to receive the loan or grant. The Committee Bill would also require that the agreement prohibit the use of loan or grant funds for carrying on propaganda, attempting to influence legislation, or marketing. The Committee Bill further stipulates that if the Secretary

determined that a grantee failed to meet the aforementioned requirements, and failed to implement appropriate corrective action within a reasonable period of time after being made aware of such failure, then the grantee would repay the Secretary 110 percent of the aggregate amount of the loans and grants received plus interest. The Secretary would then notify the Secretary of the Treasury of any failure that results in the termination of the issuer's tax exempt status under the Committee Bill.

The Committee Bill would require the Secretary to award loans and grants under the CO-OP program no later than January 1, 2012. The Committee Bill would further require that the Secretary make such awards after receiving recommendations from an advisory board consisting of 15 members appointed by the Comptroller General of the United States meeting the same qualifications for appointment to the Medicare Payment Advisory Commission. Board members would be required to be appointed within three months of enactment of the Committee Bill and would be required to satisfy ethics and conflict of interest standards protecting against insurance industry involvement and interference. Board members would also generally be subject to the requirements of the Federal Advisory Committee Act. Board members would not be compensated in any way except for travel expenses, including a per diem.

The Committee Bill would define a qualified nonprofit health insurance issuer as an organization meeting the following requirements:

(1) It must be organized as a non-profit, member corporation under State law;

(2) It must not be an existing organization that provides insurance as of July 16, 2009, and must not be an affiliate or successor of any such organization;

(3) Substantially all of its activities must 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;

(4) It must not be sponsored by a state, county, or local government, or any government instrumentality;

(5) Its governing documents incorporate ethics and conflict of interest standards protecting against insurance industry involvement and interference;

(6) Governance of the organization must be subject to a majority vote of its members;

(7) It must operate with a strong consumer focus, including timeliness, responsiveness, and accountability to members in accordance with regulations to be promulgated by the Secretary of HHS;

(8) It must be in compliance with all the other requirements that other qualified health benefits plans must meet in any state, including solvency and licensure requirements, rules on payments to providers, rules on network adequacy, rates and form filing rules, and any applicable state premium assessments. Additionally, the organization would be required to coordinate with state insurance reforms described in Sec. 2225(a)(2)(A); and

(9) Any profits made would be required to be used to lower premiums, improve benefits, or other programs intended to improve the quality of health care delivered to members.

The Committee Bill would permit organizations participating in the CO-OP program to enter into collective purchasing arrangements for services and items that increase administrative and other cost efficiencies, especially to facilitate start-up of the entities, including claims administration, general administrative services, health information technology, and actuarial services. The Committee Bill would permit establishment of a purchasing council to execute these collective purchasing agreements. The council would be explicitly prohibited from setting payment rates for health care facilities and providers. There would not be any representatives of Federal, state, or local government or any employee or affiliate of an existing private insurer on the council. The council would be subject to existing anti-trust statutes.

The Committee Bill would prohibit the Secretary of HHS from participation in any negotiations between qualified health insurance issuers or a private purchasing council and any health care facilities, providers or drug manufacturer. The Secretary would also be prohibited from establishing or maintaining a price structure or interfering in any way with the competitive nature of providing health benefits through the program.

Under the Committee Bill, an organization receiving a grant or loan under the CO-OP program qualifies for exemption from Federal income tax only 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. CO-OP organizations would also be subject to organizational and operational requirements applicable to certain non-profits under tax law, including the prohibitions on net earnings benefiting any private shareholder or individual, on substantial involvement in political activities, and on lobbying activities.

CO-OP grantees would be required to file an application for exempt status with the Internal Revenue Service and would be subject to annual information reporting requirements under the Committee Bill. In addition, CO-OP grantees would be required to disclose on their annual information return the amount of reserves required by each state in which it operates ("solvency requirement") and the amount of reserves on hand.

Under the Committee Bill, the Comptroller General of the United States would be instructed to have the U.S. Government Accountability Office (GAO) conduct an ongoing study of competition and market concentration in the health insurance market after implementation of the reforms made by this proposal. The study would include an analysis of new health insurance companies in the market and any recommendations for administrative or legislative changes deemed necessary or appropriate to increase competition in the health insurance market. The GAO would report their findings no later than December 31 of each even-numbered year beginning with 2014.

Subtitle F—Transparency and Accountability

Sec. 1501. Provisions Ensuring Transparency and Accountability.
Sec. 2229. Requirements relating to Transparency and Accountability.

Present Law

No provision.

Committee Bill

States would be required to establish an ombudsmen program to address complaints related to health benefits plan issued within the state. The program would (1) require each offeror of a health benefits plan within a state to provide an internal claims appeals process, (2) authorize an individual covered by a plan to have access to the services of an ombudsman if the internal appeal lasts more than three months or involves a life-threatening issue, or (3) to resolve problems with obtaining premium credits or cost-sharing subsidies.

Each state would establish a competitive program to provide grants to eligible entities to develop, support, and evaluate consumer assistance programs related to navigating options for, and selecting appropriate, health plan coverage. The grant application process would be fair and open and attempt to ensure regional and geographic equity. Grantee organizations may include Small Business Development Centers (SBDCs) 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. Organizations would be required to collect and report data to the Secretary on problems and inquiries. There would be $30 million appropriated for fiscal year 2014 to carry out these activities and such sums as necessary in future years.

Sec. 1502 Reporting on Utilization of Premium Dollars and Standard Hospital Charges.

Present Law

No provision.

Committee Bill

For plan years beginning after December 31, 2009, as prescribed by the Secretary of HHS, each offeror of a health benefits plan would report to the Secretary the percent of the premiums collected that are used to pay for items other than medical care. Beginning each calendar year after 2009, each hospital operating within the U.S. would establish (and update) a list of its standard charges of items and services it provides, including each diagnosis-related group included under Medicare.

Sec. 1503. Development and Utilization of Uniform Outline of Coverage Documents.

Present Law

No provision.

Committee Bill

This provision mandates the development and utilization of uniform outline of coverage documents. The Secretary of HHS would 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. In developing such standards, the NAIC shall consult with a working group composed of representatives of consumer advocacy organizations, issuers of health insurance plans, and other qualified individuals.

The standards shall ensure that the outline of coverage is presented in a uniform format of no more than four pages, with print of at least 12-point font, and written in language that is understandable to the average health plan enrollee. The standards shall also ensure that the outline of coverage includes uniform definitions of standard insurance terms as well as a description of the coverage, including dollar amounts for the following benefits: daily hospital room and board, miscellaneous hospital services, surgical services, anesthesia services, physician services, prevention and wellness services, prescription drugs, and other benefits as identified by the NAIC.

The standards should also ensure that the outline of coverage includes the exceptions, reductions and limitations on coverage; the cost-sharing provisions, including deductible, coinsurance and co-payment obligations; the renewability and continuation of coverage provisions; a statement that the outline is a summary of the policy or certificate and that the coverage document itself should be consulted to determine the governing contractual provisions and; a contact number for the consumer to call with additional questions as well as a web link where a copy of the actual individual coverage policy or group certificate of coverage can be reviewed and obtained. For individual policies issued prior to January 1, 2000, the health insurance issuer will be deemed compliant with the web link requirement if the issuer makes a copy of the actual policy available upon request.

If the NAIC submits the standards to the Secretary of HHS within 12 months of enactment, the Secretary has up to 60 days after the submission to promulgate regulations to apply such standards to entities described below. If the NAIC fails to submit to the Secretary the standards within the 12-month period, the Secretary shall, not later than 90 days after the expiration of such 12-month period, promulgate regulations providing for the application of Federal standards for outlines of coverage to entities.

Not later than 24 months after enactment of legislation, each entity described below shall deliver an outline of coverage pursuant to the standards promulgated by the Secretary to an applicant at the time of application; an enrollee at the time of enrollment; or a policyholder or certificate holder at the time of issuance of the policy or delivery of the certificate.

An entity may provide this information in paper or electronic form. An entity includes a health insurance issuer (including a group health plan) offering health insurance coverage within the U.S., a carrier for the Federal Employees Health Benefits Program, the Secretary of HHS with regard to specified Federal health insurance program. The standards would preempt any related state standards that require an outline of coverage. An entity that willfully fails to provide the information required under this section shall be subject to a fine of not more than $1,000 for each such failure. Such failure with respect to each enrollee shall constitute a separate offense for purposes of this subsection.

Sec. 1504. Development of Standard definitions, Personal scenarios, and Annual Personalized Statements.

Present Law

No Provision.

Committee Bill

The Secretary of HHS would be required to do the following:

- Develop standard definitions for health insurance terms including premium, deductible, co-insurance, co-payment, out-of-pocket limit, preferred provider, non-preferred provider, out-of-network co-payments, UCR (usual, customary and reasonable) fees, excluded services, grievance and appeals, and such other terms as the Secretary determines.

- Develop standard definitions for medical terms including hospitalization, hospital outpatient care, emergency room care, physician services, prescription drug coverage, durable medical equipment, home health care, skilled nursing care, rehabilitation services, hospice services, emergency medical transportation, and such other terms as the Secretary determines.

- Develop scenarios which include information regarding on estimated out-of-pocket cost-sharing and significant exclusions or benefit limits for such scenarios.

- Develop standards for an annual personalized statement that summarizes an individual's (including any covered dependents) use of health care services and claims paid in the previous year.

Subtitle G – Role of Public Programs

Part I – Medicaid Coverage for the Lowest Income Populations

Sec. 1601. Eligibility Standards and Methodologies.

Present Law

Eligibility Standards and Methodologies. Medicaid is a means-tested entitlement program operated by states within broad Federal guidelines. Eligibility for Medicaid is determined not only based on financial requirements, but also on categorical requirements – that is, to be eligible for Medicaid, one must be a member of a covered group, such as children, pregnant women, families with dependent children, the elderly, or the disabled. "Childless adults" (non-elderly adults who are not disabled, pregnant, and/or parents of dependent children) on the other hand, are generally not eligible for Medicaid, regardless of their income.

Medicaid's income eligibility requirements place limits on the maximum amount of assets and income individuals may possess. Additional guidelines specify how states should calculate these amounts. The specific asset and income limitations that apply to each eligibility group are set through a combination of Federal parameters and state definitions. Consequently, these standards vary across states, and different standards apply to different population groups within states. For some Medicaid eligibility groups, states are required to disregard certain amounts and/or types of income and expenses. State application of income counting rules expand eligibility to higher-income individuals.

Of the approximately 50 different eligibility "pathways" into Medicaid, some are mandatory while others may be covered at state option. Examples of mandatory groups include pregnant women and children under age six with family income below 133 percent of the Federal poverty level (FPL), children ages six through 18 up to 100 percent of FPL, and certain individuals with disabilities or over age 64 who qualify for cash assistance under the Supplemental Security Income (SSI) program. Examples of optional groups include pregnant women and infants with family income exceeding 133 percent FPL up to 185 percent FPL, and "medically needy" individuals who meet categorical requirements with income up to133 percent of the maximum payment amount applicable under states' former Aid to Families with Dependent Children (AFDC) programs based on family size.

Parents are eligible for Medicaid if they would have been eligible for the former AFDC program as of July 1, 1996. The upper-income threshold for AFDC eligibility in 1996 ranged across states from 11 percent to 68 percent of FPL, although states have the flexibility to raise eligibility to higher levels (in some states, parents are eligible for Medicaid up to 200 percent of FPL) through a state plan amendment.

Under Present Law, states are permitted to make presumptive eligibility determinations to enroll children, pregnant women, and certain women with breast or cervical cancer, for a limited period of time before full Medicaid applications are filed and processed. Medicaid enrollment for such individuals is based on a preliminary determination by Medicaid providers of likely Medicaid eligibility.

Medicaid Benefits. Medicaid benefits are identified in Federal statute and regulations and include a wide range of medical care and services. Some benefits are specific items, such as eyeglasses and prosthetic devices. Other benefits are defined in terms of specific types of providers (*e.g.*, physicians, hospitals). Still other benefits define specific types of services (*e.g.*, family planning services and supplies, pregnancy-related services) that may be delivered by any qualified medical provider that participates in Medicaid. Finally, additional benefits include

premium payments for coverage provided through managed care arrangements and Medicare premium and cost-sharing support for individuals dually eligible for both Medicare and Medicaid.

Some Medicaid benefits are mandatory, meaning they must be made available by states to the majority of Medicaid populations (*i.e.*, those classified as "categorically needy"). Other benefits may be covered at state option. Examples of standard, mandatory benefits include inpatient hospital services, physician services, services provided by Federally qualified health centers, and nursing facility services for individuals ages 21 and over. Examples of standard, optional benefits include prescription drugs (covered by all states), services furnished by other licensed practitioners (*e.g.*, optometrists, podiatrists, psychologists), nursing facility services for individuals under age 21, and physical therapy. States define the specific features of each mandatory and optional service within broad Federal guidelines.

Most Medicaid children under age 21 are entitled to early and periodic screening, diagnostic and treatment (EPSDT) services. Under EPSDT, children must receive well-child visits, immunizations, laboratory tests, vision services, dental services, and hearing services at regular intervals. In addition, medical care that is necessary to correct or ameliorate identified defects, physical and mental illness, and other conditions must be provided.
As an alternative to providing all of the mandatory and selected optional benefits under traditional Medicaid, states have the option to enroll certain state-specified groups in benchmark and benchmark-equivalent benefit plans as permitted under section 1937 of the Social Security Act. These benefit plans are nearly identical to those offered through the Children's Health Insurance Program (CHIP). The benchmark options include: (1) the Blue Cross/Blue Shield preferred provider plan under the Federal Employees Health Benefits Program (FEHBP), (2) a plan offered to state employees, (3) the largest commercial health maintenance organization in the state, and (4) Secretary-approved coverage appropriate for the targeted population.

Benchmark-equivalent coverage must have the same actuarial value as one of the benchmark plans identified above. Such coverage includes the following basic services: (1) inpatient and outpatient hospital services, (2) physician services, (3) lab and x-ray services, (4) well-child care including immunizations, and (5) other appropriate preventive care as designated by the Secretary. Such plans must also include at least 75 percent of the actuarial value of coverage under the benchmark plan for: (1) prescribed drugs, (2) mental health services, (3) vision care, and (4) hearing services. Medicaid beneficiaries enrolled in benchmark and benchmark-equivalent plans must also have access to services provided by rural health clinics and Federally-qualified health centers.

Medicaid Cost-Sharing Rules. Under traditional Medicaid, states are allowed to require certain beneficiaries to share in the cost of Medicaid services, although there are limits on (1) the amounts that states can impose, (2) the beneficiary groups that can be required to pay, and (3) the services for which cost-sharing can be charged. The rules for service-based cost-sharing (*e.g.*, copayments paid to a provider at the time of service delivery) are different from those for participation-related cost-sharing (*e.g.*, premiums paid by beneficiaries typically on a monthly basis independent of any services rendered). States may seek approval under the section 1115 waiver authority to modify certain Medicaid cost-sharing requirements.

As an alternative to traditional Medicaid, the Deficit Reduction Act of 2005 (DRA; P.L. 109-171) provides states with a new option for premiums and service-related cost-sharing that vary by family income (*i.e.*, <100 percent of FPL, 100 percent of FPL-150 percent of FPL, and >150 percent of FPL). Under this option, states may apply premiums and cost-sharing to selected groups, through Medicaid state plan amendments rather than through waiver authority, subject to specific restrictions (*e.g.*, the total aggregate amount of all cost-sharing regardless of family income cannot exceed 5 percent of monthly or quarterly family income).

Under this DRA option, certain groups (*e.g.*, some children, pregnant women, and individuals with special needs) are exempt from paying premiums. Also, certain groups and services (*e.g.*, preventive care for children, emergency care, and family planning services) are exempt from the service-related cost-sharing provisions. Nominal cost-sharing amounts in regulations are indexed by medical inflation over time. Special rules apply to cost-sharing for non-preferred prescription drugs, and for emergency room copayments for non-emergency care. Under certain circumstances, DRA also allows states to condition continuing Medicaid eligibility on the payment of premiums, and allows providers to deny care for failure to pay service-related cost-sharing.

Medicaid Program Payments. Medicaid is financed by the Federal government and the states. The Federal share for most Medicaid expenses for benefits is determined by the Federal medical assistance percentage (FMAP). FMAP is based on a formula that provides higher reimbursement to states with lower per capita income relative to the national average (and vice versa). FMAPs have a statutory minimum of 50 percent and maximum of 83 percent, although some Medicaid services receive a higher Federal match rate. FY2009 FMAPs ranged from a high of 75.8 percent in Mississippi to a low of 50.0 percent in 13 other states.

States' expenditures to administer their Medicaid programs are generally matched by Federal funding at a 50 percent matching rate. Federal matching rates for administrative expenditures are the same for all states, although some activities are matched at higher rates. Within broad Federal guidelines, states generally control Medicaid spending levels by tailoring eligibility, benefits, cost-sharing and premiums paid by beneficiaries, provider reimbursement rates, and other program components to achieve their budget and policy goals. To receive payment for the Federal share of Medicaid expenditures, states submit quarterly expenditure reports to the Centers for Medicare & Medicaid Services (CMS).

Committee Bill

New Mandatory Eligibility Group. The Committee Bill would create a new mandatory Medicaid eligibility category for all non-elderly, non-pregnant individuals (*e.g.*, childless adults and certain parents) who are otherwise ineligible for Medicaid. For such individuals, the Committee Bill would establish 133 percent of FPL (based on modified gross income as described below) as the new mandatory minimum Medicaid income eligibility level beginning on January 1, 2014.

Beginning on January 1, 2011 states would be able to provide Medicaid coverage through a state plan amendment to non-elderly, non-pregnant individuals based on income, so long as the state does not extend coverage to individuals with higher incomes before those with lower incomes.

States that opt to make medical assistance available to pregnant woman or children during a period of presumptive eligibility would also be permitted to provide for a period of presumptive eligibility for medical assistance (not to exceed 60 days) for the new mandatory Medicaid eligibility category of all non-elderly, non-pregnant individuals.

In the case of non-elderly, non-pregnant individuals who are parents, caretaker relatives or non-custodial parents of a child under 19 years of age (or such higher age as the state may have elected) who is Medicaid eligible, such parent may not enroll in Medicaid unless their child is enrolled in the state plan, a waiver, or in other health coverage.

The Committee Bill would also change the mandatory Medicaid upper income eligibility standard for children ages 6 to 19 from 100 percent FPL to 133 percent FPL (as applies to children under age 6).

New Optional Eligibility Group. Beginning on January 1, 2014, the proposal would create a new optional Medicaid eligibility category for all non-elderly, non-pregnant individuals (*e.g.*, childless adults and certain parents) who are otherwise ineligible for Medicaid. For such individuals, family income would exceed 133 percent of FPL (based on modified gross income as described below) but would not be permitted to exceed the highest income eligibility level established under the State plan or under a waiver of the plan as of the date of enactment.

States would be permitted to phase in Medicaid coverage through a state plan amendment to these new optional non-elderly, non-pregnant individuals based on income, so long as the state does not extend coverage to individuals with higher incomes before those with lower incomes.

States that opt to make medical assistance available to pregnant woman or children during a period of presumptive eligibility would also be permitted to provide for a period of presumptive eligibility for medical assistance (not to exceed 60 days) for the new optional Medicaid eligibility category of all non-elderly, non-pregnant individuals.

In the case of optional non-elderly, non-pregnant individuals who are parents, caretaker relatives, or noncustodial parents of a child under 19 years of age (or such higher age as the state may have elected) who is Medicaid eligible, such parent may not enroll in Medicaid unless their child is enrolled in the state plan, a waiver, or in other health coverage.

Maintenance of Medicaid Income Eligibility. The Committee Bill also includes a Medicaid maintenance of effort (MOE) for eligibility for all beneficiaries. States would not be eligible for Medicaid payments for calendar quarters during the period that begins on the date of enactment of the Committee Bill and ends on the date which the Secretary determines that an exchange (established by the state under section 2235 of this bill) is fully operational, if eligibility standards, methodologies, or procedures under its Medicaid plan or waiver) are more restrictive than the eligibility standards, methodologies, or procedures, under such plan or waiver that are in

effect as of the date of enactment . Compliance with the requirement to measure income using modified gross income, as defined below, would not violate the MOE requirement. The MOE requirement would continue through December 31, 2013 for adults whose modified gross income (defined below) is at or below 133 percent of poverty, and through September 30, 2019 for any child who is under age 19 (or such higher age as the State may have elected).

Between January 1, 2011 and January 1, 2014, a state would be exempt from the MOE requirement for optional, non-pregnant, non-disabled, adult populations whose family income is above 133 percent of FPL if the state certifies to the Secretary that the state is currently experiencing a budget deficit or projects to have a budget deficit in the following state fiscal year. The state may make such certification on or after December 1, 2010. Upon submission of a satisfactory certification, the MOE requirement will not apply for the remainder of the three-year period described above.

Medicaid Benefits. Newly-eligible, non-elderly, non-pregnant individuals would receive benchmark or benchmark-equivalent coverage consistent with the requirements of section 1937 of the Social Security Act, as amended by this bill. The newly eligible beneficiaries who meet the definition of currently exempted populations under section 1937, *e.g.*, blind or disabled persons, hospice patients, etc. would continue to be exempted.

The Committee Bill would also make changes to Medicaid benchmark and benchmark-equivalent packages that would apply to all eligible populations. Such packages would be required to provide at least essential benefits (as described in section 2242 of the Committee Bill and as defined and specified annually by the Secretary of HHS). For Medicaid benchmark-equivalent plans, prescription drugs and mental health services would be added to the list of services that must be covered at actuarial equivalence.

Benchmark benefit package or benchmark-equivalent coverage would be required to ensure that the financial requirements and treatment limitations applicable to such benefits comply with the mental health services parity requirements of section 2705(a) of the Public Health Services Act in the same manner as such requirements apply to a group health plan. Coverage that provides EPSDT services would be deemed as meeting the mental health services parity requirement.

The Committee Bill would allow non-elderly, non-pregnant individuals whose income is above 100 percent of FPL but below 133 percent of FPL to choose between Medicaid coverage or coverage purchased through a state exchange.

Medicaid Program Payments. Under the Committee Bill, states would continue to receive Federal financial assistance as determined by FMAP. However, beginning on January 1, 2014 additional Federal financial assistance would be provided to states in order to defray the costs of covering "newly-eligible" individuals (defined below). Those states that, as of the date of enactment, offer minimal or no coverage of the "newly-eligible" population or that offer coverage only to parents or only to non-pregnant childless adults (called "Other States") would receive more assistance initially than those states that cover at least some non-elderly, non-pregnant individuals ("Expansion States"—defined below). For 2014 to 2018, the additional

assistance would be provided through a percentage point increase in FMAP, according to the following schedule:

FOR ANY FISCAL YEAR QUARTER OCCURING IN THE CALENDAR YEAR:	EXPANSION STATES (Percentage point increase is):	OTHER STATES (Percentage point increase is):
2014	27.3	37.3
2015	28.3	36.3
2016	29.3	35.3
2017	30.3	34.3
2018	31.3	33.3

For the purpose of the above table, "Expansion States" are those with health benefits coverage for parents and non-pregnant childless adults whose family income is at least 100 percent of FPL. Such health benefit coverage may not be dependent on access to employer coverage or employment. While coverage may be less comprehensive than Medicaid, the proposal would require such coverage to be more than: (1) premium assistance, (2) hospital-only benefits, (3) a high deductible health plan (as defined in section 223(c)(2) of the Internal Revenue Code of 1986) purchased through a health savings account (HSA) (as defined under section 223(d) of the Internal Revenue Code), or (4) alternative benefits under a demonstration program authorized under section 1938 (health opportunity accounts).

Between January 1, 2014 and December 31, 2018, costs associated with services provided to "newly eligible" (defined below) individuals would be fully financed by the Federal government for "high need" states. "High-need" states would be defined as one of the 50 States or the District of Columbia that (1) has total Medicaid enrollment (under the state plan or under any waiver of the plan) that is below the national average for Medicaid enrollment as a percentage of state population on the date of enactment of this Act, and (2) had a seasonally-adjusted unemployment rate that was at least 12 percent, as determined by the Bureau of Labor Statistics of the Department of Labor for August 2009.

Beginning January 1, 2019, and for succeeding fiscal years, amounts expended for medical assistance on "newly eligible" individuals with family income less than 133 percent of FPL, the FMAP would be increased by 32.3 percentage points.

Finally, except for the temporary help for "high-needs" states, FMAP rates for amounts expended for medical assistance on "newly eligible" individuals (including percentage point increases) would not be permitted to exceed 95 percent in any year.

"Newly eligible" individuals would be defined as non-elderly, non-pregnant individuals with family income below 133 percent of FPL who are: (1) not under the age of 19 (or such higher age as the state may have elected under section 1902(l)(1)(D)); and (2) not eligible under the state plan (or a waiver) for full Medicaid benefits or Medicaid benchmark or benchmark-equivalent coverage, or who are eligible but not enrolled due to a capped waiver (or those individuals who are on a waiting list) for such benefits as of the date of enactment.

For the period that begins on October 1, 2013 and ends on September 30, 2019, the FMAP rate for applicable states or the District of Columbia with respect to amounts expended for medical assistance for individuals who are "not newly" eligible (as defined above) would be increased by 0.15 percentage point and in the case of the territories, would be increased by 0.075 percentage points**.** The increase in the FMAP rate would not be permitted to apply with respect to:

- Disproportionate Share Hospital Payments;
- Payments under title IV of the Social Security Act**;**
- Payments under title XXI of the Social Security Act (the Children's Health Insurance Program); and
- Payments under title XIX of the Social Security Act that are based on the CHIP enhanced FMAP rate.

New Reporting Requirements. The Committee Bill would require states to report changes in Medicaid enrollment beginning in January 2015, and every year thereafter. States would be required to report the total number of newly enrolled individuals in the State plan or under a waiver for the fiscal year ending on September 30th of the preceding calendar year disaggregated by: (1) children, (2) parents, (3) non-pregnant, childless adults, (4) disabled individuals, (5) elderly individuals, and (6) such other categories or sub-categories of individuals eligible for Medicaid as the Secretary may require. States would also be required to report on the outreach and enrollment processes they used to achieve such enrollment. The Secretary would be required to submit a report to the appropriate committees of Congress beginning in April 2015, and every year thereafter, on total new enrollment in Medicaid, on a national and state-by-state basis. Such report would be required to include any recommendations to Congress for improving Medicaid enrollment.

Sec. 1602. Income Eligibility For Nonelderly Determined Using Modified Gross Income.

Present Law

Eligibility for Medicaid is determined not only based on categorical requirements, but also financial requirements. Medicaid's income eligibility requirements place limits on the maximum amount of assets and income individuals may possess. Additional guidelines specify how states should calculate these amounts. The specific asset and income limitations that apply to each eligibility group are set through a combination of Federal parameters and state definitions. Consequently, these standards vary across states, and different standards apply to different groups within states. For some Medicaid eligibility groups, states are required to disregard certain amounts and/or types of income and sometimes expenses. State application of income counting rules expanded eligibility to higher-income individuals.

Committee Bill

Effective July 1, 2013, income disregards (including type of expense, block of income, or other income disregards), and asset or resource tests would no longer apply when calculating the income eligibility. Instead, the income eligibility for an individual or a family would be

measured based on modified gross income (MGI) as determined for eligibility to receive a tax credit in the state exchanges, described in section 1205 of the Committee Bill.

MGI would also be used to determine income for any other purpose applicable under the state plan, such as determining cost-sharing amounts that states may impose on an individual or a family. Existing Medicaid income counting rules would continue to apply for determining eligibility for certain exempted groups including (1) individuals that are eligible for Medicaid through another program (*e.g*., foster care children, or individuals receiving Supplemental Security Income (SSI)), (2) the elderly or Social Security Disability Insurance (SSDI) program beneficiaries, (3) the medically needy, (4) enrollees in a Medicare Savings Program *(e.g*., Qualified Medicare Beneficiaries, or QMBs), and (5) CHIP optional targeted low-income children). In addition, MGI would not affect eligibility determinations through Express Lane or for Medicare prescription drug low-income subsidies or Medicaid long-term care services. Any individual enrolled in Medicaid (under the state plan or a waiver) on July 1, 2013, who would be determined ineligible for medical assistance under the application of the new MGI income counting rule would remain Medicaid eligible (and subject to the same premiums and cost-sharing as applied to the individual on that date) until the later of March 31, 2014, or their next Medicaid eligibility redetermination date. Finally, the Secretary would not be permitted to waive compliance with the requirements of this provision, except to the extent necessary to permit a state to coordinate eligibility requirements for dual eligible individuals.

Sec. 1603. Requirement to Offer Premium Assistance for Employer-Sponsored Insurance.

Present Law

Under current Federal law, states can offer premium assistance to Medicaid-eligible individuals who have access to employer-sponsored insurance (ESI), rather than enrolling them in traditional Medicaid, if it is determined to be cost-effective and the benefits are comprehensive. A Medicaid beneficiary's enrollment in an employer health plan is considered cost-effective if paying the applicable premiums, deductible, coinsurance and other cost-sharing obligations of the employer plan is less expensive than the state's expected cost of providing Medicaid-covered services directly. To meet the comprehensiveness test under Medicaid, states are required to provide Medicaid covered services that are not included in private plans.

The recent CHIP Reauthorization Act (CHIPRA, P.L. 111-3) created a new state plan option for providing premium assistance for Medicaid and CHIP-eligible children and/or parents of Medicaid/CHIP children. For families that have access to ESI coverage that meets certain requirements – including that the employer pays at least 40 percent of the total premium – states can offer premium assistance through a state plan amendment. States choosing to do so are required to provide "wrap-around" benefit coverage for employer plans that do not meet CHIP benefit standards. If the CHIP cost of covering the entire family in the employer-sponsored plan is less than regular CHIP coverage for the eligible individual(s) alone, then the premium assistance subsidy may be used to pay the entire family's share of the premium.

Committee Bill

Effective July 1, 2013, the Committee Bill would require states to offer premium assistance and wrap-around benefits to all Medicaid beneficiaries who are offered ESI if it is cost-effective to do so, based on Present Law requirements.

Sec. 1604. Treatment of the Territories.

Present Law

Five territories (American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, and the U.S. Virgin Islands) operate Medicaid programs under rules that differ from those applicable to the 50 states and the District of Columbia (hereafter referred to as the states). The territories are not required to cover the same eligibility groups, and they use different financial standards (income and asset tests) in determining eligibility. For example, states must cover certain mandatory groups such as pregnant women, children, and qualified Medicare beneficiaries, but for the territories these groups are optional.

In the states, Medicaid is an individual entitlement. In addition, there are no limits on Federal payments for Medicaid provided that the state contributes its share of the matching funds. In contrast, Medicaid programs in the territories are subject to annual Federal spending caps. All five territories typically exhaust their caps prior to the end of the fiscal year. Once the cap is reached, the territories assume the full costs of Medicaid services or, in some instances, may suspend services or cease payments to providers until the next fiscal year.

The Federal share for most Medicaid service costs is determined by the Federal medical assistance percentage (FMAP), which is based on a formula that provides higher reimbursement to states with lower per capita incomes relative to the national average (and vice versa). FMAPs have a statutory minimum of 50 percent and maximum of 83 percent. The FMAP for territories is set at 50 percent.

Committee Bill

The Committee Bill would increase spending caps for the territories by 30 percent and the applicable FMAP by five percentage points – to 55 percent – beginning on January 1, 2011 and for each fiscal year thereafter.

Beginning with fiscal year 2014, payments made to the territories with respect to amounts expended for medical assistance for newly eligible individuals (*i.e.*, certain non-elderly, non-pregnant individuals) would not count towards the applicable Medicaid spending caps in the territories.

Sec. 1605. Medicaid Improvement Fund Rescission.

Present Law

Under section 7002 of the Supplemental Appropriations Act, 2008 (War Supplemental, P.L. 110-252), Congress required the Secretary of Health and Human Services to establish the Medicaid

Improvement Fund (MIF). The MIF would be available for the Centers for Medicare & Medicaid Services (CMS) to use to improve the management of the Medicaid program, including oversight of contracts and contractors and evaluation of demonstration projects. Payments made for these activities were intended to be in addition to payments that would otherwise be made for such activities. MIF was to have $100 million available in FY2014, and $150 million in FYs 2015-2018.

Committee Bill

The Committee Bill would rescind funds available in the MIF for fiscal years 2014 through 2018 (which total $700 million).

Part II – Children's Health Insurance Program

Sec. 1611. Additional Federal Financial Participation for CHIP.

Present Law

The Children's Health Insurance Program (CHIP) builds on Medicaid by providing health care coverage to low-income, uninsured children in families with income above Medicaid income standards. States may also extend CHIP to pregnant women when certain conditions are met. In designing their CHIP programs, states may choose to expand Medicaid, create a standalone program, or use a combined approach. As with Medicaid, states have the flexibility under CHIP to disregard amounts or types of income and expenses, effectively expanding eligibility to higher-income individuals. Federal appropriations are currently provided through FY2013.

Like Medicaid, CHIP is a Federal-state program. For each dollar of state spending, the Federal government makes a matching payment drawn from CHIP allotments. A state's share of program spending for Medicaid is equal to 100 percent minus FMAP (described above). But for CHIP, the Federal share is higher – the enhanced FMAP for CHIP lowers the state's share of CHIP expenditures by 30 percent compared to the regular Medicaid FMAP.

Federal law permits states to impose premiums and service-related cost-sharing for some enrollees and some benefits under CHIP. States that cover CHIP-eligible children through their Medicaid programs must follow the nominal premium and cost-sharing rules applicable to Medicaid. Under these rules, the majority of such children are exempt. In general, premiums are prohibited except for children enrolled in Medicaid expansion programs with incomes above 150 percent of the Federal poverty level (FPL). Service-related cost-sharing for children enrolled in Medicaid expansion programs may vary by income level. Aggregate cost-sharing for all individuals is capped at five percent of family income.

Different cost-sharing limits apply in states that provide CHIP coverage through stand alone (non-Medicaid) programs. For example, nominal premiums specified in Medicaid statute apply to children in families with income at or below 150 percent of FPL in standalone programs. Service-related cost-sharing is limited to the nominal amounts in Medicaid for the subgroup with income below 100 percent of FPL and slightly higher amounts are permitted for the subgroup

with income between 100 and 150 percent of FPL. For children in families with income over 150 percent of FPL, cost-sharing can be applied in any amount, provided that cost-sharing for higher-income children is not less than cost-sharing for lower-income children and that it does not exceed the out-of-pocket limit of five percent of family income.

Preventive services are exempt from all cost-sharing for all CHIP families regardless of income.

States are permitted to use alternative premiums and service-related cost-sharing established in the Deficit Reduction Act of 2005 (DRA, P.L. 109-171) that allow higher premiums and cost-sharing for certain Medicaid beneficiaries. Children under 18 who are covered under mandatory eligibility groups (the lowest income categories) are exempt from the DRA premium and cost-sharing provisions.

Committee Bill

The Committee Bill would maintain the current CHIP structure, although the bill does not provide CHIP appropriations for FY2014 or after.

Upon enactment, states would be required to maintain income eligibility levels for CHIP through September 30, 2019. Specifically, with the exception of waiting lists for enrolling children in CHIP, states could not implement eligibility standards, methodologies, or procedures that were more restrictive than those in place on the date of enactment. However, states could expand their current income eligibility levels—that is, state could enact *less* restrictive standards, methodologies or procedures.

From FY2014 to FY2019, states would receive a 23 percentage point increase in the CHIP match rate, subject to a cap of 100 percent. 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 related to children.

CHIP-eligible children who cannot enroll in CHIP due to Federal allotment caps would be eligible for tax credits in the state exchange.

The Medicaid and CHIP enrollment bonuses included in the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA, P.L. 111-3) would not apply beyond the current reauthorization period; bonus payments would not be available in FY2014 or after.

CHIP eligibility would be based on existing income eligibility rules, including the use of income disregards. In addition, the CHIP benefit package and cost-sharing rules would continue as under Present Law.

The new section regarding Medicaid programs' coordination with state health insurance exchanges (described below in section 16231) would also apply to CHIP programs.

Sec. 1612. Technical Corrections.

Present Law

The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA, P.L. 111-3) was signed into law on February 4, 2009, to extend and improve CHIP Federal and for other purposes. The American Recovery and Reinvestment Act of 2009 (ARRA, P.L. 111-5) was signed into law on February 17, 2009, to make supplemental appropriations for job preservation and creation, infrastructure investment, energy efficiency and science, assistance to the unemployed, and state and local fiscal stabilization, for fiscal year ending September 30, 2009, and for other purposes.

Committee Bill

The Committee Bill would make corrections to selected provisions in CHIPRA and ARRA, including for example, (1) would make an adjustment to the FY2009 and FY2010 CHIP allotments to account for changes in projected spending for certain previously approve expansion programs, (2) would change a reference to legal immigrants in CHIP statute**,** (3) would delete a reference to CHIP funds set aside for coverage of certain Medicaid non-pregnant childless adult waivers when those funds are not expended by September 30, 2011**,** (4) would make adjustments to the CPS to improve estimates used to identify high performing states (those with the lowest percentage of uninsured, low-income children) for CHIP purposes, (5) would stipulate that the alternative premiums and cost-sharing provision in Medicaid would not supersede or prevent the application of premium and cost-sharing protections for Indians under Medicaid and CHIP as established in P.L. 111-5, and (6) other technical changes.

PART III – Enrollment Simplification

Sec. 1621. Enrollment Website that Coordinates with State Health Insurance Exchanges.

Present Law

No provision.

Committee Bill

As a condition of the Medicaid state plan for receipt of any Federal financial assistance for calendar quarters after January 1, 2013, states would be required to ensure that the following requirements are met:

(1) States would be required to establish procedures for:
- enrolling individuals who are identified by a state exchange as being eligible for Medicaid or the Children's Health Insurance Program (CHIP), without any further determination by the state;
- ensuring that individuals who apply for Medicaid and/or CHIP but are determined ineligible for either program are able to apply for and be enrolled in coverage through a state exchange and, if applicable, obtain premium credits for state exchange coverage and

receive information regarding any other assistance or subsidies available through the state exchange;

- ensuring that the state Medicaid agency, the state CHIP agency, and the state exchange utilize a secure electronic interface sufficient to allow for a determination of an individual's eligibility for their programs; and
- ensuring that coverage provided to Medicaid-eligible individuals who are also enrolled in a state exchange plan is coordinated.

(2) The state Medicaid agency and the state CHIP agency may enter into an agreement with the state exchange under which each agency may determine whether a state resident is eligible for premium credits for state exchange coverage, so long as the agreement meets requirements that the Secretary of the Treasury may prescribe to reduce administrative costs and the likelihood of eligibility errors and disruptions in coverage.

(3) The state Medicaid agency and the state CHIP agency would be required to participate in and comply with the requirements for the system established under section 2239 (relating to streamlined procedures for enrollment through a state exchange, Medicaid and CHIP—*e.g.*, a single application form usable for all the programs).

(4) The Committee Bill would require states to establish a website to allow Medicaid and CHIP eligible individuals to enroll or reenroll in Medicaid and CHIP, and consent to enrollment or reenrollment through an electronic signature. In addition, the website would be linked to all websites established by any state exchange so that individuals who are identified by a state exchange as Medicaid or CHIP eligible are able to enroll in Medicaid or CHIP online without having to submit an additional or separate application. The website would also allow individuals who apply for Medicaid but are determined ineligible to apply for and be enrolled in coverage through an Exchange. If applicable, such individuals could obtain premium credits for Exchange coverage without having to submit an additional or separate application. The website would also provide information regarding any other assistance or subsidies available through the Exchange.

The Committee Bill would also require the website to allow the state to assess an individual for purposes of providing home and community-based services under the state plan or under a waiver for individuals who would be Medicaid eligible if they were in a medical institution, and with respect to whom there has been a determination that, but for the provision of home and community-based services under a waiver, they would require the level of care provided in a hospital, nursing facility, or intermediate care facility for the mentally retarded.

The website would also be required to allow individuals who are eligible for Medicaid and who are also eligible to receive premium credits for Exchange coverage to compare the benefits, premiums, and cost-sharing available to the individual under Exchange plans. In the case of a child, the website would allow for the comparison of the coverage that would be provided to the child through Medicaid with coverage that would be provided to the child through enrollment in family coverage under Exchange coverage including any supplemental coverage provided by the state under Medicaid. The website would be required to be functional no later than January 1, 2013.

States would be required to ensure that a non-pregnant, non-elderly adult whose family income exceeds 100 percent but does not exceed 133 percent of poverty who is Medicaid eligible and who is also eligible to receive premium credits for state exchange coverage is offered an option to elect to enroll themselves (or their family if applicable) in a state exchange plan instead of Medicaid. In the case of an adult, such individual would waive services under Medicaid (including Medicaid assistance for premiums and cost-sharing). Such individual must receive information comparing the benefits and cost-sharing that would be available under Medicaid for the adult (or, if applicable, the adult's family), with the benefits and cost-sharing that would be available under state exchange plans. Such individuals that elect to enroll themselves and/or their families in a state exchange plan would also be provided with assistance in selecting and enrolling in a state exchange plan.

While parents electing state exchange coverage over Medicaid coverage would waive their rights to Medicaid covered services and applicable cost-sharing requirements, states would be required to ensure that all children of parents who choose state exchange coverage would continue to receive the Medicaid benefits to which they are entitled, including early and periodic screening, diagnostic, and testing (EPSDT), and Medicaid assistance sufficient to cover the costs of premiums and cost-sharing that exceed the allowable amounts for children under Medicaid.

Beginning in 2014, states would be required to make an annual payment to the Secretary for Medicaid-eligible individuals who elect coverage through the state exchange. The amount would be the total calculated monthly for each applicable population as follows:

- the number of individuals eligible for full-benefit Medicaid who are enroll in a state exchange plan, multiplied by
- the average Medicaid cost multiplied by
- the state share of Medicaid expenditures.

In calculating the average Medicaid cost for children, only "essential benefits" (described in section 1201) would be included.

Sec. 1622. Permitting Hospitals to Make Presumptive Eligibility Determinations for All Medicaid Eligible Populations.

Present Law

Presumptive eligibility is a Medicaid option that allows states to enroll certain individuals (*e.g.*, children, pregnant women, and certain women with breast and cervical cancer) into Medicaid for a limited period of time before full Medicaid applications are filed and processed, based on a preliminary determination by a Medicaid provider of likely Medicaid eligibility. Presumptive eligibility begins on the date a qualified Medicaid provider determines that the applicant appears to meet eligibility criteria and ends on the earlier of (1) the date on which a formal determination is made regarding the individual's application for Medicaid, or (2) in the case of an individual who fails to apply for Medicaid following the presumptive eligibility determination, the last day of the month following the month in which presumptive eligibility begins. During periods of presumptive eligibility, children and certain women with breast and cervical cancer have access to the full Medicaid benefit package offered by states, while pregnant women have access to ambulatory prenatal care.

Committee Bill

The Committee Bill would permit all hospitals that participate in Medicaid under state plans to make presumptive eligibility determinations for all Medicaid eligible populations. The time period of presumptive eligibility would be consistent with Present Law. In implementing this provision, states would not be required to cover other presumptive eligibility options in Present Law. The provision would be effective on January 1, 2014 without regard to whether or not final regulations to carry out this amendment have been promulgated by such date. However, if the Secretary determined that state legislation (other than for appropriations) was needed in order for the state Medicaid plan to meet the additional requirements of this section, a state plan would not be regarded as non-compliant until a specified time after the close of the state's first legislative session following enactment.

Sec. 1623. Promoting Transparency in the Development, Implementation, and Evaluation of Medicaid and CHIP Waivers and Section 1937 State Plan Amendments.

Present Law

Section 1115 of the Social Security Act authorizes the Secretary to waive certain statutory requirements for conducting research and demonstration projects that further the goals of titles XIX (Medicaid) and XXI (CHIP). States submit proposals outlining the terms and conditions of the demonstration program to the Centers for Medicare & Medicaid Services (CMS) for approval prior to implementation.

In 1994, CMS issued program guidance that impacts the waiver approval process and includes the procedures states are expected to follow for public involvement in the development of a demonstration project. States were required to provide CMS a written description of their process for public involvement at the time their proposal was submitted.

Public involvement requirements for the waiver approval process continued through the early 2000s. In a letter to state Medicaid directors issued May 3, 2002, CMS listed examples of ways a state may meet requirements for public involvement (*e.g.*, public forums, legislative hearings, a website with information and a link for public comment).

States are required to submit a state plan describing the nature and scope of a state's Medicaid program to the Secretary of HHS for approval. The state plan must provide assurances that the program conforms to the requirements of Medicaid and to any other official program issuances (*e.g.*, rules, regulations, program guidance, etc.). After approval of the original state plan by the Secretary, any subsequent changes (*e.g.*, those required by new Federal or state statutes, rules, regulations, policy interpretations, guidance, court decisions, changes in the state's operation of the Medicaid program, etc.) must be submitted by the state to CMS in the form of a state plan amendment (SPA) so that the Secretary may determine whether the Medicaid state plan continues to meet Federal requirements. Federal regulations dictate the SPA approval process including requirements for gubernatorial review, CMS regional office review, disapproval of a SPA, and judicial review (*i.e.*, after a state's failure to conform to Federal requirements). Federal

law dictates time frames associated with the SPA review process, and requirements that the CMS Administrator must meet when notifying a state that CMS intends to withhold Federal matching payments for portions of the state plan that are out of compliance.

Committee Bill

The Committee Bill would impose 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. States would be required to: (1) provide notice of the state's intent to develop and/or renew a section 1115 waiver and convene at least one meeting of the state's medical care advisory board to discuss the impacts of the proposed changes; (2) publish for written comment a notice of the proposal that provides information on how the public can submit comments to the state and includes state projections and assumptions regarding the likely impact of the waiver; (3) post the waiver proposal on the State's Medicaid or CHIP website; and (4) convene open meetings over the course of the development of the proposal to discuss proposed changes. States would also be required to include information regarding the actions taken to meet the above-listed public notice requirements as a part of their waiver submission to CMS.

The Committee Bill would also impose additional transparency-related statutory requirements on the Secretary of HHS. The Secretary would be required to: (1) publish a *Federal Register* notice identifying monthly waiver submissions, approvals, denials, and information regarding methods by which comments on the waiver will be received from the public; (2) publish a copy of the proposed waiver to the CMS website; and (3) allow for, respond to, and make available public comments received about the proposal after it has been posted to the CMS website. Once approved, the Secretary would have to post waiver terms and conditions and related waiver approval documents, quarterly state-reported data and three-year evaluations to the CMS website. The Secretary would also be required to publish a *Federal Register* notice identifying monthly waiver approvals, denials, and returns to the state without action. In addition, the Secretary would be required to follow requirements associated with an independent evaluation of the demonstration project.

$4.5 million would be appropriated for fiscal year 2010 and each fiscal year thereafter for the purpose of carrying out independent evaluations of section 1115 demonstration waivers. Among the evaluation criteria, the Secretary would be required to assess the use of services by beneficiaries, the extent to which special populations are able to access needed health care services, the amount of out-of-pocket costs for health care services incurred by beneficiaries, administrative costs incurred under the waiver, etc.

The Committee Bill would add transparency-related statutory requirements associated with the SPA approval process for proposals that limit benefits. States would have to: (1) provide notice of the state's intent to develop a SPA and convene at least one meeting of the state's medical advisory board to discuss the impacts of the changes requested in the proposed SPA; (2) publish a notice of the proposal that provides information on how the public can submit comments to the state and includes state projections and assumptions regarding the likely impact of the SPA; (3) post the SPA proposal on the state's Medicaid or CHIP website, and (4) convene at least one

open meeting to discuss the proposed SPA. States would also be required to include information regarding the actions taken to meet the above-listed public notice requirements as a part of their SPA submission to CMS.

The Committee Bill would also impose additional transparency-related statutory requirements on the Secretary of HHS. The Secretary would be required to: (1) publish a *Federal Register* notice identifying monthly SPA submissions and information regarding methods by which comments on each SPA will be received from the public; (2) publish a copy of the proposed SPA to the CMS website; and (3) publish a *Federal Register* notice identifying monthly SPA approvals, denials, and returns to the state without action.

Sec. 1624. Standards and Best Practices to Improve Enrollment of Vulnerable and Underserved Populations.

Present Law

CHIPRA (P.L. 111-3) included provisions to facilitate access and enrollment in Medicaid and CHIP. Among the provisions related to outreach and enrollment, CHIPRA appropriated $100 million in outreach and enrollment grants above and beyond the regular CHIP allotments for fiscal years 2009 through 2013. Ten percent of the outreach and enrollment grants will be directed to a national enrollment campaign, and 10 percent will be targeted to outreach for American Indian and Alaska Native children. The remaining 80 percent will be distributed among state and local governments and to community-based organizations for purposes of conducting outreach campaigns with a particular focus on rural areas and underserved populations. Grant funds will also be targeted at proposals that address cultural and linguistic barriers to enrollment. Also as a part of the outreach-related provisions, CHIPRA requires State plans to describe the procedures used to reduce the administrative barriers to the enrollment of children and pregnant women in Medicaid and CHIP, and to ensure that such procedures are revised as often as the State determines is appropriate to reduce newly identified barriers to enrollment.

Committee Bill

The Committee Bill would require the Secretary of HHS, not later than April 1, 2011, to issue guidance to states regarding standards and best practices to help improve enrollment of vulnerable and underserved populations eligible for Medicaid and CHIP, including 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.

The guidance would (1) detail information on effective ways to inform vulnerable populations about coverage available under Medicaid and CHIP; (2) identify ways to assist vulnerable populations to enroll in the programs; (3) identify ways that application and enrollment barriers can be eliminated for such populations; and (4) address specific methods for outreach and enrollment, including out-stationing of eligibility workers, the Express Lane eligibility option, residency requirements, documentation of income and assets, presumptive eligibility, continuous

eligibility, and automatic renewal. The Secretary would work with appropriate stakeholders, including representatives of states and children's groups, to ensure that the guidance is developed and implemented effectively.

Finally, not later than two years after the enactment of this Act and annually thereafter, the Secretary would review and report to Congress on the progress made by states in implementing the standards and best practices indentified in the guidance and increasing the enrollment of vulnerable populations under Medicaid and CHIP.

Part IV – Medicaid Services

Sec. 1631. Coverage of Free-standing Birth Centers.

Present Law

Some Medicaid benefits are mandatory, but others are optional. Examples of optional benefits that are offered by many states include prescription drugs and skilled nursing facility services for individuals under age 21.

While there is statutory authority under Medicaid to pay for services rendered by nurse midwives, there is no explicit statutory authority to provide for direct payments to free-standing birthing centers for facility services.

Committee Bill

The Committee Bill would make coverage of services provided by free-standing birthing centers a mandatory benefit under Medicaid. Free-standing birth center services would be defined as services furnished to an individual at a health facility that is not a hospital, and where childbirth is planned to occur away from the pregnant woman's residence, and is licensed or otherwise authorized by the state to provide prenatal labor and delivery services covered under the plan. In addition, states would be required to separate payments to providers administering prenatal labor and delivery or postpartum care in a free-standing birth center, such as nurse midwives and other providers of services such as birth attendants recognized under state law, as deemed appropriate by the Secretary.

This provision would be effective on the date of enactment of this Act and would apply to services furnished on or after such date.

Sec. 1632. Concurrent Care for Children.

Present Law

Currently, states have the option to offer hospice services under Medicaid. In states that offer hospice services, Medicaid beneficiaries who elect to receive such services must waive the right to all other services related to the individual's diagnosis of a terminal illness or condition, including treatment.

Committee Bill

The provision would allow payment for services provided to children, as defined by the state, who are eligible for Medicaid and have voluntarily elected to receive hospice services, without foregoing coverage of and payment for other services that are related to the treatment of the child's condition for which a diagnosis of terminal illness has been made.

Sec. 1633. Funding to Expand State Aging and Disability Resource Centers.

Present Law

Title II, Sect. 202 of the Older Americans Act (OAA) establishes various functions of the Administration on Aging (AoA) and Assistant Secretary for Aging. Subsection (a)(20)(B)(iii) establishes responsibilities for a National Center on Senior Benefits Outreach and Enrollment, including efforts for Aging and Disability Resource Centers (ADRCs), and other public and private State and community-based organizations, such as faith-based organizations and coalitions, to serve as benefits enrollment centers for Federal and state programs. Subsection (b)(8) requires the Assistant Secretary to implement ADRCs in all states.

Committee Bill

The Committee Bill would appropriate to the Secretary of HHS, $10 million for each of FYs 2010 through 2014 to carry out ADRC initiatives.

Sec. 1634. Community First Choice Option.

Present Law

A personal care attendant is a person who cares for an individual with a significant disability by providing assistance with activities of daily living (ADLs) and instrumental activities of daily living (IADLs). ADLs include eating, bathing and showering, toileting, dressing, walking across a small room, and transferring (getting in or out of a bed or chair). IADLs include preparing meals, managing money, shopping for groceries or personal items, performing housework, using a telephone, doing laundry, getting around outside the home, and taking medications.

Optional Personal Care State Plan Benefit. Under current Medicaid law, states have the option to cover personal care services under their Medicaid state plan for Medicaid beneficiaries who need assistance with ADLs and IADLs. The Medicaid statute defines personal care as services furnished to an individual at home or in another location (excluding institutional settings) that are either authorized by a physician, or at state option, under a plan of care. In addition to providing care in a beneficiary's place of residence, states may also cover attendant care services to assist beneficiaries at work and in participating in community activities. Further, all relatives, except "legally responsible relatives" (*i.e.*, spouses and parents of minor children) can be paid under Medicare for providing personal care services to beneficiaries.

Optional Self-Directed Personal Care State Plan Benefit. States also have the option to cover self-directed personal care under their Medicaid state plan. Services that states can cover are similar to those that may be covered under the optional personal care state plan benefit, yet under this benefit, beneficiaries are encouraged to take on more responsibility for hiring and firing personal care workers and establishing worker schedules and job responsibilities.

Optional Home and Community-Based Services State Plan Benefit. This Medicaid option allows states to cover one or more home and community-based services, including personal care, for certain individuals with long term services and supports needs. States are not required to make services available on a statewide basis. This benefit is limited to individuals whose incomes do not exceed 150 percent FPL and who meet a state-determined level of need criteria. If states cover this option, the needs-based criteria must be less stringent than that used for institutional care eligibility. Services are limited to homemaker/home health aide, personal care, adult day health, habilitation, respite care, day treatment or other partial hospitalization services, psycho-social rehabilitation services, and clinic services for individuals with chronic mental illness. States may limit the number of individuals served.

Personal Care under Medicaid Waivers. Under waiver authority in section 1915(c) of the Social Security Act, states may offer home and community-based services, including personal care services, as well as a broad range of other services, to selected persons who would otherwise require the level-of-care offered in Medicaid-covered institutions. States that choose to offer Medicaid services under section 1115 waivers may also include personal care services as part of a benefit plan.

Committee Bill

Beginning January 1, 2014, the Committee Bill would establish an optional Medicaid benefit under which states could offer community-based attendant services and supports to Medicaid beneficiaries with disabilities who would otherwise require the level of care offered in a hospital, nursing facility, or intermediate care facility for the mentally retarded.

These services and supports would include assistance with ADLs, IADLs, and health-related tasks through hands-on assistance, supervision, or cueing, under a person-centered services and supports plan based on an assessment of functional need and agreed to in writing by the individual (or his/her representative). Services would also include: the acquisition, maintenance and enhancement of skills necessary for the individual to accomplish ADLs, IADLs, and health-related tasks; back-up systems or mechanisms (such as the use of beepers or other electronic devices); and training on how to select, manage, and dismiss attendants. Services and supports may include expenditures for transition costs – such as rent and utility deposits, bedding, basic kitchen supplies, among others, and expenditures relating to a need identified in an individual's person-centered plan that would increase independence or substitute for human assistance. Excluded services and supports would be room and board costs, special education and related services provided under the Individuals with Disabilities Education Act and vocational rehabilitation services, certain assistive technology devices and services, medical supplies and equipment, or home modifications.

Services would be provided in a home or community setting and under an agency-provider model, in which entities would contract for the provision of services and supports, or under another model, such as the provision of vouchers and, direct cash payments. Services and supports would be selected, managed, and dismissed by the individual (or, when appropriate, his or her representative); controlled, to the maximum extent possible, by the individual; and provided by a qualified individual (as defined by the Secretary), including family members. States that choose the Community First Choice Option would be eligible for an enhanced Federal match rate of an additional six percentage points for reimbursable expenses in the program. The option would sunset after five years.

To obtain approval from the Secretary to offer this benefit, states would be required to: (1) develop and implement the benefit in collaboration with a Development and Implementation Council established by the state that would include a majority of members with disabilities, elderly individuals, and their representatives; (2) provide community-based attendant services and supports to individuals on a state-wide basis and in the most integrated setting appropriate to the individual's needs; (3) maintain or exceed the level of state Medicaid expenditures for individuals with disabilities or elderly individuals attributable to the preceding fiscal year, or otherwise to individuals with disabilities or elderly individuals attributable to the proceeding year; (4) establish and maintain a comprehensive, continuous quality assurance system with respect to the community-based attendant services and supports that would incorporate feedback from consumers and their representatives, monitor the health and well-being of each individual, collect information for the purpose of approving the state plan amendment and facilitate Federal oversight, among others.

A state would be required to ensure that services and supports would be provided in accordance with requirements of the Fair Labor Standards Act of 1938, and applicable Federal and state laws regarding Federal and state income and payroll taxes, the provision of unemployment and workers compensation insurance; maintenance of general liability insurance, and occupational health and safety.

The Secretary would be required to conduct an evaluation of the community-based attendant services and supports. No later than December 31, 2017, the interim findings of this evaluation would be required to be submitted to Congress, and the final report must be submitted by December 31, 2019.

Sec. 1635. Protection for Recipients of Home and Community-Based Services Against Spousal Impoverishment.

Present Law

Medicaid law includes spousal impoverishment provisions intended to prevent the impoverishment of a spouse whose husband or wife seeks Medicaid coverage for long term services and supports. The law requires that spousal impoverishment rules for eligibility and post-eligibility treatment of income be applied to non-institutionalized spouses (*i.e.*, community spouses) of persons residing in a medical institution or nursing facility for at least 30 consecutive days.

Although Medicaid law grants states the option to apply spousal impoverishment rules to the counting of income and assets for a couple during the eligibility determination for persons applying to section 1915(c) and (d) waivers, it does not allow states to apply these rules to the eligibility determination for 1915(e) waivers. In addition, Medicaid law prohibits the application of spousal impoverishment rules for the post-eligibility treatment of income for purposes of 1915(c), (d), and (e) waivers for those who qualify for Medicaid through a state's medically needy eligibility pathway. The Secretary of HHS may grant authority for states to apply spousal impoverishment rules for eligibility and post-eligibility determination of income under section 1115 waivers which are sometimes used to offer HCBS instead of section 1915(c) waivers.

Committee Bill

The Committee Bill would amend Medicaid law to require states to apply spousal impoverishment rules to applicants who would receive HCBS under sections 1915(c), (d), (i), and (k) (as added by section 1634 of the Committee Bill) and under section 1115 of the Social Security Act. States would also be required to apply spousal impoverishment rules to people who would receive HCBS and apply for Medicaid through the medically needy, 209(b) spend-down, and other eligibility pathways. This provision would apply for a five-year period beginning on January 1, 2014.

Sec. 1636. Incentives for States to Offer Home and Community-Based Services as a Long-Term Care Alternative to Nursing Homes.

Present Law

Under Medicaid, states make available a broad range of institutional and home and community-based services (HCBS) to certain Medicaid enrollees. States are required to offer some but not all of these services. For those services that are offered, states may define them differently, using criteria that place limits on the amount, duration, and scope of the benefits. States may also restrict benefits to individuals who demonstrate medical necessity for the benefit. Under Medicaid, institutional services are generally defined as care provided in nursing facilities, intermediate care facilities for people with mental retardation (ICFs/MR), inpatient hospital services and nursing facility services for persons aged 65 and older in institutions for mental diseases. HSCBS is generally defined as long-term services and supports offered under Medicaid's home health state plan benefit, personal care state plan benefit, case management or targeted case management benefit, respiratory care benefit for persons who are ventilator-dependent, PACE (All-Inclusive Care for the Elderly), transportation benefit, HCBS state plan option, and Medicaid HCBS 1915(c) and (d) waivers.

Medicaid is an open-ended Federal state matching program. The Federal government's share of most Medicaid service costs is determined by the Federal medical assistance percentage (FMAP), which varies by state and is determined by a formula set in statute. For Medicaid administrative costs, the Federal share does not vary by state, and is generally 50 percent.

Committee Bill

States that spend less than 50 percent of their total FY2009 Medicaid spending on non-institutionally-based long-term services and supports and that meet certain other conditions would receive an FMAP rate increase for the purpose of providing new or expanded offerings of such services (including expansion through offering such services to increased numbers of enrollees). Among these states, those that spend less than 25 percent of their total Medicaid long-term care expenditures for fiscal year 2009 on HCBS would set their target for such spending at 25 percent for these services, to be achieved by October 1, 2015. Such states would receive a five percentage point increase in their FMAP. Other participating states would set their target percentage for home and community-based services as a percentage of their Medicaid long term services and supports spending at 50 percent, to be achieved by October 1, 2015. These states would receive a two percentage point increase.

To participate in the state balancing incentive payment program, qualifying states would be required to submit an application to the Secretary of HHS for approval. In addition to other requirements, the state would have to provide a description of the new and expanded non-institutionally-based long term services and supports financed under the state balancing incentive payment program, and a description of the eligibility requirements to access such services. States would also be required to submit projected increases in service utilization and state expenditures related to the expansion of such services.

Among the conditions that would be required for qualifying states to access the higher Federal matching funds under this provision is that states would have to maintain their eligibility standards, methodologies, or procedures for determining eligibility for such services at levels that are no more restrictive than those in place on December 31, 2010. States would also be required to agree to use the additional Federal funds paid to the state for the purposes of providing new or expanded offerings of non-institutional-based long-term services and supports.

States would also be required to implement several structural changes to their Medicaid programs no later than six months after the state submits its application, including: (1) the implementation of a "no wrong door policy" whereby beneficiaries would be able to access all long-term services and supports through a coordinated network, agency, or other statewide system; (2) the development of conflict-free case management services to assist beneficiaries with the transition between institutional and non-institutional services the development of a service plan; and (3) the development of core standardized assessment instruments to determine eligibility for non-institutionally-based long-term services and supports.

Additional data would be collected that would track person-level service use, quality (across a core set of measures as defined by the Secretary of HHS), and outcomes to measure beneficiary and family caregiver experience and satisfaction with services and other outcomes.
No more than $3 billion in Federal matching funds would be available to balancing incentive states for the five-year period between October 1, 2011 and September 30, 2016.

Sec. 1636A. Removal of Barriers to Providing Home and Community-Based Services.

Present Law

Under Medicaid, states make available a broad range of institutional and home and community-based services (HCBS) to certain Medicaid enrollees. States are required to offer some but not all of these services. For those services that are offered, states may define them differently, using criteria that place limits on the amount, duration, and scope of the benefits. States may also restrict benefits to individuals who demonstrate medical necessity for the benefit. Under Medicaid, institutional services are generally defined as care provided in nursing facilities, intermediate care facilities for people with mental retardation (ICFs/MR), inpatient hospital services and nursing facility services for persons aged 65 and older in institutions for mental diseases. HSCBS is generally defined as long-term services and supports offered under Medicaid's home health state plan benefit, personal care state plan benefit, case management or targeted case management benefit, respiratory care benefit for persons who are ventilator-dependent, PACE (All-Inclusive Care for the Elderly), transportation benefit, HCBS state plan option, and Medicaid HCBS 1915(c) and (d) waivers.

Committee Bill

The Committee Bill would apply specific measures to remove barriers to providing HCBS. These measures include: state-level oversight and assessment of HCBS resources, coordination of HCBS across all providers, and procedures for patients to file complaints. States would also have the option to provide more types of HCBS through a state plan amendment to individuals with higher levels of need rather than through a waiver, and states could extend full Medicaid benefits to individuals receiving HCBS under a state plan amendment. States would not have to comply with requirements for statewideness and would be able to phase-in services and eligibility as they become available, targeting the services to specific populations.

Sec. 1637. Money Follows the Persons Rebalancing Demonstration.

Present Law

Section 6071 of the Deficit Reduction Act of 2005 (DRA; P.L. 109-171) established the Money Follows the Person (MFP) Rebalancing Demonstration. The program authorizes the Secretary of HHS to award competitive grants with the following objectives: (1) increase the use of HCBS, rather than institutional, long term care services and supports; (2) eliminate barriers that prevent or restrict the flexible use of Medicaid funds to enable Medicaid-eligible individuals to receive support for appropriate and necessary long-term care services in the settings of their choice; (3) increase the ability of the Medicaid program to assure continued provision of HCBS to eligible individuals who choose to transition from an institutional to a community setting; and (4) ensure that procedures are in place to provide quality assurance for eligible individuals receiving Medicaid HCBS and to provide for continuous quality improvement in such services.

For individuals to participate in the MFP demonstration project, they must: (1) reside in, and have been residing in for not less than six months and not more than two years, an inpatient facility; (2) receive Medicaid benefits for inpatient services furnished by such inpatient facility; and (3) with respect to whom a determination has been made that, but for the provision of

HCBS, the individual would continue to require the level of care provided in an inpatient facility, among other requirements.
The DRA also required the Secretary to provide for research on, and to conduct a national evaluation of, the demonstration project and to make a final report to the President and Congress no later than September 30, 2011.

Committee Bill

The Committee Bill would extend the MFP Rebalancing Demonstration through September 30, 2016 and would extend the deadline for the submission of the final evaluation report to September 30, 2016.

The Committee Bill would also change the eligibility rules for individuals to participate in the demonstration project by requiring that individuals reside in an inpatient facility for not less than 90 consecutive days. The provision would also exclude Medicare-covered short-term rehabilitative services from the counting of the 90-day period.

The provision would take effect 30 days after this enactment.

Sec. 1638. Clarification of Definition of Medical Assistance.

Present Law

The term "medical assistance" means payment of part or all of the cost of care and services identified in Federal statute. This term is repeated throughout title XIX, of the Social Security Act.

Committee Bill

The Committee Bill would clarify that "medical assistance" encompasses both payment for services provided and the services themselves.

Sec. 1639. State Eligibility Option for Family Planning Services.

Present Law

Family planning services and supplies are a mandatory Medicaid benefit for individuals classified as categorically needy and must be available to individuals of childbearing age who are eligible under the state Medicaid plan and who desire such services and supplies. States are permitted to provide family planning services under Medicaid for populations who are not otherwise eligible for traditional Medicaid (*e.g.*, non-pregnant, non-disabled childless adults) after a special waiver has been filed and approved by the Secretary of HHS.

Committee Bill

The Committee Bill would add 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) but would also include related medical diagnosis and treatment services.

The Committee Bill would also allow states to make a presumptive eligibility determination for individuals eligible for such services through the new optional eligibility group. That is, states may enroll such individuals for a limited period of time before completed Medicaid applications are filed and processed, based on a preliminary determination by Medicaid providers of likely Medicaid eligibility. Such individuals must then formally apply for coverage within a certain timeframe to continue receiving this benefit.

This provision would be effective upon enactment.

Sec. 1640. Grants for School-Based Health Centers.

Present Law

The Children's Health Insurance Program Reauthorization Act of 2009 (P.L. 111-3,CHIPRA) defines "school-based health centers" to include a health care
clinic that: (1) is located in or near a school facility of a school district or board of an Indian tribe or tribal organization (I/T/U); (2) is organized through school, community, and health provider relationships; (3) is administered by a sponsoring facility (*e.g.*, hospital, public health department, community health center, nonprofit health care agency, school or school system, or a program administered by the Indian Health Service or Bureau of Indian Affairs, or operated by an I/T/U; (4) provides primary health services through health professionals to children in accordance with state and local law, including laws relating to licensure and certification; and (5) satisfies such other requirements as a state may establish for the operation of such a clinic.

Committee Bill

The proposal would establish a grant program to support the operation of school-based health centers (as defined in CHIPRA). The Committee Bill would appropriate $100 million for such program. The use of any such funds for any service that is not authorized or allowed by state or local law would be prohibited. The Secretary would be authorized to establish criteria and application procedures for the awarding of grants in this program. The Secretary would be directed to give preference in awarding grants to school-based health centers serving a large population of children eligible for Medicaid or CHIP.

Sec. 1641. Therapeutic Foster Care.

Present Law

In general, therapeutic foster care (TFC) temporarily places troubled youth (individuals with serious emotional and behavioral issues) with specially trained foster families. Although TFC programs vary, children/adolescents are generally placed for six to seven months in a structured environment where they are rewarded for positive social behavior and penalized for disruptive and aggressive behavior. TFC also separates repeat juvenile offenders from delinquent peers and provides close home and school supervision.

TFC is not specifically addressed in Medicaid law, although it sometimes is considered a service under the rehabilitative services benefit, where states have the option to cover rehabilitative services, including medical or remedial services to reduce physical or mental disability and restoration of best possible functional level.

Committee Bill

The Committee Bill would clarify that states would have the option under Medicaid to cover TFC for Medicaid eligible children in out-of-home placements. The provision also defines TFC as a foster care program that provides certain services to parents and children including: (1) structured daily activities that develop, improve, monitor, and reinforce age-appropriate social, communication, and behavioral skills; (2) crisis intervention and crisis support services; (3) medication monitoring; and (4) counseling; and (5) case management services. In addition, TFC would encompass specialized training for foster parents and consultation with foster parents on the management of children with mental illnesses and related health and developmental problems.

Sec. 1642. Sense of the Senate Regarding Long-Term Services & Supports.

Present Law

No provision.

Committee Bill

The Committee Bill would express the Sense of the Senate that during the 111th session of Congress, Congress should address long-term services and supports in a comprehensive way that guarantees elderly and disabled individuals the care they need. The provision would further express the Sense of the Senate that long term services and supports should be made available in the community as well as in institutions.

Part V – Medicaid Prescription Drug Coverage

Sec. 1651. Prescription Drug Rebates.

Present Law

Drug manufacturers must enter into rebate agreements with the Secretary in order to sell their products to state Medicaid programs. The rebate agreements require drug manufacturers to

provide Medicaid programs with rebates for drugs dispensed to Medicaid beneficiaries, although selected drug purchases are exempted from the Medicaid rebate agreements. Drug purchases excluded from Medicaid's rebate agreements include drugs dispensed by Medicaid managed care organizations (when prescription drugs are included in the capitation agreement), inpatient drugs, and drugs dispensed in physicians' or dentists' offices. Some states exclude drug benefits from their Medicaid MCO contracts. In these cases, Medicaid managed care beneficiaries receive their prescribed drugs through Medicaid's fee-for-service (FFS) delivery system, and states may claim manufacturer rebates for these purchases.

States use a variety of service delivery mechanisms to provide medical and related services to Medicaid beneficiaries. Service delivery mechanisms range from full-risk capitation agreements with managed care organizations (MCOs) to FFS. Under full-risk capitation agreements, MCOs are paid a fixed amount for all the care Medicaid beneficiaries will need, including prescription drugs. Services provided to about 64 percent of Medicaid beneficiaries are paid for on a partially capitated basis, while approximately 38 percent of Medicaid beneficiaries, primarily children and non-disabled adults, receive services under full risk-based capitation contracts.

Under Medicaid rebate agreements, drug makers must report to the Centers for Medicare & Medicaid Services (CMS) the following two prices for each outpatient drug covered by Medicaid: (1) the average manufacturer price (AMP), which is the average price that manufacturers receive for sales to the retail class of trade; and (2) the lowest transaction price, or "best price," that manufacturers receive from sales to private buyers of the drug. AMP and best price serve as reference points for determining manufacturers' rebate obligations.

For the purpose of determining rebates, Medicaid distinguishes between two types of drugs: (1) single source drugs (generally those still under patent) and innovator multiple source drugs (drugs originally marketed under a patent or original new drug application but for which generic alternatives now exist); and (2) non-innovator, multiple source drugs.
Rebates for the first category of drugs — drugs still under patent or those once covered by patents — have two components: a basic rebate and an additional rebate. Medicaid's basic rebate is determined by the larger of either a comparison of a drug's quarterly AMP to the best price for the same period, or a flat percentage (15.1 percent) of the drug's quarterly AMP. Drug manufacturers owe an additional rebate when their unit prices for individual products increase faster than inflation.

A manufacturer's total per drug rebate amount is determined by adding together the basic and the additional rebates, and there is no limit on total rebate liability. Currently, modifications to existing drugs—new dosages or formulations—are generally considered new products for purposes of reporting AMPs to CMS. As a result, drug makers sometimes can avoid incurring additional rebate obligations by making slight alterations to existing products, sometimes called line-extensions, while significantly increasing the price on these products. The line extension formulations of these products receive a new, higher base period AMP. With a higher base period AMP, drug manufacturers would likely owe less of an additional Medicaid rebate.

Section 340B of the Public Health Service Act (PHSA), requires pharmaceutical drug manufacturers that participate in the Medicaid drug rebate program, to enter into a

pharmaceutical pricing agreement (PPA). Under these PPAs, manufacturers agree to provide discounts on covered outpatient drugs purchased by public health facilities, called covered entities. Covered entities include hospitals owned or operated by state or local government that serve higher percentages of Medicaid beneficiaries and other publicly funded health clinics and programs. Covered entities are forbidden to divert drugs purchased under the 340B program to other organizations and are prohibited from obtaining multiple discounts, including participation in group purchasing arrangements.

Committee Bill

Beginning with drugs dispensed on January 1, 2010, the flat rebate percentage used to calculate Medicaid's basic rebate for single source and innovator multiple source outpatient prescription drugs would increase from 15.1 percent to 23.1 percent, except that clotting factors and outpatient drugs approved by the Food and Drug Administration exclusively for pediatric indications would increase to 17.1 percent. Also on January 1, 2010, the basic rebate percentage for multi-source, non-innovator drugs would increase from 11 percent to 13 percent.

This provision also would require drug manufacturers to pay rebates for drugs dispensed to Medicaid beneficiaries who receive care from a Medicaid MCO (as defined in Medicaid law) similar to the way rebates are required under Present Law for FFS beneficiaries. Drug manufacturers would be required to pay the MCO rebates directly to states, as they do under FFS. Capitation rates paid to Medicaid MCOs under this provision would be required to be based on the MCOs actual cost experience (including the drug rebate) and would be subject to Medicaid law covering actuarially sound rates. This provision would not prohibit MCOs from negotiating with drug manufacturers and wholesalers for rebates above Medicaid's statutory rebates.

Any formularies established by Medicaid MCOs subject to this provision may be based on the selection of these drugs by a formulary committee as long as drugs excluded from the formulary are available through prior authorization. Covered outpatient drugs would be excluded from the requirements in this provision when the drugs were dispensed by a health maintenance organization or Medicaid MCO that received discounts under section 340B of the PHSA.

The additional rebate for new formulations of existing single source or innovator multiple source drugs would be the greater of the basic rebate for the new product or the product of: (1) the total number of units of each dosage form and strength of the new formulation paid for by the state, (2) the AMP of the new formation the drug, and (3) the highest additional rebate (calculated as a percentage AMP) for any strength of the original single source or innovator multiple source drug. New formulations of orphan drugs would be exempted, regardless of whether the market exclusivity period has expired, so the additional rebate obligation for orphan drugs would be calculated on the new product's baseline AMP as it is under Present Law.

In addition, this proposal would limit the total rebate liability on each dosage form and strength an individual single source or innovator multiple source drug to no more than 100 percent of AMP for that drug. Other features of the drug rebate program, such Medicaid's best price provision, would remain unchanged.

Sec. 1652. Elimination of Exclusion of Coverage of Certain Drugs.

Present Law

Medicaid law excludes 11 drug classes, including barbiturates, benzodiazepines, and smoking cessation products. States have the option to cover these drugs, and most states cover barbiturates, benzodiazepines, and smoking cessation drugs. States receive Federal financial participation (FFP) when they cover these drugs. Coverage of prescription drugs for full benefit dual eligibles (individuals who are eligible for both Medicare and Medicaid) was transferred from state Medicaid programs to Medicare when Part D was implemented in January 2006.

Barbiturates and benzodiazepines were excluded from Part D. However, under the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA, P.L. 110-271), Medicare prescription drug plans and Medicare Advantage plans will be required to include benzodiazepines in their formularies for prescriptions dispensed beginning January 1, 2013. Barbiturates also will be required to be included in Medicare formularies for the indications of epilepsy, cancer, or chronic mental health disorder.

Committee Bill

Beginning with drugs dispensed on January 1, 2014, the Committee Bill would remove smoking cessation drugs, barbiturates, and benzodiazepines from Medicaid's excluded drug list.

Sec. 1653. Providing Adequate Pharmacy Reimbursement.

Present Law

Medicaid requires the Secretary to establish upper limits on the Federal share of payments for prescription drug acquisition costs. These limits are intended to encourage substitution of lower-cost generic equivalents for more costly brand-name drugs. When applied to multiple source drugs, those limits are referred to as Federal upper payment limits (FULs). FULs apply to aggregate state expenditures for each drug. CMS calculates FULs and periodically publishes these prices. Under the Deficit Reduction Act of 2005 (DRA, P.L. 109-171), new FULs issued after January 2007 were to equal 250 percent of the average manufacturer price (AMP) of the least costly therapeutic equivalent (excluding prompt pay discounts). AMP is defined in statute to be the average price paid to the manufacturer by wholesalers for drugs distributed to the retail pharmacy class of trade. Manufacturers are required to report AMP to CMS. Present Law allows the Secretary to contract for a survey of retail prices that represent a nationwide average of consumer prices for drugs, net of all discounts and rebates.

National pharmacy associations legally challenged a proposed rule CMS issued in 2007 on implementation of the DRA provision covering AMP pricing. The court issued an injunction on December 19, 2007 which prohibited CMS from setting FULs for Medicaid covered generic drugs based on AMP, and from disclosing AMP data except within HHS or to the Department of Justice (DOJ). The injunction is still in effect.

The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA, P.L. 110-275) imposed a moratorium on the use of AMPs to set FULs until October 1, 2009 so that Congress could determine whether to amend the statutory definition of AMP. In the interim, FULs are set based on the pre-DRA methodology. The FUL is set at 150 percent of the lowest published price (*i.e.*, wholesale acquisition cost, average wholesale price or direct price) for each dosage and strength of generic drug products.

Committee Bill

The proposal would require the Secretary to calculate the FUL as no less than 175 percent of the weighted average (determined on the basis of utilization) of the most recently reported monthly AMPs for pharmaceutically and therapeutically equivalent multiple source drugs available nationally through commercial pharmacies. The Secretary would be required to implement a smoothing process for average manufacturer prices, which would be similar to the process used in determining the average sales price for drugs and biologics under the Medicare program.

This provision would clarify the definition of AMP to include sales by (1) wholesalers for drugs distributed to retail community pharmacies and (2) retail community pharmacies that purchase drugs directly from manufacturers. In addition, AMP would exclude customary prompt pay discounts extended to wholesalers and service fees paid by manufacturers to wholesalers or retail pharmacies. Further, AMP would exclude reimbursement by manufacturers for recalled, damaged, expired, or otherwise unsalable returned goods reimbursement.

Moreover, AMP would exclude payments received from and rebates or discounts provided to pharmacy benefit managers, MCOs, health maintenance organizations, insurers, hospitals, clinics, mail order pharmacies, long-term care providers, manufacturers, or any other entity that does not conduct business as a wholesaler or retail community pharmacy. This provision would further clarify that the following manufacturer price concessions would be included in the AMP of covered outpatient drugs: any other discounts, rebates, payments, or other financial transactions that are received by, paid by, or passed through to retail community pharmacies.

The provision also would expand the disclosure requirement to include monthly weighted average AMPs and retail survey prices. The survey of retail prescription drugs prices would be modified to apply to retail community pharmacies.

The provisions in this subsection would take effect on the first day of the first calendar year quarter after enactment of the Committee Bill, regardless of whether final regulations to implement these provisions have been promulgated.

Sec. 1654. Study of Barriers to Appropriate Utilization of Generic Medicine in Medicaid.

Present Law

No Provision.

Committee Bill

The Government Accountability Office (GAO) would be required to conduct a study of state laws that have a negative impact on generic drug utilization in Federal health care programs. GAO's study would consider at least the impact of following restrictions: limits on pharmacists' ability to provide a generic drug substitute for a prescribed name brand drug and carve-outs of certain drug classes from generic substitution as well as any other relevant restrictions. GAO would be required to submit its report to Congress by April 1, 2012.

Part VI – Medicaid Disproportionate Share Payments

Sec. 1655. Disproportionate Share Hospital Payments.

Present Law

States pay disproportionate share (DSH) adjustments to hospitals serving a disproportionate share of low-income individuals and Medicaid beneficiaries.

Special rules apply to "low DSH states," comprised of states in which total DSH payments for FY2000 were less than three percent of the state's total Medicaid spending on benefits. DSH allotments for such states were raised for FY2004 through FY2008 to an amount that is 16 percent above the prior year's amount. For FY2009 forward, the allotment for low DSH states for each year will be equal to the prior year amount increased by the change in the CPI-U, as for all other states. States cannot obtain Federal matching payments for DSH that exceed the state's DSH allotment.

As a condition of receiving Federal Medicaid payments beginning FY2004, states are required to submit to the Secretary of HHS a detailed annual report and an independent certified audit on their DSH payments to hospitals.

States have flexibility in establishing the designation of DSH hospitals, but must include all hospitals meeting either of two minimum criteria: (1) a Medicaid inpatient utilization rate in excess of one standard deviation above the mean rate for the state, or (2) a low-income patient utilization rate of 25 percent. States may not include hospitals with a Medicaid utilization rate below one percent.

States also have flexibility in calculating DSH payment amounts to hospitals, but must pay DSH hospitals at least: (1) an amount calculated using the Medicare DSH payment methodology, or (2) an amount calculated using a payment methodology that increases each hospital's adjustment as the hospital's Medicaid inpatient utilization rate exceeds the statewide average. DSH hospital payments cannot exceed a hospital-specific cap, set at 100 percent of the costs of providing inpatient and outpatient services to Medicaid and uninsured patients, less payments received from Medicaid and uninsured patients for public hospitals.

Five states and the District of Columbia have used at least a portion of their DSH allotment to expand Medicaid eligibility through a section 1115 waiver.

Committee Bill

State DSH allotments would remain intact as under Present Law until a state trigger is tripped. The trigger would be tripped the first fiscal year after FY2012 for which 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 for FY2009. Once the trigger is tripped, low DSH state allotments would be decreased by 25 percent. DSH allotments for other states would be decreased by 50 percent.

Each year thereafter, if the state's rate of uninsurance decreases further, the state's DSH allotment would be further reduced by a percentage equal to the product of the percentage reduction in uninsurance and 35 percent. For low DSH states, the percentage reduction would be multiplied by 17.5 percent. These percentage reductions would not be applied to any portion of a state's DSH allotment approved by the Secretary to cover costs of providing Medicaid or other health coverage under a waiver in effect on July 2009. For FY2013 forward, in no case would a state's DSH allotment be less than 35 percent of the state's allotment in FY2012, increased by the percentage change in the CPI-U for each previous year occurring before the fiscal year.

Part VII – Dual Eligibles

Sec. 1661. Five-Year Period for Demonstration Projects.

Present Law

Some elderly individuals qualify for health insurance under both Medicare and Medicaid. Based on a report published in February 2009, it was estimated that 7.9 million individuals were dually eligible (duals) for both Medicare and Medicaid in 2005. These dual eligible individuals qualify for Medicare Part A and/or Parts B and D and, because they are elderly and have limited income and assets, also are eligible for Medicaid.

Under Medicaid, states may apply to the Secretary to waive some Medicaid requirements, to use Medicaid funds to target otherwise ineligible populations, or to use innovative methods for delivering or paying for Medicaid services. Section 1115 of the Social Security Act allows for the waiver of any provision of Medicaid law for demonstrations likely to assist in promoting the objectives of the program. Demonstration waivers have traditionally been granted for research purposes, like testing a program improvement (such as a new reimbursement methodology), and run for a limited period. Some demonstration waivers have been approved under both Medicare and Medicaid authorities. These Medicare and Medicaid demonstrations have mostly been statewide initiatives that have coordinated service delivery, benefit packages, and reimbursement for dual eligibles.

The Office of Management and Budget (OMB) reviews all section 1115 waivers and, since 1982, has required waivers to be budget neutral (there are no statutory requirements for determining budget neutrality). Section 1115 waivers do not have a set duration, but larger demonstrations might be extended to accommodate more startup time and more thorough evaluation.

Committee Bill

The Committee Bill would clarify that Medicaid waivers for coordinating care for dual eligibles could be authorized for as long as five years.

Sec. 1662. Providing Federal Coverage and Payment Coordination for Low-Income Medicare Beneficiaries.

Present Law

No provision.

Committee Bill

The Committee Bill would require the Secretary to establish by March 1, 2010 a Federal Coordinated Health Care Office (CHCO) within CMS. The CHCO director would report directly to the Administrator of CMS. The purpose of the CHCO 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 Medicare and Medicaid (dual eligibles) to ensure that dual eligibles have full access to the items and services to which they are entitled. The CHCO would have the following goals:

- providing dual eligible individuals full access to the benefits to which such individuals are entitled under the Medicare and Medicaid programs.
- simplifying the processes for dual eligible individuals to access the items and services they are entitled to under the Medicare and Medicaid programs.
- improving the quality of health care and long-term services for dual eligible individuals.
- increasing beneficiary understanding of and satisfaction with coverage under the Medicare and Medicaid programs.
- eliminating regulatory conflicts between rules under the Medicare and Medicaid programs.
- improving care continuity and ensuring safe and effective care transitions.
- eliminating cost-shifting between the Medicare and Medicaid programs and among related health care providers.
- improving the quality of performance of providers of services and suppliers under the Medicare and Medicaid programs."

The Committee Bill would establish the following specific responsibilities for the CHCO:

- Providing states, specialized Medicare Advantage plans for special needs individuals (special needs plans, as defined in section 1859(b)(6) of the Social Security Act), physicians, and other relevant entities or individuals with the education and tools necessary for developing programs that align Medicare and Medicaid benefits and programs for dual eligible individuals.

- Supporting state efforts to coordinate and align acute care and long-term care services for dual eligible individuals with other items and services furnished under the Medicare program.
- Providing support to states and CMS for coordination of contracting and oversight for the integration of the Medicare and Medicaid programs that supports the goals described above.

The Committee Bill would require the Secretary to submit an annual report to Congress under the annual budget transmittal. The annual report would contain recommendations for legislation that would improve care coordination and benefits for dual eligible individuals.

Part VIII – Medicaid Quality

Sec. 1671. Adult Health Quality Measures.

Present Law

The Children's Health Insurance Program Reauthorization Act (CHIPRA, P.L. 111-3) included several provisions designed to improve the quality of care provided to children under Medicaid and the Children's Health Insurance Program (CHIP). The law directs the Secretary of HHS to develop child health quality measures, a standardized format for reporting information, and procedures to encourage states to voluntarily report on the quality of pediatric care in these two programs. Examples of these initiatives include: (1) grants and contracts to develop, test, update and disseminate evidence-based measures, (2) demonstrations to evaluate promising ideas for improving the quality of children's health care under Medicaid and CHIP, (3) a demonstration to develop a comprehensive and systematic model for reducing childhood obesity, and (4) a program to encourage the creation and dissemination of a model electronic health record format for children enrolled in these two programs. The Federal share of the costs associated with developing or modifying existing state data systems to store and report child health measures is based on the matching rate applicable to benefits (FMAP) rather than one of the typically lower matching rates applied to different types of administrative expenses.

CHIPRA also improved the availability of public information regarding enrollment of children in Medicaid and CHIP. Several reporting requirements are added to states' annual CHIP reports, including, for example, data on eligibility criteria, access to primary and specialty care, and data on premium assistance for employer-sponsored coverage. CHIPRA also required the Secretary to improve the timeliness of the enrollment and eligibility data for Medicaid and CHIP children contained in the Medicaid Statistical Information System (MSIS) based on annual state reported enrollment and claims data and maintained by CMS.

Committee Bill

Similar to the quality provisions enacted in CHIPRA, the Committee Bill would direct the Secretary of HHS, in consultation with the states, to identify and publish a recommended set of health care quality measures specific to adults who are eligible for Medicaid, as well as disseminate best practices among states for measuring and reporting on the quality of care for

Medicaid adults. The Committee Bill would establish 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. The Secretary would regularly report to Congress the progress made in identifying quality measures and implementing them in each state's Medicaid program. States would receive grant funding to support the development and reporting of quality measures. For each year from FY2010 through FY2014, $60 million would be appropriated for this effort, and would remain available until expended.

Sec. 1672. Payment Adjustment for Health Care-Acquired Conditions.

Present Law

Subject to Federal rules, states generally establish their own payment policies, rates, and reimbursement methodologies for Medicaid providers, including inpatient facilities such as hospitals, nursing facilities, and intermediate care facilities for the mentally retarded. Federal regulations require that Medicaid provider rates be sufficient to enlist enough providers so that covered services are available at least to the extent that comparable care and services are available to the general population within that geographic area.

In Medicare, hospitals are reimbursed under a prospective payment system (PPS), where each admission is classified into a Medicare severity adjusted diagnosis-related group (MS-DRG) based on the patient's diagnosis and procedures performed. Each MS-DRG has a predetermined reimbursement amount. In general, a hospital is paid the same amount for an MS-DRG regardless of how long patients stay in the hospital or what is required to treat the patient. In some situations under Medicare's PPS, patients with certain complicating conditions could be reclassified into different MS-DRGs where the hospital would receive a higher payment.

To avoid additional hospital payments for complications that were acquired during patients' admissions, the Deficit Reduction Act of 2005 (DRA, P.L. 109-171) required the Secretary to initiate a hospital acquired condition (HAC) program for Medicare. In creating the HAC program, the Secretary was to select conditions that: (1) were high cost, high volume, or both; (2) were identified as complicating conditions or major complicating conditions; and (3) were reasonably preventable through the application of evidenced-based guidelines. Starting October 1, 2007, CMS required hospitals to report whether Medicare patients had certain conditions when they were admitted. Beginning October 1, 2008, if the HAC conditions identified by the Secretary were coded as present at admission, the conditions would not be considered to be acquired during the patient's hospital stay, and the case could not receive additional MS-DRG payment. In addition to the HAC policy, in January 2009, CMS issued three national coverage determinations that precluded Medicare from paying any amount for certain serious preventable medical care errors.

For Medicaid, CMS issued guidance to States in July 2008 to help states appropriately align Medicaid inpatient hospital payment policies with Medicare's HAC payment policies. In the guidance, CMS indicated that for patients eligible for both Medicare and Medicaid (dual eligibles), hospitals that were denied payment under Medicare might attempt to bill Medicaid for

HACs as the secondary payer. CMS instructed state Medicaid agencies to deny payment when dual eligible beneficiaries acquired HACs during a hospitalization. CMS also encouraged Medicaid agencies to implement policies to deny payment when other Medicaid beneficiaries acquired HACs during a hospitalization. CMS directed states to several Medicaid authorities to deny payment appropriately for HACs, but unlike Medicare, DRA did not specifically apply the HAC initiative to Medicaid. Several states have developed and implemented policies to prohibit Medicaid payments for conditions acquired during the course of care.

Committee Bill

Under the Committee Bill, the Secretary would be required to issue regulations to be effective July 1, 2011, that would prohibit Federal payments to states for Medicaid services related to health care-acquired conditions. These regulations would be required to ensure that the prohibition on payment for health care-acquired conditions would not affect the care or services provided to Medicaid beneficiaries. The Secretary would define health care-acquired conditions, consistent with Medicare's definition of hospital acquired conditions, but would not be limited to conditions acquired in hospitals. In implementing the requirements in this subsection, the Secretary may elect to apply to state Medicaid plans (or waivers) the regulations used by the Medicare program for prohibiting payments for health care-acquired conditions. The Secretary also would be required to identify current state practices that prohibit payments for certain health care-acquired conditions.

Sec. 1673. Demonstration Project to Evaluate Integrated Care Around a Hospitalization.

Present Law

No provision.

Committee Bill

The Secretary would be required to establish a demonstration project under Medicaid to evaluate the use of bundled payments to hospitals and physicians for integrated care delivered to a Medicaid beneficiary during a hospitalization. The project would take place in up to eight states, as determined by the Secretary and based on consideration of the potential to lower costs under Medicaid while improving care for beneficiaries. Under the project, selected states could target particular categories of beneficiaries (subject to certain conditions), those with certain diagnoses, or those in particular geographic regions. The project would be required to focus on those conditions in which opportunity exists for service providers and suppliers to improve the quality of care furnished to Medicaid beneficiaries while reducing total expenditures under the state's Medicaid program.

Participating states would be required to specify the one or more episodes of care the state proposes to address, the services to be included in the bundled payments, among others. The Secretary may modify the episodes of care and services to be included in the bundled payment and vary such factors among the different participating states. The Secretary would also be required to ensure that payments are adjusted for severity of illness and other characteristics,

among others requirements. Medicaid beneficiaries would not be liable for any additional cost-sharing than if care had not been subject to payment under the demonstration project.

Hospitals participating in the project would be required to have, or to establish, robust discharge planning programs to ensure that beneficiaries are appropriately placed in, or have access to, post-acute care. Beneficiaries could not be provided fewer items and services under the project than they would have been provided. The Secretary would be given the authority to waive statutory requirements to accomplish the goals of this demonstration, to ensure beneficiary access to acute and post-acute care, and to maintain quality of care. Each participating state would be required to provide the Secretary with relevant data necessary to monitor outcomes, costs, and quality, and to evaluate the rationales for the selection of the episodes of care and services specified by the state.

No later than one year after the conclusion of the demonstration project, the Secretary would be required to submit a report to Congress on the project's results.

Sec. 1674. Medicaid Global Payment System Demonstration Project.

Present Law

No Provision.

Committee Bill

The Secretary, in coordination with the CMS Innovation Center (established under section 3021 of the Committee Bill), would be required to establish and evaluate the Medicaid Global Payment System Demonstration Project, which would create an alternative payment methodology for safety net hospital systems. Participating states would be required to adjust the payments made to an eligible safety net hospital system or network from a fee-for-service payment structure to a global, capitated payment model. The Secretary would select no more than five states to participate in the demonstration project, which would operate during fiscal years 2010 to 2012. The Innovation Center would be required to test and evaluate the demonstration project to examine any changes in health care quality outcomes and spending by the eligible safety net hospital systems or networks. The Committee Bill would exempt the demonstration project from budget-neutrality requirements (demonstration projects cannot result in a higher level of Federal spending than otherwise would have been the case under the state Medicaid program if the demonstration project were not implemented) during the initial testing period by the Innovation Center. The Secretary would be required to submit a report, not later than one year after the date of completion of the demonstration project, to Congress that presents the findings of the Innovation's Center evaluation and testing, together with recommendations for such legislative and administrative action as the Secretary determines appropriate.

Sec. 1675. Pediatric Accountable Care Organization Demonstration Project.

Present Law

No Provision.

Committee Bill

The Committee Bill would establish a demonstration project, which would authorize participating states to allow pediatric medical providers who meet certain criteria to be recognized as accountable care organizations (ACOs) for the purposes of receiving incentive payments, in the same manner as an ACO would be recognized and provided with incentive payments under Medicare as per section 3022 of the Committee Bill.

In consultation with states and pediatric providers, the Secretary would be required to develop performance guidelines to ensure that the quality of care delivered to individuals by the ACOs would be at least as high as it would have been absent the demonstration project. Participating States, in consultation with the Secretary, would be required to establish an annual minimum level of savings in expenditures for items and services covered under Medicaid and CHIP that would need to be achieved by an ACO in order for the ACO to receive an incentive payment. ACOs that meet the performance guidelines established by the Secretary and achieve savings greater than the annual minimal savings level established by the state would receive an incentive payment for such year equal to a portion (as determined appropriate by the Secretary) of the amount of such excess savings. The Secretary would have the authority to establish an annual cap on incentive payments for an ACO.

Sec. 1676. Medicaid Emergency Psychiatric Demonstration Project.

Present Law

Medicaid does not reimburse for treatment provided to patients receiving care in institutions for mental disease (IMD), except to those patients under age 21 receiving inpatient psychiatric care and individuals age 65 and over. IMDs are defined under Medicaid statute as hospitals, nursing facilities, or other institutions of more than 16 beds that are primarily engaged in providing diagnosis and treatment of persons with mental diseases, including medical attention, nursing care and related services.

Federal law requires that hospital-based IMDs which have emergency departments provide a medical screening examination to individuals for whom an examination or treatment for a medical condition is requested. In such cases, the hospital-based IMD must provide for an appropriate medical screening examination to determine whether or not a medical emergency exists. If a medical emergency exists, then the hospital-based IMD must provide, within the staff and facilities available at the hospital, for further medical examination and treatment as may be required to stabilize the medical condition, or to transfer the individual to another medical facility, subject to certain limitations.

Committee Bill

The Secretary of HHS would be required to establish a three-year Medicaid demonstration project for up to eight states in which eligible states would be required to reimburse certain IMDs

that are not publicly owned or operated for services provided to Medicaid eligibles between the ages of 21 and 65 who are in need of medical assistance to stabilize a psychiatric emergency medical condition.

The Secretary would be required to establish a mechanism for in-stay review to determine whether or not the patient has been stabilized. This mechanism would commence before the third day of the inpatient stay. The term "stabilized" would mean that the psychiatric emergency medical condition no longer exists with respect to the individual and that the individual is no longer dangerous to his or her self or others.

Eligible states would be selected by the Secretary based on geographic diversity and would manage the provision of these benefits under the project through utilization review, authorization or management practices, or the application of medical necessity and appropriateness criteria applicable to behavioral health.

$75 million would be appropriated for fiscal year 2010. Such funds would remain available for obligation through December 31, 2012.

To implement this demonstration, the Secretary would be required to waive requirements pertaining to limitations on payments for serving individuals under age 65 in IMDs, statewideness, and comparability.

The Secretary would be required to submit annual reports to Congress on the progress of the demonstration project, as well as a final report that includes an evaluation of the demonstration's impact on the functioning of the health and mental health service system and on Medicaid enrollees.

Part IX – Medicaid and CHIP Payment and Access Commission

Sec. 1681. MACPAC Assessment of Policies Affecting All Medicaid Beneficiaries.

Present Law

The Children's Health Insurance Program Reauthorization Act (CHIPRA, P.L. 111-3) established a new Federal commission called the Medicaid and CHIP Payment and Access Commission, or MACPAC. This commission will 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.

Beginning in 2010, by March 1 of each year, the commission will submit a report to Congress containing the results of these reviews and MACPAC's recommendations regarding these policies. Also beginning in 2010, by June 1 of each year, the commission will submit another report to Congress containing an examination of issues affecting Medicaid and CHIP, including

the implications of changes in health care delivery in the U.S. and in the market for health care services.

MACPAC must also create an early warning system to identify provider shortage areas or other problems that threaten access to care or the health care status of Medicaid and CHIP beneficiaries.

Committee Bill

The Committee Bill would clarify the topics to be reviewed by MACPAC including Federal Medicaid and CHIP regulations, additional reports of state-specific data, as well as other changes. The provision would also authorize $11 million for MACPAC for FY2010. Of this total, $9 million would come from the Treasury out of any funds not otherwise appropriated, and $2 million would come from CHIP funds, and would remain available until expended.

The Committee Bill also expands MACPAC's mission to include assessment of adult services in Medicaid, including for dual eligbles, and more detailed reporting requirements for states and Congress. This assessment would be done in consultation with the Medicare Payment Advisory Commission (MedPAC), and with respect to recommendations regarding dual eligibles, in consultation with the Federal Coordinated Health Care Office (established in section 1662 of the Committee Bill).

In addition, 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 the Medicaid and CHIP Payment and Access Commission (MACPAC).

Part X – American Indians and Alaska Natives

Sec. 1691. Special Rules Relating to Indians.

Present Law

No provision for cost sharing in a state exchange. By regulation (42 C.F.R.136.61), the Indian Health Service (IHS) is payer of last resort for contract health services. Section 206 of the Indian Health Care Improvement Act (IHCIA, P.L. 94-437) specifies that the Indian Health Service (IHS), and an Indian Tribe or a tribal organization (I/T/U) has the right to recover reimbursements from third parties for the provision of health services. These specified Indian entities can recover costs of health services in cases where the individuals would have been reimbursed or paid the costs of services if services had been provided by a non-governmental provider. Section 206 also specifies that these specified Indian entities have the right to recover reimbursements from state worker's compensation and state no-fault automobile insurance programs and prohibits the Federal government's right of recovery in instances where health services provided were covered under a self-insurance plan that was funded by an I/T/U.

Sections 1395qq and 1396j of IHCIA permit IHS and I/T/Us to receive reimbursements from Medicare and Medicaid and section 2105(c)(6)(B) of the Social Security Act permitted these entities to receive reimbursements from CHIP.

The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA, P.L. 111-3) created a state option to facilitate Medicaid enrollment. Under CHIPRA, states can rely on a finding from specified "Express Lane" agencies (*e.g.*, those that administer programs such as Temporary Assistance for Needy Families, Medicaid, CHIP, and Food Stamps) to determine whether a child under age 19 (or an age specified by the state not to exceed 21 years of age) has met one or more of the eligibility requirements necessary to determine an individual's initial eligibility, eligibility redetermination, or renewal of eligibility for medical assistance under Medicaid or CHIP. With family consent, states will have the option to institute automatic enrollment through an Express Lane eligibility determination. Under Present Law, Indian entities including IHS and I/T/Us are not eligible "Express Lane" agencies.

Section 1139 of the Social Security Act, as amended by CHIPRA, encourages states to take steps to enroll Indians residing in or near reservations in Medicaid and CHIP. These steps may include outstationing eligibility workers; entering into agreements with Indian entities to provide outreach; education regarding eligibility, benefits, and enrollment; and translation services. The Secretary must facilitate cooperation between states and Indian entities in providing benefits to Indians under Medicaid and CHIP. This section defined Indians in terms of section 4 of the Indian Health Care Improvement Act. Under this definition, an Indian is a person who is a member of a Federally recognized tribe, band, nation, or other organized group or community, including any Alaska Native village or group, or regional or village corporation, as defined in or established pursuant to the Alaska Native Claims Settlement Act (P.L. 92-203).

Committee Bill

The Committee Bill would prohibit cost-sharing for Indians enrolled in a qualified health benefit plan in the individual market through a state exchange. The provision would also specify that nothing in the Committee Bill or the amendments made by the Committee Bill would affect the right of IHS and I/T/Us to recover reimbursements from a third-party in accordance with section 206 of IHCIA.

The Committee Bill would add IHS and I/T/Us to the list of agencies that could serve as an "Express Lane" agency able to determine Medicaid and CHIP eligibility.

Sec. 1692. Elimination of Sunset For Reimbursement for All Medicare Part B Services Furnished By Certain Indian Hospitals and Clinics.

Present Law

Medicare covers specified Part B services provided by, or at the direction of, a hospital or ambulatory care clinic (whether provider-based or free-standing) that is operated by IHS or an I/T/U. These services include physician services, health practitioners (physician assistants, nurse anesthetists, certified nurse-midwives, clinical social workers, clinical psychologists, and registered dietitians or nutrition professionals) and outpatient physical therapy services provided

by physical or occupational therapists. Section 630 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA, P.L. 108-173) instituted a five-year expansion of the items and services covered under Medicare Part B when furnished in, or at the direction of, IHS or I/T/U hospitals or ambulatory care clinics, applying to items and services on or after January 1, 2005. The current five-year reimbursement extension will expire on January 1, 2010.

Committee Bill

The Committee Bill would remove the sunset and allow IHS, IT, and TO services to continue to be reimbursed by Medicare Part B indefinitely beginning January 1, 2010.

Subtitle H – Addressing Health Disparities

Sec. 1701. Standardized Collection of Data.

Present Law

The Office of Management and Budget (OMB) Directive 15 outlines standards for the collection of race and ethnicity data on Federally-sponsored surveys, administrative forms, and other records. OMB Directive 15 does not mandate collection of such data. Generally, Federal agencies and Federally-sponsored entities must use the Directive 15 categories when collecting race and ethnicity data. The requirements may be waived if an organization can demonstrate that it is unreasonable to use the categories in a particular situation, or if it can be shown that race and ethnicity data are not critical to the administration of the program seeking this information. OMB standards do not apply to state and municipal public health departments or to Medicaid. While the standards do apply to the Children's Health Insurance Program (CHIP), they are not binding on states that opt to use CHIP funding to finance a Medicaid expansion or that employ a combined approach.

Data on race and ethnicity can be collected by asking either one or two questions. When data on race and ethnicity are collected in two questions, Directive 15 requires using a minimum of five racial categories (White, Black or African American, American Indian or Alaska Native, Asian, Native Hawaiian or Other Pacific Islander) and two ethnic categories ("Hispanic or Latino" or "not Hispanic or Latino") and the ethnicity question must be asked first. Alternately, if data are collected by one question, a minimum of six categories must be used, including the five listed above, as well as "Hispanic or Latino." Data collection instruments may include additional categories such as Mexican-American, Chicano, Puerto Rican, Cuban, or Filipino, as long as these categories can be aggregated to the standard categories. When individuals are asked to self-identify (OMB's preferred method), Directive 15 also requires that respondents be given the opportunity to report multiple races in response to a single question. Including "multiracial" as an option is not acceptable. Finally, persons who identify as Alaska Native should also be asked for their tribal affiliation.

While OMB Directive 15 does not address data on primary language, CMS mandates that this information be reported for Medicaid beneficiaries. CMS does not require the collection of

primary language data for CHIP enrollees, their parents, or legal guardians. Present Law does not require the collection of data on access to care for disabled individuals for any Federal health care program or other Federally-sponsored entities.

Committee Bill

The Committee Bill would require the Secretary, in consultation with the Director of the Office of Personnel Management, the Secretary of Defense, the Secretary of Veterans Affairs, and the head of other appropriate Federal agencies, to establish procedures to ensure that, beginning on January 1, 2011, all data collected on race, ethnicity, sex, and primary language under Federal and state health care programs complies with: (1) OMB Directive 15; (2) OMB guidance for Federal agencies that collect or use aggregate data on race; and (3) OMB guidance for Federal agencies for the allocation of multiple race responses for use in civil rights monitoring and enforcement.

The Committee Bill would also require the Secretary, in consultation with the above-mentioned agencies, to establish procedures, by January 1, 2012, for the CMS Administrator to collect data under Federal and state health care programs to assess access to care and treatment for individuals with disabilities. The section would require such procedures to include surveying health care providers to identify: (1) the locations where people with disabilities receive primary care, acute (including intensive) care, and long-term care; (2) the number of providers with accessible facilities and equipment; and (3) the number of employees of health care providers trained in disability awareness and in caring for patients with disabilities.

This section would apply to any Federal health care program, funded directly, in whole or in part, by the Federal Government.

Sec. 1702. Required Collection of Data.

Present Law

OMB Directive 15 does not require the collection of data on race and ethnicity. Many Federal data collection efforts include items measuring race and ethnicity; however, surveys often have an insufficient sample size to ensure reliable estimates with appropriate statistical precision for subpopulations. Sample size also influences the type of statistical analysis that can be conducted, for example, multivariate analysis to examine reasons for disparities. Some surveys use oversampling to increase the precision of subpopulation estimates. Other times, data from multiple years are combined to produce stable and precise estimates for subpopulations.

The Medicare Improvements for Patients and Providers Act of 2008 (MIPAA, P.L. 110-275) instructed the Secretary to evaluate approaches for collecting disparities data on Medicare beneficiaries, and to provide a report to Congress, including recommendations for reporting nationally recognized quality measures, such as Healthcare Effectiveness Data and Information Set (HEDIS) measures, on the basis of race, ethnicity, and gender. MIPAA further instructed the Secretary to implement the approaches identified in the initial report and, subsequently, report

back to Congress with recommendations for improving the identification of health care disparities among Medicare beneficiaries based on an analysis of those efforts.

Committee Bill

The Committee Bill would require that Federally-funded population surveys collect sufficient data relating to racial, ethnic, sex, primary language, and disability subgroups to generate statistically reliable estimates in studies comparing health disparities among populations. It would ensure that any quality reporting requirements under a Federal health care program include requirements for the collection of data on individuals receiving health care items or services under these programs by race, ethnicity, sex, primary language, and type of disability. The Committee Bill would also extend the MIPAA provisions regarding the collection of health disparities data on the Medicare population to Medicaid and CHIP.

The Committee Bill would require that the Secretary submit two reports to Congress. The first, to be submitted not later than 18 months after the date of enactment, will include approaches for identifying, collecting and evaluating data on health care disparities on the basis of race, ethnicity, sex, primary language and types of disability for programs under Medicaid and CHIP. The report would also include recommendations on the most effective strategies for reporting HEDIS and other quality measures, as appropriate, on such bases. The Committee Bill would also require the Secretary to implement the approaches from the evaluation within 24 months after the date of enactment.

The second, to be submitted not later than four years after the date of enactment, and four years thereafter, will include recommendations for improving identification of health disparities for Medicaid and CHIP beneficiaries.

Section 1703. Data Sharing and Protection.

Present Law

There is no Present Law that requires the Secretary of HHS to share health disparities measures, data, and analyses with other HHS agencies.

Committee Bill

The Committee Bill would require the Secretary of HHS in consultation with other appropriate Federal agencies to establish procedures for sharing data and relevant analyses on race, ethnicity, gender, primary language, and type of disability collected under a Federal health care or insurance program with other Federal and state agencies, as well as agencies within HHS.

The Committee Bill would also require the Secretary to ensure all appropriate privacy and security safeguards are followed for the collection, analysis, and sharing of these data.

Sec. 1704. Inclusion of Information about the Importance of having a Health Care Power of Attorney in Transition Planning for Children Aging out of Foster Care and Independent Living Programs.

Present Law

Transition Planning. A State is required to have in place a case review system for each child in foster care to, among other things, periodically review the child's status in foster care and to develop and carry out a permanency plan for the child. As part of the case review system for older children in care, a child's caseworker, and as appropriate, other representative(s) of the child, are to assist and support him or her in developing a transition plan that is to be implemented 90 days prior to the time when the child will age out of foster care. The plan is to be personalized by the child and as detailed as the child may elect. It must include specific options on housing, health insurance, education, local opportunities for mentors and continuing support services, and workforce supports and employment services.

Independent Living Education. Under the John H. Chafee Foster Care Independence Program (CFCIP), States may apply for funds to carry out independent living programs for older children in foster care and children who have aged out of foster care. As part of their application, States must meet certain certifications regarding how their programs will be carried out.

Health Oversight and Coordination Plan Under Title IV-B of the Social Security Act, a State is required to maintain a plan for child welfare services. As part of the plan, states must develop a coordinated strategy and oversight plan to ensure access to health care, including mental health services and dental care, for all children in foster care. This coordinated strategy and oversight plan must be a collaborative effort between the state child welfare agency and the state agency that administers Medicaid, in consultation with pediatric and other health care experts, as well as experts in, or recipients of, child welfare services. The strategy and plan must outline: (1) a schedule for initial and follow-up health screens; (2) how the health needs identified by those screens will be monitored and treated; (3) how medical information for children in care will be updated and appropriately shared; (4) steps to ensure continuity of health care services; (5) oversight of prescription medicines; and (6) how the State actively consults with and involves medical and non-medical professionals in assessing the health and well-being of children in foster care and determining their appropriate medical treatment.

Committee Bill

The Committee Bill maintains all of the Present Law provisions for transition planning but adds that the transition plan must also address health care treatment decisions. Specifically, it stipulates that the plan is to include information about the importance of designating another individual to make health care treatment decisions on behalf of the child if the child becomes unable to participate in these decisions *and* he or she does not have, or does not want, a relative who would otherwise be authorized, under state law, to make such decisions. In addition, the plan must provide the child with the option to execute a health care power of attorney, health care proxy, or other similar document recognized under state law.

The Committee Bill adds a certification that States are to ensure that an adolescent participating in the CFCIP is provided with education about the importance of designating another individual to make health care treatment decisions on his or her behalf if the adolescent becomes unable to participate in these decisions *and* the adolescent does not have, or does not want, a relative who would otherwise be authorized, under state law, to make such decisions. The certification must also ensure that the adolescent is educated about whether a health care power of attorney, health care proxy, or other similar document is recognized under state law, and how to execute such a document if the adolescent wants to do so.

The Committee Bill adds a requirement that the health care strategy and plan must also outline steps to ensure that the components of the transition plan (for children aging out of foster care) that address health care needs, are met. These components include options for health insurance; information about a health care power of attorney, health care proxy, or other similar document recognized by State law; and the option for the child to execute such a document.

This Committee Bill would be effective on October 1, 2010.

Subtitle I – Maternal and Child Health Services

Sec. 1801. Maternal, Infant, and Early Childhood Home Visiting Programs.

Present Law

Title V of the SSA authorizes the Maternal and Child Health (MCH) block grant program. The MCH block grant, which is administered by the Health Resources and Services Administration (HRSA), allocates funding to states based on a statutory formula. States use the Title V funds to design and implement a wide range of maternal and child health programs. The MCH block grant program seeks to: (1) reduce infant mortality; (2) increase the number of children appropriately immunized against disease; (3) increase the number of children in low-income families who receive health assessments and follow-up care; (4) provide comprehensive prenatal care to low-income and at-risk pregnant women; (5) provide preventive and child-care services, and rehabilitative services to disabled children; and (6) develop comprehensive, family-centered, community-based, culturally-competent, coordinated systems of care for children with special health care needs.

States must submit annual reports on Title V-funded activities and demonstrate progress made towards standardized MCH status indicators (e.g., live birth rate, low birth weight, maternal death rates, and poverty levels) in order to facilitate comparison between states. The Secretary compiles the data submitted by the states in an annual report to Congress. States are required to audit and report on the use of their funds at least once every two years.

Committee Bill

The Committee Bill would add a new Section 511 in Title V of the Social Security Act , Early Childhood Home Visitation Programs. The new provision would require states, as a condition of receiving the MCH block grant funds for FY2011, 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. The needs assessment would identify communities that have a concentration of risk factors for premature birth, low-birth weight infants, infant mortality, poor maternal and child health, poverty, crime, domestic violence, high drop-out rates, substance abuse, unemployment, and child maltreatment. The needs assessment, which would be separate from but coordinated with the assessments currently required under Title V and the Head Start Act, would also review the state's capacity to provide appropriate services to those communities. State would be required to submit the results of their needs assessment and their proposed activities to the Secretary.

In addition, the Committee Bill would establish a new state grant program for early childhood home visitation. Grantees of this new program would be required to establish appropriate process and three and five year outcome benchmarks to measure improvements in maternal and child health, childhood injury prevention, school readiness, juvenile delinquency, family economic factors and the coordination of community resources. Grantees who do not demonstrate improvement in at least four specified areas at the end of the third year of funding would receive expert technical assistance.

The program model(s) chosen to deliver services would conform to a clear consistent home visitation model that has been in existence for at least three years and is research-based, grounded in relevant empirically-based knowledge, linked to program determined outcomes, associate with a national organization or institution of higher education that has comprehensive home visitation standard that ensure high quality service delivery and continuous program quality improvement, and sustained positive outcomes. The programs can be evaluated using well-designed and rigorous randomized controlled research designs and the evaluation results have been published in a peer-reviewed journal, or the programs has been evaluated using well-designed and rigorous quasi-experimental research designs. In addition, the grantees would be permitted to use 25 percent of the award to fund a promising new program model(s) that would be rigorously evaluated.

Grantees would have to use evidence-based practices to meet the process and outcome benchmarks, employ well-trained staff and specialists as appropriate, maintain high-quality supervision, possess strong organizational capacity and linkages in the community, monitor the fidelity of the program to ensure that services are delivered in accordance with the model, and use research-based models. There would be a priority to provide services to families who are determined to be at-risk by the needs assessment, and other indicators including low-income, young maternal age, and involvement with child welfare.

In order to apply for the grant, eligible entities would need to submit a description of the target population, and service delivery model, demonstrate consistency with findings of the needs assessments, procedures and the benchmarks to be used. Grantees would be required to meet maintenance of effort standards based on previous spending by using new funds to supplement not supplant**.**

The provision would require the Secretary to conduct evaluations of the state assessments and home visitation programs by grant, contract or interagency agreement, including a report to

Congress by December 31, 2015. It would also require intra-agency collaboration among Federal agencies including the Administration for Children and Families, *the Centers for Disease Control* and Prevention, National Institute of Child Health and Human Development, and the Office of Juvenile Justice and Delinquency Prevention, *the Institute of Education Sciences of the Department of Education.*

The provision would appropriate $1.5 billion between FY2010 and FY2014 for home visitation programs: $100 million for FY2010; $250 million in $250; $350 million for FY2012; $400 million for FY2013; and $400 million for FY2014. Three percent would be used to provide home visitation services to Indian families, with eligible entities of Indian tribe, tribal organization, and urban Indian organization. At the beginning of FY2012, the Secretary may determine which other non-profit entities have the capacity to carry out the program and are eligible for unexpended amounts to serve a state that did not get a grant.

Sec. 1802. Support, Education, and Research for Postpartum Depression.

Present Law

No comparable provision exists in Present Law. However, PHSA Sec. 508 authorizes the Secretary to provide residential substance abuse treatment for pregnant and postpartum women.

Committee Bill

The Committee Bill would promote efforts to expand and intensify activities to address postpartum conditions as follows. It would define the term postpartum condition to mean "postpartum depression or postpartum psychosis," and encourage the Secretary to continue specified types of research, including epidemiology, clinical research, and public education, to expand the understanding of the causes and treatments for postpartum conditions.

The Committee Bill states that it is the sense of Congress that the Director of the National Institute of Mental Health (NIMH) may conduct a nationally representative longitudinal study (during the period FY2010-FY2019) on the relative mental health consequences for women of resolving a pregnancy, intended and unintended, in various ways. Those ways include carrying the pregnancy to term and parenting the child, miscarriage, and having an abortion. Subject to the completion of such a study, beginning within five years of enactment and periodically thereafter for the duration of the study, the NIMH Director may submit to Congress reports on the study's findings.

Additionally, the Committee Bill would add to the end of Title V of the SSA a new Sec. 512, Services to Individuals with a Postpartum Condition and their Families. This provision would authorize the Secretary to award grants, in addition to any other funds that would be provided to states under this title, to eligible entities to establish, operate and coordinate effective and cost-efficient systems for the delivery of essential services to individuals with postpartum conditions and their families. The provision would specify that grant funds be used to carry out certain activities such as providing education, delivering outpatient and home-based services, enhancing inpatient care management, and improving health care and social services. It would authorize the

Secretary to integrate with other grant programs that the Secretary carries out, including the health centers program under Sec. 330 of the PHSA.

Grantees would have to agree to the following requirements: (1) no more than five percent of the grant funds may be used for administrative functions; (2) grant funds may not supplant other existing funds; (3) the grantee must abide by any limitations that the Secretary places on payment for services; (4) grant funds may not used for services that can be paid for by certain other payers; (5) the grantee must post conspicuous notices about applicable Federal policies on charges; and (6) the grantee must submit a report for each grant period on how funds were used. The Secretary would be authorized to provide technical assistance to help grantees meet these requirements.

The following provisions in Title V would apply to the grant program: (1) Sec. 504(b)(6), relating to prohibition of payments to certain excluded individuals and entities; (2) Sec. 504(c), relating to the use of funds for purchase of technical assistance; (3) Sec. 504(d), relating to a limitation on administrative expenditures; (4) Sec. 506, relating to reports and audits; (5) Sec. 507, relating to penalties and false statements; (6) Sec. 508, relating to non-discrimination; and (7) Sec. 509(a), relating to grant administration. Entities eligible for a grant would include public or nonprofit private entities, state or local government public-private partnerships, recipients of a Healthy Start grant, public or nonprofit private hospitals, community-based organizations, hospices, ambulatory care facilities, community health centers, migrant health centers, public housing, primary care centers, or homeless health centers. The provision would authorize the appropriation of $3 million for FY2010, and such sums as may be necessary for FY2011 and FY2012 to carry out the grant program. The Secretary would be required to study the benefits of screening for postpartum conditions and, within two years of enactment, submit a report to Congress. Finally, the Secretary would be prohibited from using funds under this section to duplicate any other HHS activities or programs.

Sec. 1803. Personal Responsibility Education for Adulthood Training.

Present Law

No provision.

Committee Bill

The new provision would amend Title V of the Social Security Act to directly appropriate funding for a new program, the Personal Responsibility Education for Adulthood Training. Programs must be evidence-based, medically accurate. It would be a state formula grant program for FY2010 through FY2014 to provide personal responsibility education on topics for adulthood preparation including healthy relationships, adolescent development, financial literacy, parent-child communication, educational and career success, financial self-sufficiency, health life skills for decision making, pregnancy prevention, including abstinence and contraception, and awareness of sexually transmitted infection, including HIV/AIDS.

Under the funding allocation formula, each state would receive an amount based on the size of its youth population as a percentage of the national population. However, each state would receive a minimum allotment of at least $250,000 for each fiscal year.

In order to receive the grant, states would have to submit an application containing information on recent teen pregnancy rates and teen birth rates, state-established goals for reduction in teen pregnancy, the state's plan for using the funds to reduce pregnancies among certain at-risk youth, and other information that the Secretary may require. States would be allowed to expend allotted funds through the end of the second succeeding fiscal year. States that do not accept the grant in FY2010 and FY2011 would not be eligible to apply for the funds allotted for the period FY2010 through FY2014. The Secretary would be required to use unexpended funds resulting from states not submitting an application, or states not expending their allocation, to award three-year grants to local organizations, including faith-based organizations or consortia, in each of FY2012, FY2013 and FY2014, for use as required in states that do not apply for the allocations. The provision would require maintenance of effort by the state or organization receiving these allotments at the FY2009 level.

The Secretary would be required to reserve certain portions of the funds appropriated to carry out this provision for certain specified purposes. The Secretary would be required to reserve $10 million (out of the $75 million appropriation) to award grants to implement innovative teen pregnancy prevention strategies and target certain high-risk youth, as specified. Grantees would be required to agree to participate in a rigorous evaluation of their grant activities. The proposal would also require the Secretary to reserve five percent of the remainder of the appropriated funds to award grants to Indian tribes and tribal organizations. In addition, the Secretary would be required to reserve ten percent of the remainder of the funds: (1) to establish a teen pregnancy prevention resource center; (2) to conduct research, training and technical assistance on allotted and grantee programs; and (3) to evaluate the activities funded by allotments and grants.

The Committee Bill would require the Secretary to create a national teen pregnancy prevention resource center. The purpose of the resource center would be to provide information and technical assistance for states, Indian tribes, local communities and other organizations that are seeking to reduce teen pregnancy rates. The resource center would carry out certain specified activities such as synthesizing and disseminating effective and promising practices to prevent teen pregnancy. The resource center would be required to collaborate with other entities with relevant expertise, as specified.

The Committee Bill would appropriate $75 million for each of FY2010 through FY2014 to carry out this section. Amounts appropriated under this subsection would remain available until expended.

Sec. 1804. Restoration of Funding for Abstinence Education.

Present Law

Section 510 of the Social Security Act, the Title V Abstinence Education Block Grant to states was authorized under P.L. 104-193 (the 1996 welfare reform law). The law provided $50 million per year for five years (FY1998-FY2003) in Federal funds specifically for the abstinence education program. The Title V Abstinence Education program is considered a mandatory program and is funded by mandatory spending. It is a formula grant program. State funding is based on the proportion of low-income children in the state compared to the national total. Although the program has not been reauthorized, the last extension, contained in P.L. 110-275, continued funding for the abstinence-only block grant through June 30, 2009. Funds must be requested by states when they solicit Title V Maternal and Child Health (MCH) block grant funds and must be used exclusively for teaching abstinence. To receive Federal funds, a state must match every $4 in Federal funds with $3 in state funds.

Committee Bill

The Committee Bill would amend Sec. 510 of the SSA, by appropriating $50 million for each of FY2010 through FY2014. For FY2010, the date the appropriation is made would be the date of enactment of America's Healthy Future Act of 2009.

Subtitle J – Programs of Health Promotion and Disease Prevention

Sec. 1901. Programs of Health Promotion and Disease Prevention.

Present Law

The Health Insurance Portability and Accountability Act of 1996 (HIPAA, P.L. 104-191) amended the Employee Retirement Income Security Act (ERISA), the Public Health Service Act (PHSA), and the Internal Revenue Code (IRC) to improve portability and continuity of health coverage. Title I of HIPAA created certain nondiscrimination requirements, which provide, among other things, that a group health plan and a health insurance issuer offering group health coverage may not require an individual to pay a higher premium or contribution than another "similarly situated" participant, based on certain health-related factors such as claims experience, receipt of health care, medical history, genetic information, evidence of insurability, or disability. However, HIPAA clarifies that this requirement "do[es] not prevent a group health plan and a health insurance issuer from establishing premium discounts or rebates or modifying otherwise applicable copayments or deductibles in return for adherence to programs of health promotion and disease prevention (*i.e.*, wellness programs)."

HIPAA regulations provide standards under which a group health plan or a health insurance issuer may offer rewards such as premium discounts or rebates premiums, waivers of all or part of a cost-sharing mechanism under the plan (such as deductibles, co-payments or coinsurance), the absence of a surcharge, or the value of a benefit which would otherwise not be provided under the plan, in exchange for adherence to wellness programs

The HIPAA wellness program regulations divide wellness programs into two categories. In the first category are programs in which rewards are based solely on program participation. Examples in the existing regulation include reimbursing enrollees for the cost of gym

membership, waiving copayments for parental care, and reimbursing enrollees for the cost of smoking cessation programs, regardless of whether they successfully quit smoking. Programs in this category are automatically permissible.

Programs in the second category are those in which rewards are based on the attainment of certain health standards – for example, achieving a targeted cholesterol level, maintaining a certain body mass index, quitting smoking, or losing a specified amount of weight. Under current regulations, health plans can offer such financial incentives only if five criteria are met – one of these being that the reward cannot exceed 20 percent of the cost of the employee's coverage (*i.e.*, the employee's premium plus the employer's contribution). The regulations also provide that the reward under the program must be available to all similarly situated individuals. As part of this requirement, a reasonable
alternative standard (or waiver of the otherwise applicable standard) for obtaining the reward must be available for any individual for whom it is "unreasonably difficult" due to a medical condition to satisfy the otherwise applicable standard or it is "medically inadvisable" to attempt to satisfy the otherwise applicable standard.

The Federal Employees Health Benefits Act (P.L. 86-382), establishes a program under which Office of Personnel Management (OPM) has the authority to contract with insurance carriers to provide health insurance to Federal employees, retirees, and their families. The Act sets out various additional requirements required for the plans that are offered.

Committee Bill

The Committee Bill would codify and enhance provisions of the HIPAA wellness program regulations, which allow rewards to be provided to employees for participation in or for meeting certain health standards related to a wellness program.

Consistent with current regulation, the proposal indicates that wellness programs that do not require an individual to satisfy a standard related to a health factor as a condition for obtaining a reward, or do not offer a reward, are not in violation of the HIPAA non-discrimination requirements (assuming that participation in the programs is made available to all similarly situated individuals). Wellness programs that meet this requirement include the following programs:

- A program that reimburses all or part of the cost for memberships in a fitness center.
- A diagnostic testing program that provides a reward for participation and does not base any part of the reward on outcomes.
- A program that encourages preventive care by waiving co-payments or deductibles under a group health plan for the costs of, for example, prenatal care or well-baby visits.
- A program that reimburses employees for the cost of smoking cessation programs without regard to whether the employee quits smoking.
- A program that provides a reward to employees for attending a monthly education seminar.

The Committee Bill would also allow 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's or an employee's participation in wellness programs in which the condition for obtaining a reward is based on an individual satisfying a standard that is related to a health factor. Under these types of wellness programs, additional requirements would have to be met. For example, the proposal would cap the reward at 30 percent of the cost of the employee-only coverage under the plan, and would allow the Secretaries of Health and Human Services, Department of Labor, and Department of the Treasury the discretion to increase the reward up to 50 percent of the cost of coverage for adherence to or participation in a reasonably designed program of health promotion and disease prevention. For purposes of this paragraph, the cost of coverage is determined based on the combined amount of employers and employee contributions for the benefit package under which the employee is (or the employee and any dependents are) receiving coverage. In addition, the reward must be available to all "similarly situated" individuals. As part of this requirement, a reasonable alternative standard (or waiver of the otherwise applicable standard) for obtaining the reward must be available for any individual for whom it is "unreasonably difficult" due to a medical condition to satisfy the otherwise applicable standard or it is "medically inadvisable" to attempt to satisfy the otherwise applicable standard.. The wellness program may require verification of these circumstances, including a statement from an individual's physician.

In addition, programs which provide rewards based on the attainment of certain health standards would need to meet the following criteria:

- Be reasonably designed to promote health or prevent disease. A program complies with the preceding sentence if the program has a reasonable chance of improving the health of, or preventing disease in, participating individuals and it is not overly burdensome, is not a subterfuge for discrimination based on a health status factor, and is not highly suspect in the method chosen to promote health or prevent disease. The plan or issuer shall evaluate the program's reasonableness at least once per year.
- Provide individuals eligible for the program the opportunity to qualify for the reward under the program at least once a year.
- 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.

The Committee Bill would apply the above described provisions to carriers providing Federal Employees Health Benefit Plans. This section would be effective on the date of enactment of the proposal, and would apply to contracts that take effect with respect to calendar years beginning more than one year after that date.

The proposal would require the Secretaries of Health and Human Services and the Treasury to establish a ten-state pilot program in 2014. States that choose to participate in the pilot program would be allowed to apply the above described provisions to programs of health promotion offered in the individual market in a manner that is 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 in the individual market, including verification that premium discounts do not create undue burdens or lead to cost shifting. In 2017, the demonstration program may be expanded to include other states, pending evidence of the program's effectiveness as determined by the Secretary of Health and Human Services in consultation with the Secretary of Treasury. Nothing in this section would preempt any state law (related to programs of health promotion offered by a health insurance issuer in the individual market) that was established or adopted by state law on or after the date of enactment of this section.

Furthermore, this provision would require the Secretary of Health and Human Services, in consultation with the Secretary of Treasury, and the Secretary of Labor, to submit to the appropriate committees of Congress a report examining the effectiveness of wellness and disease prevention programs in promoting health and preventing disease, the impact of a wellness program on a participant's access to care and the affordability of coverage, and the impact of premium-based and cost-sharing incentives on employee behavior and their role of such programs and from state and Federal agencies in changing behavior. In developing the report, the Secretaries will gather relevant information from employers who provide employees with access to wellness programs to gather the above-described information. The report will be due no later than three years after the date of enactment of the proposal.

Subtitle K – Elder Justice Act

The following are the findings of Congress:

1. The proportion of the United States population age 60 or older will drastically increase in the next 30 years as more than 76,000,000 baby boomers approach retirement and old age.

2. Each year, anywhere between 500,000 and 5,000,000 elders in the United States are abused, neglected, or exploited.

3. Elder abuse, neglect, and exploitation have no boundaries, and cross all racial, social class, gender, and geographic lines.

4. Victims of elder abuse, neglect, and exploitation are not only subject to injury from mistreatment and neglect, they are also 3.1 times more likely than elders who were not victims of elder abuse, neglect, and exploitation to die at an earlier age than expected.

5. There is a general dearth of data as to the nature and scope of elder abuse, neglect and exploitation. In recognition of the need to improve data collection efforts with respect to elder abuse, neglect, and exploitation, Congress required the Secretary to conduct a study by the end of 2008 on establishing a uniform national database on elder abuse under section 405 of title IV of Division C of the Tax Relief and Health Care Act of 2006 (Public Law 109-432).

6. Despite the dearth of data in the field, experts agree that most cases of elder abuse, neglect, and exploitation are never reported and that abuse, neglect, and exploitation shorten a victim's life, often triggering a downward spiral of an otherwise productive, self-sufficient elder's life. Programs addressing other difficult issues such as domestic violence and child abuse and neglect have demonstrated the need for a multifaceted law, combining public health, social service and law enforcement approaches.

7. For over 20 years, Congress has been presented with facts and testimony calling for a coordinated Federal effort to combat elder abuse, neglect, and exploitation.

8. The Federal government has been slow to respond to the needs of victims of elder abuse, neglect, and exploitation or to undertake prevention efforts.

9. No Federal law has been enacted that adequately and comprehensively addresses the issues of elder abuse, neglect, and exploitation and there are very limited resources available to those in the field that directly deal with the issues.

10. Differences in State laws and practices in the areas of elder abuse, neglect, and exploitation lead to significant disparities in prevention, protective, and social services, treatment systems, and law enforcement, and lead to other inequities.

11. The Federal government has played an important role in promoting research, training, public safety, and data collection, and the identification, development, and dissemination of promising health care, social and protective services, and law enforcement practices, relating to child abuse and neglect, domestic violence, and violence against women. The Federal government should promote similar efforts and protections relating to elder abuse, neglect, and exploitation.

12. The Federal government should provide leadership and assist States and communities in efforts to protect elders in the United States by –
    A. promoting coordinated planning among all levels of government;
    B. generating and sharing knowledge relevant to protecting elders;
    C. providing leadership to combat the abuse, neglect, and exploitation of the Nation's elders; and
    D. providing resources to States and communities to promote elder justice.

13. The problem of elder abuse, neglect, and exploitation requires a comprehensive approach that –
    A. integrates the work of health, legal, and social services agencies and organizations;
    B. emphasizes the need for prevention, reporting, investigation, assessment, treatment, and prosecution of elder abuse, neglect, and exploitation at all levels of government;
    C. ensures that sufficient numbers of properly trained personnel with specialized knowledge are in place to treat, assess, and provide services related to elder abuse, neglect, and exploitation and carry out the elder protection duties;
    D. is sensitive to ethnic and cultural diversity;

E. recognizes the role of mental health, disability, dementia, substance abuse, medication mismanagement, and family dysfunction problems in increasing and exacerbating elder abuse, neglect, and exploitation; and
F. balances elders' right to self-determination with society's responsibility to protect elders.

14. The human, social, and economic cost of elder abuse, neglect, and exploitation is high and includes unnecessary expenditures of funds from many public programs.

15. The failure to coordinate activities relating to, and comprehensively prevent and treat, elder abuse, neglect, and exploitation threatens the future and well-being of millions of elders in the United States.

16. All elements of society in the United States have a shared responsibility in responding to a national problem of elder abuse, neglect, and exploitation.

The following are the purposes of the Elder Justice Act:

1. To enhance the social security of the Nation by 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.

2. To bring a comprehensive approach to preventing and combating elder abuse, neglect, and exploitation, a long invisible problem that afflicts the most vulnerable among the aging population of the United States.

3. To raise the issue of elder abuse, neglect, and exploitation to national attention, and to create the infrastructure at the Federal, State and local levels to ensure that individuals and organizations on the front lines, who are fighting elder abuse, neglect, and exploitation with scarce resource and fragmented systems, have the resources and information needed to carry out their fight.

4. To bring a comprehensive multidisciplinary approach to elder justice.

5. To set in motion research and data collection to fill gaps in knowledge about elder abuse, neglect, and exploitation.

6. To supplement the activities of service providers and programs, to enhance training, and to leverage scarce resources efficiently, in order to ensure that elder justice receives the attention it deserves as the Nation's population ages.

7. To recognize and address the role of mental health, disability, dementia, substance abuse, medication mismanagement, and family dysfunction problems in increasing and exacerbating elder abuse, neglect and exploitation.

8. To create short- and long-term strategic plans for the development and coordination of elder justice research, programs, studies, training, and other efforts nationwide.

9. To promote collaborative efforts and diminish overlap and gaps in efforts in developing the important field of elder justice.

10. To honor and respect the right of all individuals with diminished capacity to decision making autonomy, self-determination, and dignity of choice.

11. To respect the wishes of individuals with diminished capacity and their family members in providing supportive services and care plans intended to protect elders from abuse, neglect (including self-neglect), and exploitation.

Sec. 1911. Short Title.

Present Law

No provision.

Committee Bill

The Committee Bill sets forth the title as the Elder Justice Act of 2009.

Sec. 1912. Definitions.

Present Law

No provision.

Committee Bill

The Committee Bill would adopt the meaning of any term that is defined in Section 2011 of the Social Security Act, as the meaning set forth by such section of the Committee Bill.

Sec. 1913. Elder Justice.

Elder Justice

Present Law

No provision.

Committee Bill

The Committee Bill would amend the Social Security Act (SSA) by inserting "Elder Justice" to an amended Title XX, that would be entitled "Block Grants to States for Social Services and

Elder Justice." The provision would insert a new "Subtitle 1 – Block Grants to States for Social Services" before Section 2001 of the SSA and add a new "Subtitle 2 – Elder Justice."

Definitions

Present Law

Under Present Law "abuse," "caregiver," "elder justice," "exploitation," "fiduciary," "long-term care," "long-term care facility," "neglect," "nursing facility," and "self-neglect" are defined in the Older Americans Act (OAA), and "sexually violent offense" is defined in the Violent Crime Control and Enforcement Act.

Committee Bill

The Committee Bill also defines the following terms: abuse, adult protective services, caregiver, direct care, elder, elder justice, eligible entity, exploitation, fiduciary, grant, guardianship, Indian tribe, law enforcement, long-term care, loss of capacity for self-care, long-term care facility, neglect, nursing facility, self-neglect, serious bodily injury, criminal sexual abuse, social, state legal assistance developer, and State Long-Term Care Ombudsman.

General Provisions

Present Law

Section 264 of the Health Insurance Portability and Accountability Act of 1996 (HIPAA, P.L. 104-191) governs the protection of individual health privacy.

Committee Bill

The Committee Bill would require the Secretaryto ensure the protection of individual health privacy consistent with the regulations promulgated under section 264(c) of HIPAA and applicable state and local privacy regulations. It would prohibit the proposed subtitle from being construed to interfere with or abridge an elder's right to practice his or her religion through reliance on prayer alone for healing when this choice is: (1) expressed, either orally or in writing, (2) set forth in a living will, health care proxy, or other advance directive documents, or (3) may be deduced from an elder's life history.

Part I – National Coordination of Elder Justice Activities and Research

"Subpart A – Elder Justice Coordinating Council and Advisory Board on Elder Abuse, Neglect, and Exploitation"

Elder Justice Coordinating Council

Present Law

No provision.

Committee Bill

The provision would establish an Elder Justice Coordinating Council in the Office of the Secretary composed of the following members: the Secretary who will chair the Council and the Attorney General. Membership would also include the head of each Federal department or agency, identified by the Chair, as having administrative responsibility or administering programs related to elder abuse, neglect or exploitation. The Council would be required to make recommendations to the Secretary regarding coordination of activities of HHS, the Department of Justice (DoJ), and other relevant Federal, state, local, and private agencies and entities, relating to prevention of elder abuse, neglect, and exploitation and other crimes against elders. The Council would be required to submit a report to the appropriate committees of Congress within two years of enactment and every two years thereafter that describes its activities and challenges; and makes recommendations for legislation, model laws, and other actions deemed appropriate. The provision also sets forth requirements for powers of the Council, membership, meeting requirements, travel expenses, and detail of Federal government employees to the Council. Section 14 of the Federal Advisory Committee Act would not apply to the Council.

Advisory Board on Elder Abuse, Neglect and Exploitation

Present Law

No provision.

Committee Bill

The Committee Bill would establish the Advisory Board on Elder Abuse, Neglect and Exploitation to create a short- and long-term multidisciplinary plan for development of the field of elder justice and make recommendations to the Elder Justice Coordinating Council. The Board would be composed of 27 members from the general public appointed by the Secretary to serve for staggered three-year terms, and must have experience and expertise in prevention of elder abuse, neglect, and exploitation. The Secretary would be required to publish a notice in the *Federal Register* soliciting nominations for Advisory Board membership. The Advisory Board would be required to develop collaborative approaches to improving the quality of long-term services and supports and to establish multidisciplinary panels to address these subjects by examining relevant research and identifying best practices. Within 18 months of enactment, and annually thereafter, the Board would be required to prepare and submit to the Elder Justice Coordinating Council and the appropriate committees of Congress a report containing information on Federal, state, and local public and private elder justice activities. The report would also contain recommendations on programs, research, services, practice, enforcement, and coordination among entities that carry out elder justice and other related activities; modifications needed in Federal and state laws, research, training, and national data collection; and on a multidisciplinary strategic plan to guide the field of elder justice. The provision sets forth requirements relating to powers of the Board, vacancies, expired terms, election of officers,

travel expenses, and detail of government employees to the Board. Section 14 of the Federal Advisory Committee Act would not apply to the Council.

Research Protections

Present Law

Subpart A of Part 46 of title VL, Code of Federal Regulations, known as the Common Rule, that governs most Federally-funded human subjects research, currently defines the term "legally authorized representative" as "an individual or judicial or other body authorized under applicable law to consent on behalf of a prospective subject to the subject's participation in the procedure(s) involved in the research." No guidelines are currently in place to assist researchers who work in the areas of elder abuse, neglect, and exploitation, with issues relating to human subjects research.

Committee Bill

The Committee Bill would define "legally authorized representative," for purposes of research under this subpart, to mean, unless otherwise provided by law, the individual, or judicial or other body authorized under the applicable law to consent to medical treatment on behalf of another person. It would also require the Secretary to promulgate guidelines to assist researchers working in the areas of elder abuse, neglect, and exploitation, with issues relating to human subjects protections.

Authorization of Appropriations

Present Law

No provision.

Committee Bill

To carry out the functions under this subpart, the Committee Bill would authorize to be appropriated $6.5 million for FY2010, and $7.0 million for each of FYs 20011-2013.

"Subpart B – Elder Abuse, Neglect, Exploitation Forensic Centers"

Establishment and Support of Elder Abuse, Neglect, and Exploitation Forensic Centers

Present Law

No provision.

Committee Bill

The Committee Bill would require the Secretary, in consultation with the Attorney General, to award grants to eligible entities to establish and operate both stationary and mobile forensic centers and to develop forensic expertise pertaining to elder abuse, neglect, and exploitation. With respect to the stationary forensic centers, the Committee Bill would require the Secretary to make four grants to higher education institutions with demonstrated expertise in forensics or commitment to preventing or treating elder abuse, neglect, or exploitation; and, with respect to mobile forensic centers, the Committee Bill would require the Secretary to make six grants to appropriate entities. Funding would be authorized for the centers to: (1) develop forensic markers that would determine whether abuse or neglect occurred and whether a crime was committed, and determine methodologies for how and when intervention should occur; (2) develop forensic expertise with respect to elder abuse, neglect, and exploitation in order to provide relevant evaluation, intervention, support and advocacy, case review and tracking; and (3) in coordination with the Attorney General, use data made available by grant recipients under this section to develop the capacity of geriatric health care professionals and law enforcement to collect forensic evidence, including forensic evidence relating to a potential determination of elder abuse, neglect, or exploitation. The provision would authorize to be appropriated $4 million in FY2010, $6 million in FY2011, and $8 million for each of FYs 2012 and 2013 to carry out these activities.

Part II – Programs to Promote Elder Justice

Enhancement of Long-Term Care

Present Law

The Omnibus Budget and Reconciliation Act of 1987 (OBRA 1987, P.L. 100-203) established Federal minimum statutory requirements that nursing homes must meet in order to receive payments for providing health care services to Medicare and Medicaid beneficiaries. These provisions apply to skilled nursing facilities (SNF) participating in Medicare and nursing facilities (NF) participating in Medicaid . Often these provisions are identical. OBRA 1987 also established requirements pertaining to the survey and certification process for determining whether providers meet the requirements for participation, and it included penalties the Secretary and states may impose against noncompliant providers. The Secretary has promulgated regulations and issued accompanying guidance on the implementation of the statute. For the purposes of determining compliance with these requirements, the Secretary contracts with State survey, licensing, and certification agencies, often referred to as “state survey agencies,” who then assume oversight of those providers participating in Medicare only and those dually participating in Medicare and Medicaid. The state assumes responsibility for oversight of those providers participating only in the Medicaid program.

Medicare and Medicaid law require nursing facilities to meet certain Federal statutory requirements for the training and competency levels of certified nurse aides (CNAs) working in facilities that participate in these programs. Present Law and Federal regulation 42 CFR 483.75(e)(2) state that a facility may not use a nurse aide for more than four months, on a full-time basis, unless the nurse aide has completed a Nurse Aide Training and Competency Evaluation Program (NATCEP) approved by the state, or completed a competency evaluation

exam that meets Federal standards. Federal regulation 42 CFR 483.152 specifies that a state-approved nurse aide training program must consist of a minimum of 75 hours of training, which includes at least 16 hours of supervised practical or clinical training. Some states have chosen to require additional hours of classroom and clinical training. Under Federal regulation 42 CFR 483.75, facilities must also complete a performance review of each CNA at least every 12 months and provide a minimum of 12 hours of in-service training per year based on the outcome of these reviews.

Existing health professions education and training programs authorized under Title VII of the Public Health Service Act (PHSA) provide funding to medical schools and other facilities to promote community-based and rural practice, primary care, and opportunities for minorities and disadvantaged students. Title VIII of the PHSA authorizes a comparable set of programs to promote nursing education and training. Appropriations authority for most Title VII and VIII programs has expired, though many of them continue to receive funding. However, Title VII and VIII PHSA education and training programs are not specifically directed toward individuals seeking employment as direct care providers in long-term care facilities.

Committee Bill

The Committee Bill would require the Secretary to carry out activities that provide incentives for individuals to train for, seek, and maintain employment providing direct care in long-term care facilities. Specifically, the Secretary would be required to coordinate activities with the Secretary of Labor to provide incentives for individuals to train for and seek employment as direct care providers in long-term care facilities. The Secretary would be required to award grants to long-term care facilities to conduct programs that offer direct care employees continuing training and varying levels of certification. Grants would also be used to provide for or make arrangements with employers to pay bonuses, or other increased compensation or benefits, to employees who obtain certification. To receive grant funds, long-term care facilities would submit applications directly to the Secretary.

The Secretary would also be required to award grants to long-term care facilities for training and technical assistance to eligible employees regarding management practices using methods that are demonstrated to promote retention such as those specified. Long-term care facilities would submit applications to the Secretary to qualify for grant funds. The Secretary would be required to develop accountability measures to ensure that funded activities under this subsection benefit eligible employees and increase the stability of the long-term care workforce.

The Secretary would be authorized to make grants to long-term care facilities (the "Informatics Systems Grant Program") for specified activities that would assist such entities in offsetting the costs related to purchasing, leasing, developing, and implementing standardized clinical health care informatics systems designed to improve patient safety and reduce adverse events and health care complications resulting from medication errors. Long-term care facilities would submit applications to the Secretary to qualify for grant funds. The Secretary would be required to develop accountability measures to ensure that funded activities under this subsection help improve patient safety and reduce adverse events and health care complications resulting from medication errors.

Within one year of enactment of the Committee Bill, the Secretary would be required to ensure that the department includes, as part of the information provided for comparison of nursing facilities on the Federal government's Nursing Home Compare website for Medicare beneficiaries, specified information related to the number of adjudicated instances of criminal violations by a nursing facility or crimes committed by an employee of a nursing facility. Within one year of enactment of the Committee Bill, the Secretary would be required to ensure that the Department, as part of the information provided for comparison of nursing facilities on the Federal government's Nursing Home Compare website, develops and includes a consumer rights information page, as specified.

The Secretary would be required to develop and adopt uniform and open electronic standards for the submission of clinical data by long-term care facilities to the Secretary. Such standards shall include messaging and nomenclature standards. The standards developed and adopted must be compatible with standards established under part C of Title XI, standards established under subsections (b)(2)(B)(i) and (e)(4) of section 1860D-4 of the Social Security Act (SSA), and with general health information technology standards. Within ten years after the date of the Committee Bill's enactment, the Secretary would be required to have procedures in place to accept the optional electronic submission of clinical data by long-term care facilities.

The Secretary would be required to promulgate regulations to carry out: (1) the inclusion of certain crimes on the Nursing Home Compare website; (2) consumer rights information page on Nursing Home Compare website; and (3) standards involving clinical data by long-term care facilities. Such regulations would require a state, as a condition of the receipt of funds under Part B, to conduct such data collection and reporting as the Secretary determines necessary. The provision would authorize to be appropriated $20 million for FY2010, $17.5 million for FY2011, and $15 million for each of FYs 2012 and 2013 to carry out these activities.

Adult Protective Service Functions and Grant Program

Present Law

No provision exists in Present Law for state formula grants that are solely and specifically targeted at providing adult protective services and carrying out projects to employ workers having caseloads of elders alone. Provisions related to some functions of adult protective services are found in Title XX of SSA, the Social Services Block Grant program (SSBG), administered by the Administration on Children and Families (ACF), and in the Older Americans Act (OAA), administered by the Administration on Aging (AoA), both in HHS, as follows.

Title XX of SSA permanently authorizes SSBG as a "capped" entitlement to states to carry out a wide range of social services on behalf of various groups. The statute sets out a number of goals for the use of these funds, including the goal of "preventing or remedying neglect, abuse, or exploitation of children and adults unable to protect their own interests ...." Funds are generally administered by state social services or human services agencies (for this purpose, sometimes referred to as adult protective services offices), and/or state agencies on aging. No match is

required for Title XX funds, and Federal law does not specify a sub-state allocation formula. In other words, states have complete discretion for the distribution of funds within their borders.

Title II of OAA authorizes the HHS Assistant Secretary for Aging to designate within AoA a person with responsibility for elder abuse prevention and services to develop objectives, priorities, policy, and a long-term plan for facilitating the development, implementation, and improvement of a coordinated, multidisciplinary elder justice system; providing Federal leadership to support state efforts in carrying out elder justice programs; establishing Federal guidelines and disseminating best practices for data collection and reporting by states; working with states, the DoJ, and other Federal entities to disseminate data relating to elder abuse, neglect, and exploitation; conducting research related to elder abuse, neglect, and exploitation; and promoting collaborative efforts and reducing duplicative efforts in the development and carrying out of elder justice programs at the Federal, state and local levels, among other things. It is also the Assistant Secretary's duty, acting through the person with responsibility for elder abuse prevention and services, to assist states and other eligible entities under Title VII to develop strategic plans to better coordinate elder justice activities, research, and training (see below).

Title II of the OAA also requires the Assistant Secretary to establish a National Center on Elder Abuse, administered by the AoA. The Center is required to, among other things, compile, publish and disseminate research and training materials on prevention of elder abuse, neglect, and exploitation; maintain a clearinghouse on programs showing promise in preventing elder abuse, neglect, and exploitation; conduct research and demonstration projects that identify causes and prevention, and treatment; and provide technical assistance to state agencies and other organizations in planning and improving prevention programs.

Title III of the OAA authorizes, but does not require, state agencies on aging to conduct various activities related to prevention of elder abuse, neglect and exploitation. No Federal funds are separately appropriated for this purpose under Title III, and states decide how much of their Title III allotments are to be used for prevention activities. In many states, state agencies on aging administer funds for adult protective services funded under Title XX of the SSA (described above).

Title VII of the OAA authorizes a program of grants to states to carry out activities related to prevention of elder abuse, neglect, and exploitation. Funds are administered by state agencies on aging. Title VII, Subtitle B, Native American Organization and Elder Justice Provisions of the OAA, also authorizes a state grant program to promote comprehensive elder justice systems. The Assistant Secretary is authorized to award competitive grants to states for elder justice systems which are to provide for convenient public access to the range of available elder justice information, programs and services; coordinate the efforts of public health, social service and law enforcement authorities to identify and diminish duplication and gaps in the system; and provide a uniform method for standardization, collection, management, analysis and reporting data on elder justice issues.

No provision in Present Law specifically authorizes a dedicated amount of funds for state adult protective service demonstration programs. However, the OAA authorizes a related

demonstration program, but no specific authorization is specified by law. Section 413 of the OAA, Older Individuals' Protection from Violence Projects, requires the Assistant Secretary to award funds to states, area agencies on aging, nonprofit organizations, or tribal organizations to carry out a wide range of projects related to protection of older persons from violence. Funds are to be used to: support local communities to coordinate activities regarding intervention in and prevention of abuse, neglect, and exploitation; develop outreach to assist victims; expand access to family violence and sexual assault programs as well as mental health services, safety planning, and other services; and promote research on legal organization and training impediments to providing services through shelters and other programs.

Committee Bill

The Committee Bill would require the Secretary to ensure that HHS: (1) provides authorized funding to state and local adult protective services offices that investigate reports of elder abuse, neglect, and exploitation of elders; (2) collects and disseminates related data in coordination with the Department of Justice; (3) develops and disseminates information on best practices regarding, and provides training on, carrying out adult protective services; (4) conducts research related to the provision of adult protective services; and (5) provides technical assistance to states and other entities that provide or fund the provision of adult protective services. To carry out these functions, the provision would authorize to be appropriated $3 million for FY2010, and $4 million for each of FYs 2011-2013.

The Committee Bill would also provide for grants to improve Adult Protective Services. Specifically, the Secretary would be required to award annual grants to enhance adult protective service programs provided by states and local governments. Distribution of funds to states would be based on a formula that takes into account the number of elders (people age 60 or older) residing in a state relative to the total U.S. population of elders. States would receive no less than 0.75 percent of the grant program's annual appropriation. The District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam, and American Samoa would receive no less than 0.1 percent of the annual appropriation. In order to comply with these minimum amount requirements, the Secretary would be required to make pro rata reductions in amounts to be allotted.

Funds would be authorized to be used only by states and local governments to provide adult protective services. States receiving funds would be required to provide these funds to the agency or unit of state government having legal responsibility for providing adult protective services in the state. Each state would be required to use these funds to supplement and not supplant other Federal, state, and local public funds expended to provide adult protective services. Each state would be required to submit a report to the Secretary on the number of elders served by the grants, as specified. The provision would authorize to be appropriated $100 million for each of FYs 2010-2013.

The provision would require the Secretary to establish grants to states for adult protective service demonstration programs. Funds may be used by state and local units of government to conduct demonstration programs that test: training modules developed for the purpose of detecting or preventing elder abuse; methods to detect or prevent financial exploitation and elder abuse; whether training on elder abuse forensics enhances the detection of abuse by employees of state

or local government; and other related matters. States would be required to submit applications to the Secretary. Each state receiving funds would be required to submit a report on the demonstration to the Secretary, as specified. The provision would authorize to be appropriated $25 million for each of FYs 2010-2013 to carry out these activities.

Long-Term Care Ombudsman Program Grants and Training

Present Law

Title VII of the OAA authorizes allotments for vulnerable elder rights protection activities, including the State Long-Term Care Ombudsman programs administered by AoA. The purpose of the programs are to investigate and resolve complaints made by, or on behalf of, older persons who are residents of long-term care facilities. There are 53 state Long-Term Care Ombudsman programs operating in all 50 States, the District of Columbia, Guam, and Puerto Rico, and 569 local programs as of 2007.

Title II of the OAA requires the Assistant Secretary for Aging to establish the National Long-Term Care Ombudsman Resource Center under the Director of the Long-Term Care Ombudsman program. The Center is required to, through grants and contracts, conduct research, provide training, technical assistance and information to support the activities of state and local long-term care ombudsmen. The Center also assists state long-term care ombudsmen in the implementation of the State Long-term Care Ombudsman program.

Committee Bill

The Committee Bill would require the Secretary to award grants to eligible entities with relevant expertise and experience in abuse and neglect in long-term care facilities or long-term care ombudsman programs to: (1) improve the capacity of state long-term care ombudsman programs to respond to and resolve abuse and neglect complaints; (2) conduct pilot programs with state or local long-term care ombudsman offices; and (3) provide support for such state Long-Term Care Ombudsman Programs and such pilot programs. The Committee Bill would authorize to be appropriated $5 million for FY 2010, $7.5 million for FY2011, and $10 million for FYs 2012 and 2013. The Committee Bill would also require the Secretary to establish programs to provide and improve ombudsman training with respect to elder abuse, neglect, and exploitation for national organizations and State Long-term Care Ombudsman programs. The Committee Bill would authorize to be appropriated $10 million for each of FYs 2010-2013.

Provision of Information Regarding, and Evaluation of, Elder Justice Programs

Present Law

No provision.

Committee Bill

To be eligible to receive a grant under Part B – Programs to Promote Elder Justice, the Committee Bill would require an applicant to (1) agree to provide the required information to eligible entities conducting an evaluation of the activities funded through the grant; and (2) in the case of an applicant for a grant under the "Informatics Systems Grant Program," as established in the Committee Bill, to provide the Secretary with such information as may be required by the Secretary. The provision would require the Secretary to reserve a portion of the funds appropriated in each program under Part B (no less than two percent) to be used to provide assistance to eligible entities to conduct validated evaluations of the effectiveness of the activities funded under that program. To be eligible to receive these funds, an eligible entity must submit an application to the Secretary following the timing requirement prescribed by the Secretary including a proposal for the evaluation. Entities would be required to submit to the Secretary and appropriate congressional committees a report containing the results of the evaluation together with any recommendations deemed appropriate. The report would be due by the date specified by the Secretary. These evaluation activities would not apply to the Informatics Systems Grant Program, instead the Secretary would be required to conduct an evaluation of the activities funded under these grants.

Report

Present Law

Section 402 of the Social Security Act (SSA) regarding eligible states and state plan requirements for Temporary Assistance to Needy Families (TANF) does not require State agency assistance with the employment of welfare recipients or recipients of TANF in long-term care facilities or other occupations related to elder care.

Title XI, Part A of the SSA provides for general provisions related to various administrative functions established under the Act. Section 1128A of the SSA specifies conditions for imposing civil monetary penalties, the process for determining the amount or scope of a penalty, assessment, or exclusion, and the process for appeal.

No present law exists concerning a National Training Institute for surveyors or grants to state survey agencies.

No present law exists concerning Federal requirements for mandatory reporting of elder abuse. Most states mandate certain individuals who assume the care for older adults, including health care providers, to report known or suspected cases of elder abuse. However, state laws vary as to who is a mandated reporter and who is encouraged to report incidents of elder/adult abuse. State law also varies as to whether there are statutory consequences for failure of mandated reporters to report abuse and with regard to specifying a time frame within which reporters are required to report suspicion of abuse.

If a long-term care facility that receives Federal funds through participation in Medicare and/or Medicaid closes, current Federal laws and regulations provide some guidance on the parties that need to be notified and the process for relocating residents. If a facility wants to terminate its status as a Medicare provider (for example, due to facility closure), the facility must notify both

the CMS and the public no later than 15 days in advance of the proposed termination date. If a facility wants to terminate its status as a Medicaid provider, Federal regulations do not specify a timeframe for notifying Federal or state agencies; however, the facility is required to notify Medicaid residents at least 30 days before transferring or discharging them. Facility closure is one circumstance in which a resident would need to be transferred.

The state Medicaid agency has the primary responsibility for relocating Medicaid patients and for ensuring their safe and orderly transfer from a facility that no longer participates in Medicaid to a participating facility that meets acceptable standards. CMS has provided guidance to States concerning relocating patients. Each State is expected to have a plan that describes the relocation of patients. Additionally, the notice to residents is to include information as to how to contact the state Long-Term Care Ombudsman established by the OAA.

Medicare and Medicaid law require states to establish and maintain a nurse aide registry of all individuals who have satisfactorily completed a state approved nurse aide training and competency evaluation program, or a nurse aide competency evaluation program. No present law exists concerning a nurse aide registry study.

Committee Bill

The Committee Bill would set forth reporting requirements and add an option for a state's TANF plan to assist individuals seeking employment in long-term care facilities. Not later than October 1, 2013, the Secretary would be required to submit a report to the Elder Justice Coordinating Council and appropriate congressional committees, compiling, summarizing, and analyzing state reports submitted under the Adult Protective Services grant programs and recommendations for legislative or administrative action. The provision would also amend Section 402(a)(1)(B) of the SSA to add an option for a state's TANF plan to indicate whether the state intends to assist individuals who train for, seek, and maintain employment providing direct care in a long-term care facility or in other occupations related to elder care. States that add this option would be required to provide an overview of such assistance. The amendment would take effect on January 1, 2010.

The provision would also require the Secretary to enter into a contract to establish and operate the National Training Institute for Federal and state surveyors to carry out specified activities that provide and improve the training of surveyors investigating allegations of abuse, neglect, and misappropriation of property in programs and long-term care facilities that receive payments under Medicare and/or Medicaid. The Committee Bill would authorize to be appropriated $12 million for each of FYs 2010-2013 to carry out these activities.

The Secretary would be required to award grants to state survey agencies that perform surveys of Medicaid and/or Medicare participating facilities to design and implement complaint investigation systems, as specified. The Committee Bill would authorize $5 million for each of FYs 2010-2013 to carry out these activities.

The Committee Bill would amend Part A of Title XI of the SSA by adding the following new Section 1150A related to "Reporting to Law Enforcement of Crimes Occurring in Federally

Funded Long-Term Care Facilities." It would require the reporting of crimes occurring in Federally funded long-term care facilities that receive at least $10,000 during the preceding year. The owner or operator of these facilities would be required to annually notify each individual who is an owner, operator, employee, manager, agent, or contractor of a long-term care facility that they are required to report any reasonable suspicion of a crime against any person who is a resident of or receiving care from the facility. These individuals are referred to in this section as "covered individuals." Suspected crimes must be reported to the Secretary and one or more law enforcement entities for the political subdivision in which the facility is located.

If the events that cause the suspicion of a crime result in serious bodily injury, the covered individual must report the suspicion immediately, but not later than two hours after forming the suspicion. If the events that cause the suspicion do not result in serious bodily injury, the individual must report the suspicion not later than 24 hours after forming the suspicion. If a covered individual does not report suspicion of a crime within the timeframe described above, the individual will be subject to a civil money penalty of up to $200,000, or the Secretary would be required to classify the individual as an 'excluded individual' (*i.e.*, any employer of the individual is unable to receive Federal funds) for a period of not more than three years.

If a covered individual does not report his/her suspicion of a crime within the timeframe described above and this violation exacerbates the harm to the victim, or results in harm to another person, the individual will be subject to a civil money penalty of up to $300,000, and the Secretary shall classify the individual as an 'excluded individual' (*i.e.*, any employer of the individual is unable to receive Federal funds) for a period of not more than three years. If an individual is classified as an "excluded individual," any entity that employs that individual will not be eligible to receive Federal funds. The Secretary would be authorized to take into account the financial burden on providers with underserved population, as defined, in determining any penalty to be imposed under this section.

A long-term care facility may not retaliate against an employee for making a report, causing a report to be made, or for taking steps to make a report. Retaliation includes discharge, demotion, suspension, threats, harassment, denial of a promotion or other employment-related benefit, or any other manner of discrimination against an employee in the terms and conditions of employment because of lawful acts done by the employee. Long-term care facilities may also not retaliate against a nurse by filing a complaint or report with the appropriate State professional disciplinary agency because of lawful acts done by the nurse. If a long-term care facility does retaliate, it would be subject to a civil money penalty of up to $200,000, or the Secretary may exclude it from participation in any Federal health care program for a period of two years. Each long-term care facility must post conspicuously, in an appropriate location, a sign specifying the rights of employees under this section, as described.

The Committee Bill would also amend Part A of Title XI of the SSA to add a new section "Ensuring Safety of Residents when Federally Funded Long-Term Care Facilities Close." The new Section 1150B would require the owner or operator of a long-term care facility (that receives at least $10,000 in Federal funds during the previous year) to submit to the Secretary and the appropriate State regulatory agency written notification of an impending closure within 60 days prior to the closure. In the notice, the owner or operator must include a plan for transfer

and adequate relocation of residents, as specified. Within ten days after the facility closes, the owner or operator of the facility must submit to the Secretary, and the appropriate state agency, information on where the residents were transferred to and when. In the case of a long-term care facility for which the Secretary has issued a termination notice for the facility to close by no later than 15 days after issuance of such notice, the Secretary would be required to establish requirements for the notification, transfer, and adequate relocation of residents within an appropriate timeframe.

Anyone who owns a skilled nursing facility that fails to comply with the notification of closure and reporting requirements would be subject to a civil monetary penalty of up to $1 million, exclusion from participation in the programs under the SSA, and any other applicable civil monetary penalties and assessments. A civil monetary penalty or assessment will be imposed in the same manner as a civil monetary penalty, assessment or exclusion under Section 1128A of the SSA (other than subsection (a) and (b) and the second sentence of subsection (f)).

The Secretary, in consultation with appropriate government agencies and private sector organizations, would be required to conduct a study on establishing a national nurse aide registry that includes an evaluation, as specified. In conducting the study and preparing the report the Secretary would be required to take into consideration the findings and conclusion of relevant reports and resources, as specified. Not later than 18 months after the date of enactment of the Committee Bill, the Secretary would be required to submit a report to the Elder Justice Coordinating Council and appropriate congressional committees containing the findings and recommendations of the study. The Committee Bill would require funding not to exceed $500,000 for this study. It would also require the appropriate congressional committees to take appropriate action based on the recommendations contained in the report. The Committee Bill would authorize to be appropriated such sums as may be necessary to carry these activities.

Subtitle L – Provisions of General Application

Sec. 1921. Protecting Americans and Ensuring Taxpayer Funds in Government Health Care Plans Do Not Support or Fund Physician-Assisted Suicide; Prohibition Against Discrimination on Assisted Suicide.

Present Law

Section 3 of the Assisted Suicide Funding Restriction Act of 1997 (P.L. 105-12) prohibits funds appropriated by Congress to be used to (1) provide any health care item or service furnished for the purpose of causing, or assisting in causing, the death of any individual, such as by assisted suicide, euthanasia, or mercy killing; (2) pay for such an item or service, including payment of expenses relating to such an item or service; or (3) pay for health benefit coverage that includes any coverage of such an item or service or of any related expenses. Nothing in the Act is construed to apply to or to affect any limitation related to (1) the withholding or withdrawing of medical treatment or medical care; (2) the withholding or withdrawing of nutrition or hydration; (3) abortion; or (4) the use of an item, good, benefit, or service furnished for the purpose of alleviating pain or discomfort, even if such use may increase the risk of death, so long as it is not also furnished for the purpose of causing, or assisting in causing, death. These funding

restrictions apply to the following programs: Medicare, Medicaid, Title XX Social Services Block Grant, Maternal and Child Health Block Grant, Public Health Service Act, Indian Health Care Improvement Act, Federal Employees Health Benefits Program, Military Health Care System (including Tricare and CHAMPUS), Veterans Medical Care, health services for Peace Corps volunteers, and medical services for Federal prisoners.

With respect to health care items or services, Section 3 of the Act also prohibits an item or service furnished for the purpose of causing, or assisting in causing, the death of any individual, such as by assisted suicide, euthanasia, or mercy killing from being furnished by or in a health care facility owned or operated by the Federal government, or by any physician or other individual employed by the Federal government. This applies to facilities and personnel of the Military Health Care System, Veterans Medical Care, and the Public Health Service.

Committee Bill

The provision would prohibit the Federal government, and any State or local government or health care provider that receives Federal financial assistance under this Committee Bill (or under an amendment made by this Committee Bill) or any health plan created under this Committee Bill (or under an amendment made by this Committee Bill) from (1) paying for or reimbursing any health care entity to provide for any health care item or service furnished for the purpose of causing, or for the purpose of assisting in causing, the death of any individual, such as by assisted suicide, euthanasia, or mercy killing and (2) subjecting an individual or institutional health care entity to discrimination on the basis that the entity does not provide any health care item or service furnished for the purpose of causing, or assisting in causing, the death of any individuals, such as by assisted suicide, euthanasia, or mercy killing. The HHS Office of Civil Rights would be designated to receive complaints of discrimination on this basis.

Nothing in the above would be construed to apply or to affect any limitation relating to (1) the withholding or withdrawing of medical treatment or medical care; (2) the withholding or withdrawing of nutrition or hydration; (3) abortion; or (4) the use of an item, good, benefit, or service furnished for the purpose of alleviating pain or discomfort, even if such use may increase the risk of death, so long as it is not also furnished for the purpose of causing, or assisting in causing, death.

Sec. 1922. Protection of Access to Quality Health Care through the Department Of Veterans Affairs and the Department of Defense.

Present Law

No comparable provision. In general, eligibility for health care services provided by the Department of Veterans Affairs (VA) is based primarily on veteran's status, disability resulting from military service, and income. Veterans generally must enroll in the VA health care system to receive inpatient and outpatient medical care. VA provides this care through its network of medical centers, nursing homes, and community-based outpatient clinics (CBOCs). Under certain circumstances, VA also pays for care provided to veterans by independent providers and practitioners on a fee basis. Eligible dependents of veterans receive inpatient and outpatient care

in the private sector under the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA).

The Department of Defense (DOD) health care system and its health plan known as "TRICARE," offers benefits to active duty personnel and other beneficiaries, including dependents of active duty personnel, military retirees, and dependents of retirees. TRICARE has four main benefit plans including a health maintenance organization option (TRICARE Prime), a preferred provider option (TRICARE Extra), a fee-for-service option (TRICARE Standard), and a Medicare wrap-around option (TRICARE for Life) for Medicare-eligible retirees. Options available to beneficiaries vary by the beneficiary's duty status and location. The DOD health system provides health care services through either its own medical treatment facilities, as space is available, or, through private health care providers.

Committee Bill

The Committee Bill stipulates that nothing in the bill shall prohibit or penalize veterans, eligible military health care beneficiaries, or their eligible family members from receiving timely access to quality health care from a VA or DOD medical treatment facility or a contracted health care provider (TRICARE or TRICARE for Life).

Section 1923. Continued Application of Antitrust Law.

Present Law

Current policy is that absent the provision of a specific antitrust exemption, one is generally not implied. Thus, the antitrust laws are generally assumed to apply to any market participant's behavior.

Committee Bill

The section makes clear that no provision in the Act "shall be construed to modify, impair, or supersede the operation of any of the antitrust laws." "Antitrust laws" are defined as those laws set out in subsection (a) of the first section of the Clayton Act (15 U.S.C. § 12(a), *i.e.*, the Sherman Act (15 U.S.C. §§ 1-7, the Wilson Tariff Act (15 U.S.C. §§ 8-11), and the Clayton Act itself (15 U.S.C. §§ 12-27)); and also includes section 5 of the Federal Trade Commission Act (15 U.S.C. § 45) to the extent that it applies to "unfair methods of competition."

TITLE II—PROMOTING DISEASE PREVENTION AND WELLNESS

Subtitle A – Medicare

Sec. 2001. Coverage of Annual Wellness Visit Providing a Personalized Prevention Plan.

Present Law

In addition to a number of specific preventive services enumerated in law, Medicare covers a one-time initial preventive physical examination (IPPE), with no deductible. The IPPE is reimbursable only if provided within one year of Medicare Part B enrollment. Medicare does not otherwise cover periodic routine health examinations.

The United States Preventive Services Task Force (USPSTF), administered by the Health and Human Services Agency for Healthcare Research and Quality (AHRQ), is an independent panel of private-sector experts in primary care and prevention that assesses scientific evidence of the effectiveness of clinical preventive services, including screening, counseling, and preventive medications. It provides evidence-based recommendations for the use of preventive services, which may vary depending on age, gender, and risk factors for disease, among other considerations. Services are given a rating of A, B, C, D or I. Services rated A or B are recommended. For services rated C, USPSTF makes no recommendation for or against their routine use. For services rated D, USPSTF recommends against routinely providing the service to asymptomatic patients, based on evidence that the service is not beneficial and may be harmful. Finally, services rated I are deemed to have insufficient evidence to recommend for or against their routine use.

Committee Bill

Beginning in 2011, Medicare would cover an annual wellness visit and personalized prevention plan services. Such services would include a comprehensive health risk assessment, to be completed prior to or as part of a visit with a health professional. Health professionals authorized to conduct such a visit would be physicians, physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, certified nurse-midwives, clinical social workers, clinical psychologists, other medical professionals (including health educators, registered dietitians, or nutrition professionals), or a team of medical professionals, as determined appropriate by the Secretary, under the supervision of a physician.

The personalized prevention plan would take into account the findings of the health risk assessment and include the following required elements: review and update of medical and family history; a five- to ten-year screening schedule and referral for services recommended by USPSTF; a list of identified risk factors and conditions and a strategy to address them; a list of all medications currently prescribed and all providers regularly involved in the patient's care; health advice and referral to education and preventive counseling or community-based interventions to address modifiable risk factors such as weight, physical activity, smoking, and nutrition; measurement of height, weight, body mass index (or waist circumference, if appropriate), and blood pressure; and other elements determined appropriate by the Secretary. Optional elements could include review or referral for testing and treatment of possible chronic conditions, a cognitive impairment assessment, and administration of or referral for appropriate Medicare-covered immunizations and screening tests, among others.

Within one year of enactment, the Secretary would be required to publish guidelines for health risk assessments and a health risk assessment model. Guidelines would identify chronic diseases, modifiable risk factors, and urgent health needs. The assessment could be provided through an

interactive telephonic or web-based program, during an encounter with a health professional, or through other means established by the Secretary. The Secretary would be required to set standards for the electronic tools that could be used to deliver the assessment, take steps to make beneficiaries and providers aware of the need to conduct such assessment prior to or in conjunction with receipt of the personalized prevention plan service; and encourage the use of appropriate health information technology in carrying out these activities.

All enrolled beneficiaries would be eligible for the wellness visit once every year. No co-payment or deductible would apply. The Secretary would be required to issue guidance regarding the frequency at which specific elements of the plan must be furnished. During the first year of Part B enrollment, beneficiaries could receive either the IPPE or the personalized prevention plan service, but not both. All required and optional plan elements must be covered for the first personalized prevention plan visit.

The amendments made by this section would apply to services furnished on or after January 1, 2011.

Sec. 2002. Removal of Barriers to Preventive Services.

Present Law

In general, Medicare authorizes the Secretary to cover services for the diagnosis and treatment of illness, while coverage of preventive services has generally required legislation. Section 1861 of the Social Security Act requires coverage of a number of specified preventive services under Medicare Part B, but there is no definition of preventive services in the law that refers to them collectively. The Social Security Act outlines specific coverage criteria for many preventive services, including factors such as the types of screenings covered and the age or risk profiles to which a service applies. Also, in section 101 of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA, P.L. 110-275), Congress provided administrative authority for the Secretary to add coverage of additional preventive services, if, among other things, such a service is recommended with a grade of A or B by the USPSTF. Under Present Law, beneficiaries would not be required to make a co-payment for any additional preventive service covered under this new authority, but the deductible would apply.

Section 1833(a) of the Social Security Act establishes coinsurance for the beneficiary, generally requiring Medicare to cover 80 percent of the costs of covered services under Part B, with specified exceptions. Section 1833(b) establishes an annual deductible for which the beneficiary is responsible. These sections have been amended over the years to waive coinsurance and/or the deductible for many, but not all, covered preventive services.

Committee Bill

The Committee Bill would amend section 1861 of the Social Security Act to define preventive services covered by Medicare to mean a specified list of currently covered services, excluding an electrocardiogram, and including colorectal cancer screening services regardless of the code applied. The list would also include the IPPE, and the personalized prevention plan services that

would be covered pursuant to section 2001 of the Committee Bill. This provision would also clarify the definition of additional preventive services that could be added pursuant to the Secretary's authority. Coverage would continue to be subject to all criteria that apply to each listed preventive service under Present Law.

The Committee Bill would amend section 1833(a) of the Social Security Act to waive beneficiary coinsurance requirements for most preventive services, requiring Medicare to cover 100 percent of the costs. Services for which no coinsurance would be required are the IPPE, personalized prevention plan services, any additional preventive service covered under the Secretary's administrative authority, and any currently covered preventive service (including medical nutrition therapy and excluding electrocardiograms) if it is recommended with a grade of A or B by the USPSTF. The subsection would make conforming amendments to clarify that the above waivers of coinsurance would apply when such services were furnished by hospital outpatient departments.

The Committee Bill would generally waive the application of the deductible for the same types of preventive services for which coinsurance would be waived. The deductible waiver would apply to colorectal cancer screening services even if, as noted above, diagnostic or treatment services were furnished in connection with the screening. This provision would not, however, waive the application of the deductible to any additional preventive service covered under the Secretary's administrative authority.

The amendments made by this section would apply to services furnished on or after January 1, 2011.

Sec. 2003. Evidence-based Coverage of Preventive Services.

Present Law

Although the Secretary has the authority to add additional preventive services if, among other things, the USPSTF recommends such services, the Secretary is not authorized to modify any statutory criteria for the coverage of currently authorized preventive services. Such criteria do not always comport with current USPSTF recommendations regarding the use of these services.

Committee Bill

The Committee Bill would authorize the Secretary to modify the coverage of any currently covered preventive service (including services included in the IPPE, but not the IPPE itself), to the extent that the modification is consistent with USPSTF recommendations. The Committee Bill would also prohibit payment for any currently covered preventive service rated D by the USPSTF. The enhanced authority and the prohibition would not apply to services furnished for the purposes of diagnosis or treatment. The Committee Bill would appropriate $15 million from the Treasury to the Centers for Medicare & Medicaid Services (CMS) for FY2010, to remain available until expended, for a provider and beneficiary outreach program regarding covered preventive services. The Secretary would be authorized to use up to $1 million of these funds to study and report to Congress certain aspects of preventive services coverage under Medicare.

The Committee Bill would also appropriate $2 million for a Government Accountability Office (GAO) study of the utilization of and payment for Medicare covered preventive services, the use of health information technology in coordinating such services, and whether there are barriers to the utilization of such services.

Sec. 2004. GAO Study and Report on Medicare Beneficiary Access to Vaccines.

Present Law

Medicare coverage and administration of vaccines is established in statute. Section 1861(s) of the Social Security Act provides Medicare Part B coverage and administration of three vaccines: influenza, pneumococcal, and for individuals at increased risk, hepatitis B. The Medicare Modernization Act of 2003 (MMA, P.L. 108-173) provided coverage and administration of any other vaccine that is approved by the Food and Drug Administration under Part D (when prescribed by a physician).

Committee Bill

The Committee Bill would require a GAO study and report to Congress on coverage of vaccines under Medicare Part D and the impact on access to those vaccines. The Committee Bill would appropriate from the Treasury $1 million for FY2010 for this study.

Sec. 2005. Incentives for Healthy Lifestyles.

Present Law

No provision.

Committee Bill

The Committee Bill would require the Secretary to conduct a Medicare demonstration project to test programs that provide incentives to reduce the risk of avoidable health problems associated with lifestyle choices, including smoking, exercise, and diet. Prior to establishing the initiative, the Secretary would review evidence concerning healthy lifestyle programs and provide incentives to individuals for participating in such programs. The Secretary would be required to select not more than 10 project sites, according to specific criteria; to conduct the project for an initial period of three years, beginning not later than July 1, 2010; and to continue for an additional two years any program or program component that is determined to be effective. The project would include evidence-based approaches for tobacco cessation; management of weight, cholesterol, and blood pressure; diabetes prevention or management; falls prevention; and other effective approaches as determined by the Secretary.

Each participating site would be required to monitor participation, validate changes in health risks and outcomes, and establish standards and health status targets among participating beneficiaries. The Secretary would be required to submit an interim report to Congress by January 1, 2014, that includes a preliminary evaluation of the project (including an independent

evaluation of any impact on utilization of health services and costs to the Medicare program) and any programs or parts of the project that are determined to be effective that will be authorized to continue for another two years. The Secretary would be required to submit a final report on the program to Congress by January 1, 2016, including any recommendations for legislative and administrative action.

Any incentives provided to a participating Medicare beneficiary could not be taken into account in determining the beneficiary's eligibility for, or amount of benefits under, any Federal program.

To carry out this program, the Committee Bill would appropriate from the Treasury to CMS $15 million for each of six fiscal years 2010 through 2015. Funds would remain available until expended. Of these amounts, $5 million would be available for the required evaluations.

Subtitle B – Medicaid

Sec. 2101. Improving Access to Preventive Services for Eligible Adults.

Present Law

The United States Preventive Services Task Force (USPSTF), administered by the Health and Human Services Agency for Healthcare Research and Quality (AHRQ), is an independent panel of private-sector experts in primary care and prevention that assesses scientific evidence of the effectiveness of clinical preventive services, including screening, counseling, and preventive medications. It provides evidence-based recommendations for the use of preventive services, which may vary depending on age, gender, and risk factors for disease, among other considerations. Services are given a rating of A, B, C, D or I. Services rated A or B are recommended. For services rated C, USPSTF makes no recommendation for or against their routine use. For services rated D, USPSTF recommends against routinely providing the service to asymptomatic patients, based on evidence that the service is not beneficial and may be harmful. Finally, services rated I are deemed to have insufficient evidence to recommend for or against their routine use.

Under Medicaid, states are required to cover a package of well-child and preventive service benefits for the majority of eligible children under the age of 21, called the early and periodic screening, diagnostic, and treatment (EPSDT) services. For eligible beneficiaries including adults, states are required to cover family planning services and supplies, and certain pregnancy-associated services, including prenatal, delivery and postpartum care. Otherwise, state coverage of screening and preventive services for eligible adults is optional.

With some exceptions, premiums and enrollment fees are generally prohibited under traditional Medicaid. When premiums and enrollment fees are applicable, nominal amounts for such charges range from roughly $1 to $19 per month, depending on family income. States are also allowed to establish nominal service-related cost-sharing requirements, which generally range from $0.50 to $3, depending on the cost of the service provided.

The Deficit Reduction Act of 2005 (DRA, P.L. 109-171) gave states an option to apply higher premium and cost-sharing obligations to certain Medicaid beneficiaries. As with traditional Medicaid, specific groups (*e.g.*, some children, pregnant women, and individuals with special needs) are exempt from the DRA premium provisions. Likewise, specific services and groups (*e.g.*, some children, pregnant women for pregnancy-related services, individuals receiving hospice care, and residents of certain institutions) are exempt from service-related cost-sharing under both traditional Medicaid and the DRA.

Committee Bill

The current state option to provide other diagnostic, screening, preventive, and rehabilitation services would be expanded to include: (1) any clinical preventive service assigned a grade of A or B by the USPSTF and (2) with respect to adults, immunizations recommended by the Advisory Committee on Immunization Practices (ACIP) and their administration. States that elect to cover these additional services and vaccines, and also prohibit cost-sharing for such services and vaccines, would receive an increased Federal medical assistance percentage (FMAP) of one percentage point for these services, and for counseling and pharmacotherapy for cessation of tobacco use by pregnant women (described below). The effective date for this provision would be January 1, 2013.

Sec. 2102. Coverage of Comprehensive Tobacco Cessation Services for Pregnant Women.

Present Law

Under the optional Medicaid prescription drug benefit, states are permitted to exclude coverage of 11 drug classes, including barbiturates, benzodiazepine, and smoking cessation products. Medicaid programs may cover tobacco cessation counseling services for pregnant women.

With some exceptions, premiums and enrollment fees are generally prohibited under traditional Medicaid. When premiums and enrollment fees are applicable, nominal amounts for such charges range from roughly $1 to $19 per month, depending on family income. States are also allowed to establish nominal service-related cost-sharing requirements, which generally range from $0.50 to $3, depending on the cost of the service provided.

The Deficit Reduction Act of 2005 (DRA, P.L. 109-171) gave states an option to apply higher premium and cost-sharing obligations to certain Medicaid beneficiaries. As with traditional Medicaid, specific groups (*e.g.*, some children, pregnant women, and individuals with special needs) are exempt from the DRA premium provisions. Likewise, specific services and groups (*e.g.*, some children, pregnant women for pregnancy-related services, individuals receiving hospice care, and residents of certain institutions) are exempt from service-related cost-sharing under both traditional Medicaid and the DRA.

Committee Bill

States would be required to provide Medicaid coverage for counseling and pharmacotherapy to pregnant women for cessation of tobacco use. Such services would include diagnostic, therapy

and counseling services, and pharmacotherapy (including the coverage of prescription and nonprescription tobacco cessation agents approved by the Food and Drug Administration) for cessation of tobacco use by pregnant women. These services would be limited to those recommended for pregnant women in, "Treating Tobacco Use and Dependence" (published by the Public Health Service in May 2008, or any subsequent modification of such Guideline), and other services that the Secretary recognizes to be effective for cessation of tobacco use by pregnant women. These services would exclude coverage for drugs or biologics that are not otherwise covered under Medicaid.

With respect to the prescription drug benefit under Medicaid, states would continue to be allowed to exclude coverage of agents used to promote smoking cessation, except in the case of pregnant women, in accordance with this provision as described above.

Finally, the Committee Bill would prohibit cost-sharing under traditional Medicaid for counseling and pharmacotherapy provided to pregnant women for cessation of tobacco use, as well as for covered outpatient prescription and non-prescription drugs used by pregnant women to promote tobacco cessation. With respect to the DRA cost-sharing option, the provision would also prohibit cost-sharing for counseling and pharmacotherapy provided to pregnant women for cessation of tobacco use.

These provisions would take effect on October 1, 2010.

Sec. 2103 Incentives for Healthy Lifestyles.

Present Law

No provision.

Committee Bill

The Secretary of HHS would award grants to states to provide incentives for Medicaid beneficiaries to participate in programs providing incentives for healthy lifestyles. These programs must be comprehensive and uniquely suited to address the needs of Medicaid eligible beneficiaries and must have demonstrated success in helping individuals lower or control cholesterol and/or blood pressure, lose weight, quit smoking and/or manage or prevent diabetes, and may address co-morbidities, such as depression, associated with these conditions. The purpose of this initiative is to test approaches that may encourage behavior modification and determine scalable solutions.

The Committee Bill authorizes $100 million in funding for these grants during a five-year period. The Secretary shall award grants beginning on January 1, 2011 or when the Secretary develops program criteria, whichever comes first. These criteria will be developed using relevant evidence-based research including the Guide to Community Preventive Services, the Guide to Clinical Preventive Services, and the National Registry of Evidence-Based Programs and Practices. State initiatives shall last at least 3 years and must be carried out during the five-year authorization period.

In order to carry out this initiative the Secretary may waive Medicaid requirements related to statewideness and comparability.

The Secretary would set targets for measuring health status improvements. After the Secretary develops criteria and institutes an outreach and education campaign to make states aware of the grants, states could design a proposal and apply for such funds to provide incentives to Medicaid enrollees who successfully complete healthy lifestyle programs. States are permitted to collaborate with community-based programs, non-profit organizations, providers, and faith-based groups, among others. The state is required to establish a system to monitor beneficiary participation and validate health outcomes, establish standards and health status targets for participants, evaluate the effectiveness of the program and provide the Secretary with these evaluations, report to the Secretary on processes that have been developed and lessons learned, and report on preventive services as part of reporting on quality measures of Medicaid managed care programs. A state awarded a grant shall submit semi-annual reports including information on the specific use of the funds, an assessment of program implementation, an assessment of quality improvements, and an estimate of the cost savings resulting from such program.

The Committee Bill provides for an independent assessment of the initiatives as well. An initial report shall be submitted to Congress by the Secretary no later than January 1, 2014. This initial report shall include an interim evaluation based on information provided by the states and a recommendation regarding whether funding for expanding or extending the initiatives should continue beyond January 1, 2016. A final report would be submitted not later than July 1, 2016 that would include the independent assessment together with recommendations for appropriate legislative and administrative actions.

Any incentives received by a beneficiary shall not be taken into account for the purpose of determining eligibility for, or the amount of benefits under, any program funded with Federal funds.

Sec. 2104. State Option to Provide Health Homes for Enrollees with Chronic Conditions.

Present Law

No provision.

Committee Bill

Beginning January 1, 2011, the Committee Bill would establish a new Medicaid state plan option under which Medicaid enrollees with: (1) at least two chronic conditions or (2) one chronic condition and at risk of having a second chronic condition (including a serious and persistent mental health condition), could designate a provider as a health home. Qualifying health home providers, including providers that work in teams of health care professionals, would provide: comprehensive, timely, and high-quality care management; care coordination and health promotion; transitional care, including appropriate follow-up from inpatient to other settings;

patient and family support; referral to community and social support services, if relevant; and use of health information technology to link services, as feasible and appropriate.

Health home providers would include physicians, clinical practice or clinical group practices, rural clinics, community health centers, community mental health centers, home health agencies, or other entities or providers (including pediatricians and obstetricians) approved by the Secretary. They would be required to meet certain standards established by the Secretary and to demonstrate that they have the systems and infrastructure in place to provide health home services. Teams of health care professionals would include physicians and other professionals, such as a nurse care coordinator, nutritionist, social worker, behavioral health professional, or any professional deemed appropriate by the state. Such teams could be free-standing, virtual, or based at a hospital, community health clinic, clinical practice, clinical group practice, or academic health center, as deemed appropriate by the state and approved by the Secretary.

States would be required to make Medicaid payments to each provider, or to the team of health home professionals, for the health home services it provides to each eligible participant. The state would be required to specify the methodology it would use to pay health home providers in its state plan amendment. Such methodologies would be required to result in sufficient payments to enlist enough providers in a geographic area, and be consistent with efficiency, economy, and quality of care, among other requirements. Methodologies could also be tiered to reflect the severity or number of each individual's chronic conditions, and the specific capabilities of the provider or team. Methodologies would not be limited to a per-member per-month payment.

States would be reimbursed by the Federal government at an enhanced FMAP rate of 90 percent for these payments for first eight fiscal quarters that the state plan amendments would be in effect. In addition, the Secretary would award planning grants to states, the total of which could not exceed $25 million, to develop state plan amendments for health home services. States must also contribute its state's share for each fiscal year for which the grant is awarded.

States would be required to mandate Medicaid-participating hospitals to establish procedures for referring any eligible individual with chronic conditions who seeks or needs treatment in a hospital emergency department to designated providers. As appropriate, states would also be required to consult and coordinate with the Substance Abuse and Mental Health Services Administration in addressing the prevention and treatment of mental illness and substance abuse among eligible individuals with chronic conditions.

The state plan amendment would include methodology for tracking avoidable hospital readmissions and calculating savings that result from improved chronic care coordination and management. It would also include a proposal for the use of health information technology in providing these Medicaid-covered health home services and in improving service delivery and coordination across the care continuum.

Designated providers would be required to report to the state on all applicable measures, in accordance with requirements specified by the Secretary, to determine the quality of such services. When appropriate and feasible, a designated provider would be required to use health information technology to provide the state with such information.

The Secretary would be allowed to establish higher levels of eligibility in regards to the number or severity of chronic or mental health conditions. Chronic conditions would include, a mental health condition, substance abuse, asthma, diabetes, heart disease, and being overweight, as evidenced by a body mass index (BMI) over 25.

No later than January 1, 2013, the Secretary would be required to enter into a contract with an independent entity or organization to conduct an evaluation and assessment of the states that have elected the option to provide coordinated care through a health home for Medicaid beneficiaries with chronic conditions to determine its effect on reducing hospital readmissions, emergency room visits, and admissions to skilled nursing facilities. The Secretary would be required to report to Congress on this evaluation and assessment no later than January 1, 2017.

No later than January 1, 2014, the Secretary would be required to survey states and report to Congress on the nature, extent, and use of this option, particularly as it pertains to hospital admission rates, chronic disease management, and coordination of care for individuals with chronic conditions, among others. States would be required to report to the Secretary, as necessary, on processes that have been developed and lessons learned.

Sec. 2105. Funding for Childhood Obesity Demonstration Project.

Present Law

The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA, P.L. 111-3) included several provisions designed to improve the quality of care under Medicaid and CHIP. Among other quality initiatives this law directed the Secretary to initiate a demonstration project to develop a comprehensive and systematic model for reducing childhood obesity. Twenty-five million dollars was authorized to be appropriated over fiscal years 2009 through 2013.

Committee Bill

The Committee Bill authorizes and appropriates $25 million for the childhood obesity demonstration project and adjusts the demonstration time period to fiscal years 2010 through 2014.

Sec. 2106. Public Awareness of Preventive and Obesity-related Services.

Present Law

No provision.

Committee Bill

This Committee Bill would require the Secretary to provide guidance and relevant information to states and health care providers regarding preventive and obesity-related services that are available to Medicaid enrollees, including obesity screening and counseling for children and adults. Each state would be required to design a public awareness campaign to educate Medicaid

enrollees regarding availability and coverage of such services. The Secretary would be required to report to Congress on these efforts, beginning on January 1, 2011, and every three years thereafter, through January 1, 2017.

TITLE III—IMPROVING THE QUALITY AND EFFICIENCY OF HEALTH CARE

Subtitle A – Transforming the Health Care Delivery System

PART I – Linking Payment To Quality Outcomes Under The Medicare System

Sec. 3001. Hospital Value-Based Purchasing Program.

Present Law

As required by the Medicare Prescription Drug, Improvement and Modernization Act (MMA, P.L.108-173), since FY2005, acute care hospitals that submit required quality data have received higher payments than those hospitals that do not submit such information under Medicare's Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU) program (often referred to as the hospital pay-for-reporting program or P4R program). As subsequently modified by Section 5001(a) of the Deficit Reduction Act of 2005 (DRA, P.L. 109-171), beginning in FY2007, hospitals were required to submit data for an expanded set of quality measures to participate in the RHQDAPU program, and nonparticipating hospitals received a reduction of 2.0 percentage points in their Medicare annual update for that fiscal year.

The Secretary has the authority to expand the set of measures that are included in the RHQDAPU program. Specifically, the Secretary can add other measures that reflect consensus among affected parties and, to the extent feasible and practicable, can include measures set forth by one or more national consensus building entities. The Secretary may replace any measures or indicators in appropriate cases, such as where all hospitals are effectively in compliance or the measures or indicators have been subsequently shown not to represent the best clinical practice.

Currently, there are 44 quality measures collected in the RHAQDPU program that impact the FY2010 payment update. In some cases, the Centers for Medicare and Medicaid Services (CMS) gathers quality information by abstracting claims data. In these instances, hospitals are not required to report data on these specific measures since the information is collected directly by CMS. Today, the RHAQDPU program collects quality data on the following conditions: acute myocardial infarction (AMI); heart failure; pneumonia; and surgical care improvement. The program also collects information on 30-day mortality rates for AMI, heart failure and pneumonia patients; readmission rates for heart failure, AMI, and pneumonia; a nursing sensitive measure; several Agency for Health Care Research and Quality (AHRQ) Patient Safety and Inpatient Quality Indicators; a indicator for participation in the cardiac surgery data base; and patients' experience of care through the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey.

Procedures for making reported quality data available to the public must be established and hospitals must be granted the opportunity to review quality data prior to such information being made public. The required quality measures of process, structure, outcome, patients' perspectives on care, efficiency, and costs of care that relate to services furnished in inpatient settings in hospitals must be reported on the Internet website of CMS. Currently, individual hospital performance on specific quality measures and on certain conditions is available on Hospital Compare available on the CMS website.

DRA also required the Secretary to formulate and report on a plan to implement a value-based purchasing program for payments under the Medicare program for acute care hospitals (also referred to as IPPS or subsection(d) hospitals) beginning with FY2009. On November 17, 2007, CMS responded to this mandate by releasing the report, "Report to Congress: Plan to Implement a Medicare Hospital Value-Based Purchasing Program." This report recommends expanding the RQHDAPU program in order to financially reward hospitals differentially for performance, rather than for simply reporting quality data. Public reporting of performance would be a key component, as well.

As of 2008, nearly 95 percent of the acute care hospitals successfully participated in the RHAQDPU program, which means that the majority of the hospitals paid under Medicare's inpatient prospective payment system (IPPS) complied with the quality data reporting requirements and were not subject to payment penalties that would have occurred in the case of not meeting the reporting requirements.

Committee Bill

Starting for discharges on October 1, 2012, the Secretary would establish a hospital value-based purchasing (VBP) program in Medicare to provide incentive payments to acute care hospitals (referred to as subsection (d) hospitals) that meet established performance standards for the performance period in a fiscal year. The first year of the program would be a data collection/performance baseline year. Beginning in FY2013, hospital payments would be adjusted based on performance under the VBP program. Certain hospitals would be excluded from the VBP program, including those that fail to report quality measures under the RHQDAPU program; 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 hospitals for which a minimum number of patients with conditions related to the quality measures or a minimum number of quality measures do not apply. The Secretary would conduct an independent analysis to determine the standard to determine these minimum numbers.

The Secretary would select measures for the hospital VBP program from those used in the RHQDAPU program. In FY2013, the measures would cover at least the following five conditions: heart attack (AMI); heart failure; pneumonia; surgeries (as measured by the Surgical Care Improvement Project); patient perception of care; and 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 issued by the Department of Health and Human Service plan). For VBP payments for discharges occurring during FY2014 and

subsequently, the Secretary would ensure that measures would include efficiency measures. Such measures would include Medicare spending per beneficiary adjusted by factors including age, sex, race, severity of illness and other appropriate factors.

The Secretary would not select a measure for the VBP program for a performance period in a fiscal year unless it has been included the RQHDAPU program and included on the Hospital Compare Internet website for at least 1 year prior to the beginning of the performance period. The measures would not apply to a hospital if it does not furnish services appropriate to the measure. The Secretary would have the same authority to replace a measure if it is found that all hospitals are effectively in compliance with the measure or if the measure no longer represents a best practice as in the RQHDAPU program.

The Secretary would establish performance standards with respect to the VBP measures for a performance period for a fiscal year. These standards would include levels of achievement and improvement. The performance standards would be announced at least 60 days prior to the performance period for which they would apply. The following factors would be considered when establishing the standards: practical experience with the measures, historical performance standards, improvement rates, and the opportunity for continued improvement. The established performance period would begin and end prior to the beginning of the fiscal year.

The Secretary would develop a methodology for assessing the total performance of each hospital based on the standards for the selected measures for the period. Using this methodology, the Secretary would provide for an assessment or hospital performance score for each hospital for the relevant period.

The Secretary would ensure that the resulting distribution of value-based incentive payments among hospitals with different levels of performance scores was appropriate; hospitals with the highest scores would receive the largest VBP payments. The methodology would provide that the hospital performance score is determined using the higher of its achievement or improvement score for each measure. This methodology would include the assignment of weights for appropriate categories of measures. There would not be a minimum performance standard in determining the performance score for any hospital. A hospital's performance score would reflect the measures that apply to the hospital.

Hospitals that meet or exceed the established standards for a performance period would receive an increased base operating DRG payment for each discharge in the fiscal year. The increase would be the VBP payment amount which a percentage of the base operating DRG payment, as specified by the Secretary for a hospital. In establishing this percentage, the Secretary would ensure that the percentage increase is related to the hospital's performance score and the total amount of VBP payments to hospitals in a fiscal year equals the total amount available for such payments. This total amount would equal the amount of the reduction in acute care hospital payments.

Starting in FY2013, the Secretary would reduce the base operating DRG payment for a hospital for each discharge in a fiscal year by an applicable percentage. These reductions would apply to all hospitals regardless of whether or not the hospital would receive a VBP payment for that

year. The applicable percentage would be 1.0 percent in FY2013; 1.25 percent in FY2014; 1.5 percent in FY2015; 1.75 percent in FY2016; and 2.0 percent in FY2017 and in subsequent years. The base operating DRG payment would be the IPPS payment amount that would otherwise be paid for a discharge reduced by any payment attributable to outlier status, indirect medical education adjustments, disproportionate share hospital adjustments, or low volume hospital adjustments. Special payments to Medicare dependent hospitals and sole community hospitals would be exempt as well.

The Secretary would inform each hospital of the adjustments to the discharge payments no later than 60 days prior to the start of each fiscal year. Payment adjustments or reductions under the hospital VBP program would only apply to a relevant fiscal year and would not be taken into account in calculating payments in future fiscal years.

Individual hospital performance on each specific quality measure, on each condition or procedure, and on total performance would all be publicly reported. The Secretary would ensure that a hospital has the opportunity to review and correct the information prior to it being publicly reported. The information would be posted on the Hospital Compare Internet website in an easily understandable format. Aggregate information on VBP payments would be periodically published including the number of hospitals receiving incentive payments (as well as the range and total amount of the VBP payments) and the number of hospitals receiving less than the maximum VBP incentive payments (as well as the range and total amount of the VBP payments).

A process would be established that allows hospitals to appeal their performance assessment and score; these appeals would be resolved in a timely manner. There would be no judicial or administrative review of the following items: (1) the methodology used to determine the amount and determination of the VBP payments; (2) the determination of the amount of available VBP payments; (3) the establishment of the hospital performance standards; (4) the quality measures that are selected for inclusion in RHQDAPU or the VBP program; (5) the methodology that is used to calculate hospital performance scores and the calculation of those scores; and (6) the methodology for validating hospital performance.

The Secretary would consult with small rural and urban hospitals on the application of the VBP program to such hospitals. The selection of measures, the development of the methodology for calculating performance scores and the development of the methodology for calculating VBP payments would established through the promulgation of regulation.

The RHAQDPU program would be modified. The Secretary would be able to require hospitals to submit data on measures that are not used for the determination of VBP payments. Also, effective for FY2013 payments, the Secretary would be required to provide for appropriate risk adjustment for quality measures for outcomes of care.

The requirement that the Secretary add measures that reflect consensus among affected parties and include, to the extent possible, measures that are set forth by one or more consensus building entities would terminate in FY2012. Effective for FY2013 payments, each specified measure would be endorsed by qualified consensus-based entities or, if not, established under the process

established in Sec. 3014. The Secretary would, with input from consensus organizations and other stakeholders, take steps to ensure that RHAQDPU measures are coordinated and aligned with measures applicable to physicians and other providers of services and supplies.

In addition, the requirement that the Secretary establish procedures for submitting data under RHAQDPU would be changed to indicate that the information regarding submitted measures would be available publicly. The Secretary would develop standard Internet website reports after seeking input from stakeholders. The Hospital Compare Internet website would be modified to make information more readily available. The Secretary would establish an appropriate process to validate RHAQDPU measures including the auditing a sufficient number of randomly selected hospitals that have an opportunity to appeal the validation of their measures.

The Government Accountability Office (GAO) would conduct a study of the VBP program including an analysis of the impact of the program on the quality of care provided to Medicare beneficiaries, Medicare program expenditures, the quality performance among safety net hospitals, and small rural and small urban hospitals. GAO would submit an interim report including recommendations regarding necessary legislative and administrative action by October 1, 2015. A final report to Congress would be due by July 1, 2017.

The Secretary would conduct a study of the VBP program including an analysis of necessary program improvements to address unintended consequences. The report to Congress, including recommendations regarding necessary legislative and administrative action, would be due by January 1, 2016. Such study shall also evaluate whether the VBP program resulted in lower Medicare spending or other financial savings to hospitals and the appropriateness of the Medicare program sharing in the savings generated through this program.

In addition, no later than 2 years from enactment, the Secretary would establish three-year VBP demonstration projects in critical access hospitals (CAHs) and in hospitals excluded from VBP because of an insufficient number of qualifying cases. These demonstration programs would include an appropriate number of participants to ensure representation of the spectrum of CAHs and small hospitals. The Secretary would waive Medicare and Medicaid program requirements as necessary. The Secretary would be required to submit a report to Congress, including recommendations on the permanent establishment of VBP programs for these providers as well as necessary legislative and administrative action, no later than 18 months after completion of the projects.

Sec. 3002. Improvements To The Physician Quality Reporting System.

Present Law

TRHCA required the establishment of a physician quality reporting system that would include an incentive payment, based on a percentage of the allowed Medicare charges for all such covered professional services, to eligible professionals who satisfactorily report data on quality measures. CMS named this program the Physician Quality Reporting Initiative (PQRI). MIPPA made this program permanent and extended the bonuses through 2010; the incentive payment was

increased from 1.5 percent of total allowable charges under the physician fee schedule in 2007 and 2008 to two percent in 2009 and 2010.

Providers that successfully report for services provided in calendar year 2009 will receive an incentive payment of two percent of total allowable charges for the physician fee schedule. Providers may choose claims-based reporting or registry-based reporting. For claims-based reporting, providers seeking incentive payments for the entire calendar year may meet the requirement by reporting on one measures group for a sample of 30 consecutive Medicare Part B fee-for-service patients (FFS), or report for one measures group for 80 percent of applicable Medicare Part B FFS. For providers seeking to report for the six-month period beginning July 1, 2009, similar criteria apply for those that report through CMS approved registries.

Committee Bill

The Committee Bill would extend PQRI incentive payments beyond 2010. Eligible professionals who successfully report in 2010 would receive a 1 percent bonus in 2011, and eligible professionals who successfully report in 2011 would receive a 0.5 percent bonus in 2011. Eligible professionals who failed to participate successfully in the program would face a 1.5 percent payment penalty in 2013, based on their 2012 reporting period. The incentive payments and adjustments in payment would be based on the allowed charges for all covered services furnished by the eligible professional, based on the applicable percent of the fee schedule amount. For 2013, the applicable percent would be calculated as 98.5 percent of their total allowed charges. For 2014 and in subsequent years, the penalties for non-reporting would be two percent, calculated as 98 percent of the provider's total allowed Medicare charges. The penalty would be assessed on an annual basis and would not be cumulative.

The Committee Bill would establish a new PQRI option in addition to the options within the current program detailed above. Beginning with the 2011 reporting period, CMS would be required to make PQRI incentive payments available for two successive years to eligible professionals who voluntarily complete the following on a biennial (every two years) basis: (1) participate in a qualified American Board of Medical Specialties certification, known as Maintenance of Certification (MOC), or equivalent programs, and (2) complete a qualified MOC practice assessment. A qualified MOC practice assessment would include an initial assessment of a participant's practice, designed to demonstrate the physician's use of evidence-based medicine, and would seek to improve quality of care through follow-up assessments. The methods, measures, and data used for the MOC would be submitted by the Boards to CMS in accordance with requirements established by the Secretary in consultation with the Boards. As part of this consultation, the Secretary would ensure that methods, measures and data to be submitted allow for innovation and appropriateness by specialty.

The Committee Bill would require CMS to develop a plan to integrate the PQRI program with the standards for meaningful use of certified electronic health records as created in the American Recovery and Reinvestment Act of 2009. The bill would require CMS to make two additional enhancements to the program. First, CMS would be required to provide timely feedback to eligible professionals on their performance with respect to satisfactorily submitting data on quality measures. Second, 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.

Sec. 3003. Improvements to the Physician Feedback Program.

Present Law

Both MedPAC and GAO have recently recommended providing information to physicians on their resource use. MedPAC asserts that physicians would be able to assess their practice styles, evaluate whether they tend to use more resources than their peers or what evidence-based research (if available) recommends, and revise practice styles as appropriate. MedPAC notes that in certain instances, the private sector use of feedback has led to a small downward trend in resource use. The GAO noted that certain public and private health care purchasers routinely evaluate physicians in their networks using measures of efficiency and other factors and that the purchasers it studied linked their evaluation results to a range of incentives to encourage efficiency.

MIPPA established a physician feedback program with the intent to improve efficiency and to control costs. Under the Physician Feedback Program, the Secretary will use Medicare claims data to provide confidential reports to physicians that measure the resources involved in furnishing care to Medicare beneficiaries. The resources to be considered in this program may be measured on an episode basis, on a per capita basis, or on both an episode and a per capita basis. The GAO will conduct a study of the Physician Feedback Program, including the implementation of the program, and will submit a report to Congress by March 1, 2011 containing the results of the study, together with recommendations for such legislation and administrative action as the Comptroller General determines appropriate.

Committee Bill

The Committee Bill would require the Secretary, beginning in 2012, to provide reports to physicians that compare their resource use with that of other physicians or groups of physicians caring for patients with similar conditions. Resource use would be measured based on the items and services furnished or ordered by physicians or groups of physicians. Feedback reports would be based on an episode-grouper methodology established by the Secretary that would combine separate but clinically-related services into an episode of care for which the physician is accountable. The episode-grouper would be required to be developed by January 1, 2012. The Secretary would be required to make the methodology available to the public, and the Secretary would be required to seek endorsement of the episode-grouper by the entity with a contract with the Secretary under section 1890(a) of the Social Security Act.

In preparing feedback reports, the Secretary would be required to make appropriate data adjustments, including adjustments to (1) account for differences in the demographic characteristics and health status of individuals, so as not to penalize those physicians who tend to serve less healthy individuals who may require more intensive interventions; and (2) eliminate the effect of geographic adjustments in payment rates.

The Secretary would have the authority to exclude certain information regarding an item or service from feedback reports if the Secretary determines that there is insufficient information relating to such item or service to provide a valid assessment of utilization. The Secretary would be required to provide for education and outreach activities to physicians on the operation of, and methodologies used, under the Feedback Program. The Secretary would coordinate the physician feedback program with other relevant value-based purchasing reforms under the Medicare program.

Beginning in 2014, payment would be reduced by 5 percent if an aggregation of the physician's resource use is at or above the 90th percentile of national utilization. After five years, the Secretary would have the authority to convert the 90th percentile threshold for payment reductions to a standard measure of utilization, such as deviations from the national mean.

Sec. 3004. Quality Reporting for Long-term Care Hospitals, Inpatient Rehabilitation Hospitals and Hospice Programs.

Present Law

Under Present Law, inpatient rehabilitation facilities (IRFs), long term care hospitals (LTCHs) and hospices are not required to report quality data to CMS. However, Medicare does require an IRF to submit a clinician's comprehensive assessment of each Medicare patient upon admission and again at discharge. These documented assessments must be based on the direct observation of and communication with the patient and information may be supplemented with information from other sources, including family members or other clinicians. The IRF's patient assessment instrument (PAI) form, the Uniform Data Set for Medical Rehabilitation (UDSMR), encompasses about 55 questions used to ascertain a patient's functional independence including motor skills and cognitive capacities and to establish a patient's co-morbidities. A patient's assessments (from both admission and discharge) are transmitted to CMS electronically in one submission. Failure to meet the IRF-PAI transmission deadlines results in a 25 percent reduction in Medicare's payment in all but extraordinary circumstances. No comparable patient reporting requirements have been established for LTCHs and hospices.

Medicare pays for inpatient care provided by IRFs and LTCHs using different prospective payment systems (PPS). Each PPS is updated annually using a market basket (MB) index which measures the estimated change in the price of goods and services purchased by the provider to produce a unit of output. Medicare payments to hospices are predetermined fixed amounts for each case, according to the general type of care provided to a beneficiary on a daily basis. Payments for hospice care are based on one of four prospectively determined units of payment, which correspond to four different levels of care (i.e., routine home care, continuous home care, inpatient respite care, and general inpatient care) for each day a beneficiary is under the care of the hospice. Hospice payments are updated annually based on the hospital MB index.

Committee Bill

The Secretary would be directed to establish quality reporting programs for LTCHs, IRFs, LTCHs and hospices.

Starting in rate year 2014, LTCHs would be required to submit data on specified quality measures. The required measures would be selected from those that have been be endorsed by qualified consensus-based entities or, if not, established under the process established in Sec. 3014 of this legislation. No later than October 1, 2012, the required measures for rate year 2014 would be published. The Secretary would establish procedures for making this data publicly available. These procedures would ensure that LTCHs have the opportunity to review their data prior to it being made available. Quality measures would be reported on the Internet website of CMS. LTCHs that did not submit the required quality measures would have reduction in their annual update of two percentage points. Any reduction would not affect payments in subsequent rate years.

Starting in FY2014, IRFs would be required to submit data on specified quality measures. The required measures would be selected from those that have been be endorsed by qualified consensus-based entities or, if not, established under the process established in Sec. 3014 of this legislation. No later than October 1, 2012, the required measures for FY2014 would be published. The Secretary would establish procedures for making this data publicly available. These procedures would ensure that IRFs have the opportunity to review their data prior to it being made available. Quality measures would be reported on the Internet website of CMS. IRFs that did not submit the required quality measures would have reduction in their annual update of 2 percentage points. Any reduction would not affect payments in subsequent rate years.

Starting in FY2014, hospices would be required to submit data on specified quality measures. The required measures would be selected from those that have been be endorsed by qualified consensus-based entities or, if not, established under the process established in Sec. 3014 of this legislation. No later than October 1, 2012, the required measures for FY2014 would be published. The Secretary would establish procedures for making this data publicly available. These procedures would ensure that hospices have the opportunity to review their data prior to it being made available. Quality measures would be reported on the Internet website of CMS. IRFs that did not submit the required quality measures would have reduction in their annual update of 2 percentage points. Any reduction would not affect payments in subsequent rate years.

Sec. 3005. Quality Reporting for PPS-exempt Cancer Hospitals.

Present Law

Eleven cancer hospitals are exempt from the Medicare inpatient prospective payment system (IPPS) used to pay inpatient hospital services provided by acute care hospitals. As part of these exemptions, these facilities are paid on a reasonable cost basis for providing inpatient services, subject to certain payment limitations and incentives. These hospitals are also held harmless under the outpatient prospective payment system (OPPS) and will not receive less from Medicare under this payment system than under the prior outpatient payment system. Under OPPS, Medicare pays for outpatient services using ambulatory payment classification (APC) groups. Currently, there are no quality reporting requirements for these hospitals.

Committee Bill

The Secretary would be directed to establish quality reporting programs for IPPS-exempt cancer hospitals starting FY2014. The required measures would be selected from those that have been be endorsed by qualified consensus-based entities or, if not, established under the process established in Sec. 3014 of this legislation. No later than October 1, 2012, the required measures for FY2014 would be published. The Secretary would establish procedures for making this data publicly available. These procedures would ensure that cancer hospitals have the opportunity to review their data prior to it being made available. Quality measures would be reported on the Internet website of CMS.

Sec. 3006. Plans for a Value-Based Purchasing Program for Skilled Nursing Facilities and Home Health Agencies.

Present Law

As required by Section 5201(c) of the Deficit Reduction Act of 2005 (DRA, P.L. 109-171), beginning in 2007, home health agencies (HHAs) were required to submit data for a set of quality measures. HHAs that did not submit these data received a reduction of 2.0 percent in their Medicare annual update for that year. As a Medicare condition of participation, skilled nursing facilities (SNFs) are required to submit data on quality to the Secretary.

Currently, individual HHA and SNF performance data on specific quality measures and on certain conditions are available on *Home Health Compare* and *Nursing Home Compare*, which are available on the CMS website.

Medicare payment demonstrations have been or are to be implemented that will test value-based purchasing for HHAs and SNFs.

Section 5201(d) of the DRA also required the Medicare Payment Advisory Commission (MedPAC) to submit a report to Congress on considerations for implementing a value-based payment system for Medicare home health services. MedPAC submitted this report to Congress in June 2007.

Committee Bill

The Secretary would be required to develop a plan to implement a Medicare value-based purchasing program for HHAs and SNFs and submit a report to Congress on these plans by FY2011 and FY2012, respectively.

In developing the plan for HHAs and SNFs, the Secretary would be required to consider the following for each: (1) the development, selection, and modification process of measures, to the extent feasible and practicable, of all dimensions of quality and efficiency; (2) the reporting, collection, and validation of quality data; (3) a structure of proposed value-based payment adjustments, including the determination of thresholds or improvements in quality that would

substantiate a payment adjustment, the size of such payments, and the sources of funding for value-based incentive payments; (4) methods for publicly disclosing performance information on SNFs; and (5) and any other issues determined appropriate by the Secretary. In developing each plan, the Secretary would be required to consult with relevant affected parties; and take into consideration experience with demonstrations that are relevant to value-based purchasing in each setting.

Sec. 3007. Value Based Payment Modifier Under the Physician Fee Schedule.

Present Law

Medicare payments for services of physicians and certain non-physician practitioners are made on the basis of a fee schedule system, which assigns a reimbursement to each of over 7,500 service codes, also known as the Healthcare Common Procedure Coding System (HCPCS). The reimbursement system assigns relative value units (RVUs) according to a resource-based relative value scale to each service that reflect physician work (i.e., time, skill, and intensity it takes to provide the service), practice expenses, and malpractice costs.

Committee Bill

The Committee Bill would create a new "value-based payment modifier" that would provide for differential payment to a physician or a group of physicians under the Medicare fee schedule based upon the relative quality of care compared to the relative cost of the care furnished by a physician or group of physicians to Medicare beneficiaries. The value-based payment modifier would be separate from the geographic adjustment factors.

The quality of care would be evaluated based on a composite of measures of the quality of care furnished as established by the Secretary, as follows. The Secretary would establish appropriate measures of the quality of care furnished by a physician or group of physicians to Medicare enrollees, such as measures that reflect health outcomes. The measures would be risk adjusted as determined appropriate by the Secretary. The Secretary would seek endorsement of the quality measures by the consensus-based entity (such as the National Quality Forum) with a contract with the Secretary under section 1890(a) of the Social Security Act.

In constructing the value-based payment modifier, the Secretary would evaluate a composite of appropriate measures of costs that eliminate the effect of geographic adjustments in payment rates, and take into account risk factors such as the demographic characteristics and health status of Medicare beneficiaries and other factors determined appropriate by the Secretary.

Not later than January 1, 2012, the Secretary would publish the following: (1) the measures of quality of care and costs mentioned above; (2) the dates for implementation of the payment modifier; and (3) the initial performance period. The Secretary would begin implementing the value-based payment modifier through the rule making process during 2013 for the Medicare fee schedule. The initial performance period would begin during 2014. During the initial performance period, the Secretary would provide information to physicians and groups of

physicians about the quality of the care compared to the cost of the care furnished by the physician or group of physicians to Medicare beneficiaries.

The Secretary would apply the value-based payment modifier for items and services furnished (1) beginning on January 1, 2015, with respect to specific physicians and groups of physicians the Secretary determines appropriate; and (2) beginning not later than January 1, 2017, with respect to all physicians and groups of physicians.

The value-based payment modifier would be implemented in a budget neutral manner. The Secretary would apply the value-based payment modifier in a manner that would promote systems-based care, and take into account the special circumstances of physicians or groups of physicians in rural areas and other underserved communities, as appropriate.

The initial application of the value-based payment modifier would apply to "physicians" as defined under Present Law (SSA section 1861(r)) during the period beginning on January 1, 2015, and ending on December 31, 2016. On or after January 1, 2017, the Secretary could apply the value-based payment modifier eligible professionals (as defined in subsection (k)(3)(B)), as the Secretary determines appropriate.

Sec. 3008. Payment Adjustment for Conditions Acquired in Hospitals.

Present Law

Medicare pays for inpatient services provided by acute care hospitals under section 1886(d) of the Social Security Act using the inpatient prospective payment system (IPPS), where each patient is classified into a Medicare severity adjusted diagnosis-related group (MS-DRG) based on diagnoses and procedures performed. Generally, except for outlier cases, a hospital receives a predetermined amount for a given MS-DRG regardless of the services provided to a patient. In some instances, Medicare patients may be assigned to a different MS-DRG with a higher payment rate based on secondary diagnoses. Inpatient services provided by acute care hospitals in Maryland are paid under a state-specific Medicare payment system under section 1814(b)(3) of the Social Security Act.

As established by the Deficit Reduction Act of 2005 (DRA, P.L. 109-171), hospitals will not receive additional Medicare payment for complications that were acquired during a patient's hospital stay. By statute, these hospital acquired conditions (HACs) are: (1) high cost, high volume, or both; (2) identified though a secondary diagnosis that will result in the assignment to a different, higher paid MS-DRG; and (3) reasonably preventable through the application of evidence-based guidelines. Starting October 1, 2007 (FY2008), CMS required hospitals to report whether certain conditions (secondary diagnoses) for Medicare patients were present at admission. Starting October 1, 2008, IPPS hospitals do not receive additional payment for secondary diagnoses resulting from HACs for certain select conditions.

Committee Bill

Starting for discharges during FY2015, acute care hospitals (including those in Maryland paid under their state specific Medicare system) in the top quartile of national, risk-adjusted HAC

rates for an applicable period in a fiscal year would receive 99 percent of their otherwise applicable Medicare payments for inpatient hospital services in a given year. A HAC would be defined as a condition that an individual acquires during a hospital stay, as determined by the Secretary.

Prior to FY2015, the hospitals would receive confidential reports with respect to their HAC conditions. The information would be made publicly available on the Hospital Compare Internet website after the hospital has the opportunity to review and correct the data.

There would be no administrative or judicial review of the HAC ranking criteria, the specification of HACs, the specification of an applicable period, the provision of reports to hospitals, or the information made publicly available.

PART II—Strengthening The Quality Infrastructure

Sec. 3011. National Strategy.

Present Law

There are no provisions in Present Law requiring the Secretary to develop a national quality strategy, strategic plan, or improvement priorities. However, MIPPA requires the Secretary to identify and have in effect a contract with a consensus-based entity, such as the National Quality Forum (NQF), to perform the following duties: (1) synthesize evidence and convene stakeholders to make recommendations, with respect to activities conducted under this Act, on an integrated national strategy and priorities for health care performance measurement in all applicable settings; (2) provide for the endorsement of standardized health care performance measures; (3) establish and implement a process to ensure that endorsed measures are updated or retired based on new evidence; (4) promote the development of electronic health records that facilitate the collection of performance measurement data; and (5) report annually to Congress. The NQF has been awarded this contract and recently released its first report, *Improving Healthcare Performance: Setting Priorities and Enhancing Measurement Capacity*, in fulfillment of this statutory requirement.

Committee Bill

Generally, this section would direct the Secretary to establish a national quality improvement strategy, to include both the development of national priorities for quality improvement and a comprehensive strategic plan to achieve these priorities. The Secretary would be required to ensure that the national priorities for quality improvement would achieve certain aims (e.g., reducing health disparities) and the strategic plan would include provisions for addressing a number of issues, including coordination among agencies within the Department of Health and Human Services.

This section would direct the Secretary to establish a national quality improvement strategy, including the development of national priorities for improvement, to improve the delivery of

health care services, patient health outcomes, and population health through a transparent and collaborative process.

In developing these priorities, the Secretary would ensure that they will: (1) have the greatest potential for improving health outcomes, efficiency, and patient-centeredness of health care; (2) identify areas in the delivery of health care services that have the potential for rapid improvement in the quality and efficiency of patient care; (3) address gaps in quality, efficiency, and health outcomes measures and data aggregation techniques; (4) improve Federal payment policy to emphasize quality and efficiency; (5) enhance the use of health care data to improve quality, efficiency, transparency, and outcomes; (6) address the health care provided to patients with high-cost chronic diseases; (7) improve strategies and best practices to improve patient safety and reduce medical errors, preventable admissions and readmissions, and health care-associated infections; (8) reduce health disparities across health disparity populations and geographic areas; and (9) address other areas as determined appropriate by the Secretary. In addition, in identifying these priorities, the Secretary would be required to consider both the recommendations submitted by qualified consensus-based entities, as required under Sec. 3014 of this Act and the recommendations of the Interagency Coordinating Working Group on Health Care Quality established under Sec. 3012 of this Act.

The national strategy would also include a comprehensive strategic plan to achieve the priorities described above. At a minimum, the strategic plan would include provisions for addressing coordination among agencies within HHS; agency-specific strategic plans and annual benchmarks to achieve the priorities; a process for regular reporting by the agencies to the Secretary on the implementation of the strategic plan; strategies to align incentives among public and private payers with regard to quality and patient safety efforts; and incorporating quality improvement and measurement in the strategic plan for health information technology (required by ARRA).

The Secretary would update the national strategy not less than triennially and the first report would be due to Congress not later than December 31, 2010. Any update would include a review of short- and long-term goals as well as an analysis of progress in meeting these goals. In addition, the Secretary would create an Internet website to make public information regarding the national priorities for health care quality improvement; the agency-specific strategic plans for health care quality; and other information the Secretary may determine to be appropriate.

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

Present Law

No provision.

Committee Bill

This section would require the President to convene a working group consisting of senior level representatives of relevant Federal departments and agencies[21] with the goals of achieving (1) collaboration, cooperation and consultation between Federal departments and agencies with respect to developing and disseminating strategies, goals, models, and timetables that are consistent with the national priorities for improvement; and (2) avoidance of duplication of quality improvement efforts and resources. The Working Group would be chaired by the Secretary, and members of the Working Group would serve as Vice Chair on a rotating basis. Not later than a date determined appropriate by the Secretary, and annually thereafter, the Working Group would submit a report to the relevant Committees of Congress, and make publicly available, a report on the progress and recommendations of the Working Group.

Sec. 3013. Quality Measure Development.

Present Law

The Agency for Healthcare Research and Quality (AHRQ) has significant authorities with respect to the development of quality measures. Specifically, the Agency's mission, among other things, is to promote healthcare quality improvement by conducting and supporting research that develops and presents scientific evidence regarding all aspects of health care, including methods for measuring quality and strategies for improving quality. AHRQ also is required to provide support for public and private efforts to improve healthcare quality, including the ongoing development, testing, and dissemination of quality measures. To comply with this last requirement, the Agency has established the National Quality Measures Clearinghouse, an online resource that compiles and catalogues quality measures. AHRQ also develops annual reports to Congress on trends in healthcare quality and in healthcare disparities. Finally, AHRQ is required to coordinate all research, evaluations, and demonstrations related to health services research, quality measurement and quality improvement activities undertaken and supported by the Federal Government.

Committee Bill

Generally, this section would facilitate quality measure development by requiring the Secretary to identify and measure gaps, and award grants to entities to develop measures in these gap areas. Measures developed by entities receiving such grants, contracts or agreements would have to meet certain requirements (e.g., be free of charge to users, be publicly available), and the Secretary would prioritize the development of measures with specific characteristics (e.g., measures that allow the assessment of coordination of health care across episodes of care).

[21] Relevant Federal departments and agencies shall include: The Centers for Medicare and Medicaid Services (CMS), National Institutes of Health (NIH), Centers for Disease Control and Prevention; Food and Drug Administration (FDA), The Health Resources and Services Administration (HRSA), The Agency for Healthcare Research and Quality (AHRQ), and the Administration on Children and Families within The Department of Health and Human Services (HHS); The Department of Labor; The Department of Defense; The Department of Veterans Affairs; The Veterans Health Administration; The Department of Commerce; The Office of Personnel Management; The Office of Management and Budget; The U.S. Coast Guard; The Federal Bureau of Prisons; The National Highway Transportation and Safety Administration; and The Federal Trade Commission.

This section would require the Secretary to identify, not less than triennially, gaps where no quality measures exist, or where current quality measures must be improved, updated or expanded consistent with the national strategy and priorities. A qualified consensus-based entity that receives a grant or contract under Sec. 3014 would be required to submit a report, not less than annually, to the Secretary describing areas where gaps in quality measures exist and areas in which evidence is insufficient to support endorsement of quality measures in the priority areas identified by the Secretary in the national strategy. In identifying measure gaps, the Secretary would take into consideration the gaps identified by the consensus-based entity.

The Secretary would award grants, contracts or intergovernmental agreements to eligible entities for purposes of developing, updating, or expanding quality measures in identified gap areas. In awarding these grants, contracts or agreements, the Secretary would give priority to the development of measures that allow the assessment of health outcomes and functional status of patients; the coordination of health care across episodes of care and care transitions; the meaningful use of health information technology; safety, effectiveness, patient-centeredness, appropriateness, and timeliness of care; efficiency of care; equity of health services across health disparity populations and geographic areas; patient experience and satisfaction; and other areas determined appropriate by the Secretary.

Entities eligible for a grant or contract under this section would have to demonstrate expertise and capacity in the development and evaluation of quality measures; have procedures in place to take into account the view of payers or providers whose performance will be assessed by the measures and the views of other parties who will use the measures, such as consumers and health care purchasers; have transparent policies regarding governance and conflicts of interest; and collaborate with a qualified consensus-based entity and the Secretary, so that measures developed by the eligible entity will meet the requirements to be considered for endorsement by such qualified consensus-based entity.

An entity that receives a grant under this section would use such funding to develop quality measures that meet the following requirements: build on measures required to be reported pursuant to Title XVIII of the Social Security Act; can be collected, using health information technologies, to the extent practicable; are free of charge to users of such measures; and are publicly available on an Internet website. The Secretary may use amounts available under this section to update and test, where applicable, quality measures endorsed by a qualified consensus-based entity or adopted by the Secretary.

The section would authorize to be appropriated $75 million for each of the fiscal years 2010 through 2014 to carry out this section.

Sec. 3014. Quality Measure Endorsement.

Present Law

MIPPA requires the Secretary to identify and have in effect a contract with a consensus-based entity, such as the National Quality Forum (NQF), to perform the following duties: (1) synthesize evidence and convene stakeholders to make recommendations, with respect to

activities conducted under this Act, on an integrated national strategy and priorities for health care performance measurement in all applicable settings; (2) provide for the endorsement of standardized health care performance measures; (3) establish and implement a process to ensure that endorsed measures are updated or retired based on new evidence; (4) promote the development of electronic health records that facilitate the collection of performance measurement data; and (5) report annually to Congress. The NQF has been awarded this contract and recently released its first report, *Improving Healthcare Performance: Setting Priorities and Enhancing Measurement Capacity*, in fulfillment of this statutory requirement.

Committee Bill

Generally, this section would allow for the provision of a grant or contract to a qualified consensus-based entity to carry out a number of duties, including identifying gaps in endorsed quality measures, updating endorsed measures, and making recommendations to the Secretary for national priorities for performance improvement. This entity would also provide guidance on the selection of measures for use in public reporting or Federal health programs. The Secretary would be required to establish a pre-rulemaking process to obtain input on the selection of measures and to review and disseminate quality measures, among other things.

This section would allow a qualified consensus-based entity to receive a grant or contract to (1) make recommendations to the Secretary for national priorities for performance improvement; (2) identify gaps in endorsed quality measures; (3) identify and endorse quality measures; (4) update endorsed quality measures at least every three years; (5) make endorsed measures publicly available and have a plan for dissemination of such endorsed measures; and (6) transmit endorsed quality measures to the Secretary. This entity would provide a report to the Secretary outlining where gaps exist, and regarding areas in which evidence is insufficient to support endorsement of quality measures in priority areas identified by the Secretary under Sec. 3011. In addition, this entity would evaluate evidence and convene multi-stakeholder groups to make recommendations to the Secretary for national priorities for improvement. In convening multi-stakeholder groups, the entity would provide for an open and transparent process, and would ensure that the selection of members of these groups provide for public nominations for, and the opportunity for public comment on, such selection.

The entity would also convene multi-stakeholder groups to provide guidance on the selection of individual or composite measures for use in reporting performance information to the public or for use in Federal health programs. These measures would be selected from those endorsed by the entity and those that have not been considered for endorsement by the entity, but are used, or proposed to be used, by the Secretary in Federal health programs.

The Secretary would be required to establish a pre-rulemaking process to obtain input from the consensus-based entity and multi-stakeholder group on the selection of quality measures. Under this process, by not later than December 1st of each year, starting in 2010, the Secretary shall make public a list of measures being considered for selection with respect to quality reporting and payment systems under Title XVIII of the Social Security Act. Not later than February 1st of each year, beginning with 2011, the entity must transmit to the Secretary the guidance of the multi-stakeholder groups. In convening the multi-stakeholder groups, the entity would provide

for an open and transparent process, and would ensure that the selection of members of these groups provide for public nominations for, and the opportunity for public comment on, such selection.

With respect to endorsed quality measures, the Secretary could make a determination to use such measures only after taking into account the guidance of the multi-stakeholder groups as provided through the pre-rulemaking process. With respect to non-endorsed measures, the Secretary could use a measure that has not been endorsed, provided that the Secretary transmits the measure to the entity for consideration for endorsement and for the multi-stakeholder consultation process; publishes the rationale for the use of the measure in the *Federal Register*; and phases out use of the measures upon a decision of the entity not to endorse the measure, contingent on the availability of an adequate alternative endorsed measure (as determined by the Secretary). If an adequate alternative is not available, the Secretary would support the development of such an alternative endorsed measure.

Not less than once every three years, the Secretary would review quality measures used by the Secretary to determine whether to maintain use of such measures or to phase them out. In conducting this review, the Secretary would seek to avoid duplication of measures and take into consideration both current innovative strategies for quality improvement and measures endorsed by a quality consensus-based entity since the previous review.

The Secretary would also set forth a process to disseminate measures used by the Secretary and incorporate such measures, where applicable, in workforce programs, training curricula, payment programs, and any other means of dissemination deemed appropriate by the Secretary. The Secretary would establish a process to disseminate such quality measures to the Working Group established in Sec. 3012 of this Act. The Secretary would be allowed to contract with one or more entities to carry out this dissemination process. These entities must be non-profit; have at least five years experience in developing and implementing quality improvement strategies; have operated programs on a statewide or multi-state basis to improve patient safety and quality of health care delivered in hospitals, including at minimum, in hospital intensive care units, hospital associated infections, hospital peri-operative patient safety and hospital emergency rooms; and have worked with a variety of health care providers in implementing these initiatives.

In addition, the Secretary would provide technical assistance to providers of services and suppliers required to report on measures under Title XVIII of the Social Security Act. In providing such assistance, the Secretary would prioritize rural and urban providers of services and suppliers with limited infrastructure to implement quality improvement activities and providers of services and suppliers with poor performance scores and with disparities in care among subgroups or patients.

For purposes of carrying out this section, 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 Supplementary Medical Insurance Trust Fund (in such proportion as the Secretary determines appropriate), to the CMS Program Management Account.

PART IIII – Encouraging Development Of New Patient Care Models

Sec. 3021. Establishment of Center for Medicare and Medicaid Innovation Within CMS.

Present Law

Under the Social Security Act, the Secretary of HHS has broad authority to develop research and demonstration projects to test new approaches to paying providers, delivering health care services, or providing benefits to Medicare beneficiaries. Specifically, demonstrations designed to test changes in provider payment are required to increase the efficiency and economy of health care services without adversely affecting quality. Currently, CMS is conducting approximately 30 Medicare demonstrations. Some of the key themes addressed in these demonstrations include care coordination, pay for performance, Health Information Technology, and quality improvement. Although demonstrations may be initiated by both the agency and Congress, the number of congressionally mandated demonstrations has increased in recent years.

Section 646 of the MMA mandated CMS to conduct a five-year demonstration program to test ways to improve health outcomes while increasing efficiency. This demonstration, called the Medicare Health Care Quality Demonstration (Section 1866C of the Social Security Act), aims to improve patient safety, enhance quality, and reduce variation in medical practice that may result in higher cost. One of the major goals of this demonstration is to determine whether Medicare can improve outcomes while simultaneously achieving cost savings. Improvements in care coordination are one strategy that CMS anticipates providers will attempt as they strive to improve quality while simultaneously reducing costs. Two demonstration projects under this demonstration are scheduled to begin in 2009, with two others to begin soon thereafter.

Committee Bill

This Committee Bill would require the Secretary, no later than January 1, 2011, to establish a Medicare and Medicaid Innovation Center within CMS. The Innovation Center (hereafter called the "Center") would test innovative payment and service delivery models to reduce program expenditures under Medicare, Medicaid, and CHIP while preserving or enhancing the quality of care furnished to individuals under such titles. In selecting such models, the Secretary shall give preference to models that also improve the coordination, quality, and efficiency of health care services furnished to such individuals. The Center may also give preference to the testing of models that would improve the coordination, quality, and efficiency of health care services for individuals who are dually-eligible for Medicare and Medicaid. In carrying out this section, the Secretary would consult with individuals and stakeholders, as specified.

This section sets forth requirements for both the testing of these models (PHASE I) and the expansion of these models (PHASE II). The section would require the Secretary to select models to be tested where the Secretary determines that there is evidence that the model addresses a defined population for which there are deficits in care leading to poor clinical outcomes or potentially avoidable expenditures. The models selected may include, but not be limited to, those with any of sixteen specified characteristics, including, for example, those that promote broad payment and practice reform in primary care, contract directly with groups of providers of services and suppliers to promote innovative care delivery models, promote care coordination between providers of services and suppliers that transition health care providers away from fee-

for-service based reimbursement and toward salary-based payment, and utilize medication therapy management services, among others.

Additionally, this section would require the Center, when selecting models for testing, to consider the following seven factors: (1) whether the model includes a regular process for monitoring and updating patient care plans in a manner that is consistent with the needs and preferences of Medicare beneficiaries; (2) whether the model places the Medicare beneficiary at the center of the care team; (3) whether the model provides for in-person contact with Medicare beneficiaries; (4) whether the model utilizes technology, such as electronic health records and patient-based remote monitoring systems, to coordinate care over time and across settings; (5) whether the model provides for the maintenance of a close relationship between care coordinators, primary care practitioners, specialist physicians, and other providers of services and suppliers; (6) whether the model relies on a team-based approach to interventions, such as comprehensive care assessments, care planning, and self-management coaching; and (7) whether, under the model, providers of services and suppliers are able to share information with other providers of services and suppliers on a real time basis.

The Secretary would conduct an evaluation of each model tested, including an analysis of (i) the quality of care furnished under the model, including the measurement of patient-level outcomes; and (ii) the changes in spending under the applicable titles by reason of the model.

Under this section, the Secretary could not require, as a condition for testing a model, that the design of the model ensure that the model is budget neutral initially with respect to expenditures under Titles XVIII and XIX of the Social Security Act. The Secretary would terminate or modify the design and implementation of a model unless the Secretary determines that the model is expected to (1) improve the quality of patient care without increasing spending; (2) reduce spending under such Titles without reducing the quality of care; or (3) improve quality and reduce spending.

With respect to the expansion of models, this section would allow the Secretary to expand the duration and the scope of a model that is being tested under this section or a demonstration project, to the extent determined appropriate by the Secretary, if the Secretary determines that such expansion would reduce spending under this title without reducing the quality of patient care. In determining whether to expand the scope or duration of a model or demonstration project, the Secretary would consider the results of the evaluation conducted under this section.

The Center would be headed by a director who would report directly to the Administrator of CMS. In addition, for the purposes of carrying out the provisions of this section, this section would allow the Secretary to waive such requirements of Title XI (General Provisions, Peer Review, and Administrative Simplification) and Title XVIII (Medicare), and Section 1902(a)(1), Section 1902(a)(13) and Section 1903(m)(2)(A)(iii) of the Social Security Act which require state Medicaid plans to be in effect statewide, provide for a public process for determining payment rates for hospital services, nursing facility services and services of intermediate care facilities for the mentally retarded, and which provide for payments for Medicaid managed care plans, as the Secretary determines appropriate solely for purposes of carrying out this section.

The Secretary would provide for the transfer, from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund, of $10 billion for the activities initiated under this section for the period of fiscal years 2011 through 2019. Funding would remain until expended. Out of the amounts transferred, not less than $25 million would be made available each fiscal year to design, implement, and evaluate models.

The Center would be allowed to carry out activities under this section with respect to CHIP (Title XXI) in the same manner as provided under this section with respect to Medicare and Medicaid (Titles XVIII and XIX) of the Social Security Act. In addition, there would be no administrative or judicial review (under Section 1869 and 1878 of the Social Security Act) of the following: (1) the selection of models to be tested; (2) the selection of organizations, sites, or participants to test those models selected; (3) the termination of a model or site at which a model is tested; and (4) the determination of models to be expanded.

Beginning in 2012, and not less than once every other year thereafter, the Secretary would be required to submit to Congress a report on activities under this section. Each such report shall describe: (1) the models tested by the Center, including the number of individuals participating in such models and payments made under the applicable titles for services on behalf of such individuals, (2) any models chosen for expansion, and (3) the results from evaluations under this section. In addition, each such report shall provide such recommendations as the Secretary determines are appropriate for legislative action to facilitate the development and expansion of successful payment models.

Finally, this section would strike "five-year" each place it appears in subsections (b) and (f) of Section 1866C of the Social Security Act, thus removing this time limit from the Health Care Quality Demonstration Program.

Sec. 3022. Medicare Shared Savings Program.

Present Law

There are no existing laws that directly address the ability of organizations or systems of integrated providers to share in the efficiency gains resulting from the joint responsibility and care of Medicare beneficiaries. However, while some providers who deliver care in a vertically integrated managed care environment under Medicare are able to achieve these efficiency gains (e.g., a staff-model managed care organization), other providers face obstacles to this type of practice and related potential sharing (e.g., fee-for-service providers who practice across a range of separate legal entities).

Experts define groups of providers (e.g. combinations of one or more hospitals, physician groups including primary care physicians and possibly specialists, and other health care providers) that are jointly responsible, through shared bonuses or penalties, for the quality and cost of health care services for a population of beneficiaries as accountable care organizations (ACOs). MedPAC has been among the proponents that have encouraged this type of gain sharing through accountable care organizations.

Medicare has some practical experience with ACO-like organizations. The Medicare Physician Group Practice (PGP) Demonstration, mandated by BIPA, created pay-for-performance incentives for physician groups (being paid fee-for-service) to coordinate the overall care delivered to Medicare patients. The physician groups were rewarded for improving the quality and cost efficiency of health care services through increased coordination of Part A and Part B services, investment in care management programs, process redesign, and improved patient health outcomes, especially for beneficiaries with chronic illness, multiple co-morbidities and those near the end of life. CMS selected ten physician groups on a competitive basis to participate in the demonstration, favoring multi-specialty physician groups with well-developed clinical and management information systems. The ten physician groups represented 5,000 physicians and 224,000 Medicare fee-for-service beneficiaries. Groups that were able to meet quality-of-care benchmarks and reduce their total expected Medicare spending by more than two percent were allowed to share in the savings they generate to the Medicare program.

Results from the PGP demo suggest that the concept shows promise. Preliminary results from the demonstration and reports from participants suggest that the program has achieved its goals of better coordination of care for the chronically ill, careful attention to hospital discharge processes, expanded role for non-physician providers, and investments in information technology. In the most recent year of the PGP demo, all participants demonstrated improvements in quality and achieved below average growth in costs. In addition, four were awarded with incentive payments for reducing costs below the two percent threshold. Accountable care organizations would go beyond the PGP model, which is based on physician groups, to include additional providers.

Committee Bill

The Committee Bill would allow groups of providers who voluntarily meet certain statutory criteria, including quality measurements, to be recognized as ACOs and be eligible to share in the cost-savings they achieve for the Medicare program. Beginning on Jan. 1, 2012, eligible ACOs would have the opportunity to qualify for an incentive bonus.

Eligible ACOs would be defined as groups of providers and suppliers who have an established mechanism for joint decision making. The following groups of providers and suppliers would be eligible for participation: practitioners in group practice arrangements; networks of practices; partnerships or joint-venture arrangements between hospitals and practitioners; hospitals employing practitioners; and such other groups of providers of services and suppliers as the Secretary determines appropriate. Practitioners would be defined as physicians, regardless of specialty, nurse practitioners, physician assistants, and clinical nurse specialists.

To qualify as an ACO, 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 practitioners participating in the ACO as the Secretary deems appropriate; (6) have in place a leadership and management structure, including with regard to

clinical and administrative systems; (7) define processes to promote evidence-based medicine, report on quality and costs measure, and coordinate care such as through the use of telehealth, remote patient monitoring, and other such enabling technologies; and (8) 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.

To earn the incentive payment, the organization would have to meet certain quality thresholds. In determining the quality of care furnished by an ACO, the Secretary would be required to use measures such as: (1) clinical processes and outcomes; (2) patient perspectives on care; and (3) utilization (such as rates of ambulatory-sensitive admissions and readmissions). ACOs would be required to submit data on measures the Secretary determines necessary to evaluate the quality of care furnished by the ACO. The Secretary would be required to establish performance standards for measures of the quality of care furnished by ACOs. The Secretary would be required to seek to improve the quality of care furnished by ACOs over time by specifying higher standards for purposes of assessing quality of care.

The Secretary would be authorized to incorporate reporting requirements and incentive payments and penalties related to the physician quality reporting initiative (PQRI), electronic prescribing, electronic health records, and other similar initiatives into the reporting requirements for ACOs.

CMS would assign Medicare fee-for-service beneficiaries to ACOs based on their use of Medicare items and services in preceding periods. The achievement thresholds and rewards for the ACO would be as follows. The spending baseline would be determined by using the most recent three years of total per beneficiary spending for Medicare parts A and B for those beneficiaries assigned to the ACO. The benchmark would be set by the baseline amount that is adjusted for beneficiary characteristics and updated by the projected absolute amount of growth in national per capita expenditures for parts A and B services under the Medicare fee-for-service program.. Benchmarks would be re-set at thr end of the three-year period.

ACOs 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. The Secretary would be required to set a minimum threshold of savings that would need to be achieved by an ACO before savings would be shared. The Secretary would have the authority to adjust the savings thresholds to account for the varying sizes of participating ACOs. If the Secretary determines that an ACO 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 ACOs.

Sec. 3023. National Pilot Program on Payment Bundling.

Present Law

Medicare pays for most acute care hospital stays and post-acute care services, including inpatient rehabilitation and long term care hospitals stays, skilled nursing facility (SNF) stays, and home health care visits, under prospective payment systems (PPS) established for each type of provider. Under each PPS, a predetermined rate is paid for each unit of service, such as a hospital

discharge, or a payment classification group. Payment classification groups are based on an estimate of the relative resources needed to care for a patient with a specific diagnosis and set of care needs. (The patient classification system used by hospitals, for example, is referred to as Medicare Severity diagnosis related groups or MS-DRGs).

Generally, PPS payments include a national standardized amount adjusted by a wage index that is associated with the area where the provider is located or, for some hospitals, where it has been reclassified. Medicare law provides for annual updates of the program payments to reflect inflation and other factors. In some cases, these updates are linked to the consumer price index for all urban consumers (CPI-U) or to a provider-specific market basket (MB) index which measures the change in the price of goods and services purchased by the provider to produce a unit of output.

As Medicare beneficiaries with complex health conditions and multiple co-morbidities move between hospital stays and a range of post-acute care providers, Medicare makes separate payments to each provider for covered services. The Medicare Payment Advisory Commission (MedPAC), among others, has suggested that Medicare test new incentives and payment models to encourage providers to better coordinate across patients' episodes of care and to evaluate the full spectrum of care a patient may receive during these episodes. Specifically, in its June 2008 report, MedPAC recommended that a bundled payment system for an episode of care be explored in a pilot program. Under this voluntary program, a single provider entity would receive a bundled payment intended to cover the costs of the full range of care needed over the hospitalization episode, including 30 days post-discharge.

Committee Bill

The Secretary would be required to 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. If evaluations find that the pilot program achieves goals of improving patient outcomes, reducing costs and improving efficiency, then the Secretary would be required to submit an implementation plan to Congress on expanding the pilot program to an extent to be determined by the Secretary.

Prior to the start of the pilot program, the Secretary would be required to determine which patient assessment instrument (such as the Continuity Assessment Record and Evaluation, or CARE tool) should be used to evaluate a patient's clinical condition for the purposes of determining the most clinically-appropriate site for post-acute care. The Secretary would be required to work with the Agency for Healthcare Research and Quality (AHRQ) and the qualified consensus-based entity as defined in MIPPA to develop episode of care quality measures and post-acute quality measures in compliance with the quality measurement and endorsement procedures laid out in Quality Infrastructure section of this legislation. Finally, the Secretary would be required to determine which Medicare statutory provisions and related regulations would be appropriate to waive in order to conduct the pilot program.

The duration of the pilot project would be for five years. However, the Secretary would be able to extend the pilot program for participating providers, if the Secretary determines that an extension of the pilot program would result in either (1) an improvement in the quality of patient care without an increase in expenditures under this title, or (2) a reduction in expenditures under this title without a reduction in the quality of patient care. The length of the extension would be determined by the Secretary.

The Secretary would select eight conditions to be included in the pilot program by 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; (3) conditions with significant variation in readmissions and post acute care spending; (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. To be an applicable beneficiary under this pilot program, individuals must be entitled to, or enrolled in part A and enrolled in part B, but not enrolled in part C, and be admitted to a hospital for an applicable condition.

The pilot program may cover the following services: acute care inpatient services; physician services delivered inside and outside of the acute care hospital setting; outpatient hospital services, including emergency department visits; services associated with acute care hospital readmissions; PAC services including home health, skilled nursing, inpatient rehabilitation, long term care hospital; and other services that the Secretary determines appropriate.

The episode of care established in the pilot program would start three days prior to a qualifying admission to the hospital and span the length of the hospital stay and 30 days following the patient discharge, unless the Secretary determines another timeframe is more appropriate for purposes of the pilot. The Secretary would develop policies to ensure the traditional fee-for-service program provides payment for PAC services in the appropriate setting for those patients who require continued PAC services after the 30th day following the discharge.

With respect to payments for the participating providers in the pilot program, the Secretary could test alternative payment methodologies, which could include bundled payments or arrangements in which providers continue to receive reimbursement under current payment systems, but are held jointly accountable for the quality and cost of care provided to Medicare patients. Payments would be adjusted for patient severity of illness and other patient characteristics, including having a major diagnosis of substance abuse or mental illness, resources needed to provide care as well as adjustments for differences in hospital average hourly wages, physician work, practice expense, malpractice expense, and geographic adjustment factors. The pilot program's payment methodology would also take into account the provision of services such as care coordination, medication reconciliation, discharge planning and transitional care services and other patient-centered activities as defined appropriate by the Secretary.

The pilot program's bundled 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 rehospitalizations 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 episode of care for patient.

Any Medicare provider, including hospitals, physician groups, or post-acute entities interested in assuming responsibility for the bundled payment would be able to apply to participate in the pilot program. Any entity assuming responsibility for the bundled Medicare payment would be required to have an arrangement with an acute hospital for initiation of bundled services. All services provided under the bundle would be required to be provided or directed by Medicare-participating providers. Eligible entities would receive the bundled payment for each patient served, regardless of whether patient receives certain levels of physician or post acute care.

In those instances a condition selected for the pilot program is also subject to Medicare's readmissions policy, hospitals participating in the pilot would be exempt from readmissions penalty for that condition. The bundled payment to a pilot participant would cover any preventable readmissions within the covered period. In the case where a patient with 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 MS-DRG payment amounts that would otherwise be made if this policy did not apply. The Secretary would then adjust the bundled payment to recoup these same amounts.

The Secretary would be directed to establish quality measures related to care provided across all providers participating in the pilot. These quality measures would be risk-adjusted and would include: episode of care measures; measures of improved functional status; rates of readmission; rates of preventable readmissions as defined in the readmissions policy; rates of return to the community; rates of admission to the ER after hospitalization (as distinctly separate from readmission rates); efficiency measures; measures of patient-centeredness of care; patient perception of care measures; measures to monitor and detect the under provision of necessary care; and other measures deemed appropriate by the Secretary.

The Secretary would be given the authority to delete, revise, and add quality measures as deemed appropriate related to the care being provided to patients within the pilot program. All providers who participate in pilot would be required to report to the Secretary on quality measures during each year of the program. At the discretion of the Secretary, to the extent practicable, these measures would be required to be reported through a qualified electronic health record in a manner prescribed by the Secretary.

The Secretary would be required to conduct an independent evaluation of the pilot program and submit an interim report to Congress no later than two years after date of implementation of the pilot program and a final report no later three years after date of the implementation. The evaluation would include an examination of the extent of performance improvement related to quality measures, health outcomes, access to care and financial outcomes.

If the Secretary finds that the pilot program results in either improvements in the quality of patient care without an increase in Medicare expenditures or a reduction in Medicare expenditures without a reduction in the quality of patient care, then the Secretary would be required to submit an implementation plan to Congress not later than January 1, 2016 with

recommendations regarding expansion of the pilot program by not later than January 1, 2018, to an extent determined appropriate by the Secretary.

The Secretary would also consult with representatives of small and rural hospitals, including critical access hospitals (CAHs), to determine appropriate and effective methods for hospitals to participate in the pilot program or in a similar pilot program. The Secretary would consider innovative methods of implementing bundling in these hospitals, including the challenges associated with the small volume of services provided to Medicare beneficiaries by these facilities. Not later than two years after the date of enactment of this Act, the Secretary would submit to Congress a report on the results of this consultation including recommendations with the respect to the appropriate application of bundling to small and rural hospitals, including CAHs.

Sec. 3024. Independence at Home Pilot Program.

Present Law

The Department of Veterans Affairs has been implementing a Home Based Primary Care (HBPC) program since 1972. HBPC provides comprehensive, interdisciplinary primary care in the homes of veterans with complex medical, social, and behavioral conditions for whom routine clinic-based care is not effective. HBPC targets frail, chronically ill veterans who require interdisciplinary health care teams, continuity, coordination of care, and the integration of diverse services to cover their complex medical, social, rehabilitative, and behavioral care needs. These veterans need comprehensive, longitudinal home care services as they age to maximize function, minimize institutionalization, and maintain quality of life. HBPC currently operates at over 130 locations in 48 states and Puerto Rico, and has shown substantial reductions in hospital days, nursing home days, and total costs of care.

Committee Bill

The Committee Bill would require the Secretary to conduct a Medicare pilot program, beginning no later than January 1, 2012, to test a payment incentive and service delivery model that utilizes physician and nurse practitioner directed home-based primary care teams designed to reduce expenditures and improve health outcomes in the provision of items and services to certain chronically ill Medicare beneficiaries. The pilot would be required to test whether such a model, which is accountable for providing comprehensive, coordinated, continuous, and accessible care to high-need populations at home and coordinating health care across all treatment settings, would result in the following goals of reducing preventable hospitalizations; preventing hospital readmissions; reducing emergency room visits; improving health outcomes commensurate with the beneficiaries' stage of chronic illness; improving the efficiency of care, such as by reducing duplicative diagnostic and laboratory tests; reducing the cost of Medicare health care services covered under this proposed legislation; and achieving beneficiary and family caregiver satisfaction.

The Secretary would enter into agreements with qualifying independence at home medical practices, legal entities comprised of an individual physician or nurse practitioner or group of physicians and nurse practitioners that provide care as part of a team that includes physicians,

nurses, physician assistants, pharmacists, and other health and social services staff, as appropriate. These practice staff would have experience providing home-based primary care services to applicable beneficiaries. The practice would be organized in part for the purpose of providing the services of a physician, who has the medical training or experience to fulfill the physician's role in the practice; would have documented experience in providing home-based primary care services to high-cost chronically ill beneficiaries; would have the capacity to provide services to at least 200 applicable beneficiaries; and would use electronic health information systems, remote monitoring, and mobile diagnostic technology.

Practice staff would make in-home visits, and be available 24 hours per day, seven days per week to implement care plans tailored to the individual beneficiary's chronic conditions and designed to reduce expenditures and improve health outcomes in the provision of items and services to applicable beneficiaries. The practice would be required to report on quality measures and other data, as specified by the Secretary. The Secretary would be required to develop quality performance standards for practices participating in the pilot program. A home-based primary care team could be led by a nurse practitioner or physician assistant, if such providers have the medical training or experience to fulfill these roles in the practice, comply with the requirements of this provision, and act consistently with State law.

The provision would not prohibit practices from including participating provider or practitioners that are affiliated with the medical practice under an arrangement structured so that such provider or practitioner would participate in the pilot program and share in any of its savings. A participating practitioner is defined as a physician assistant, nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, certified nurse-midwife, clinical social worker, clinical psychologist, or registered dietitian or nutrition professional.

The Secretary would establish a methodology for sharing savings with independence at home medical practices. Target spending levels for each practice would account for normal variation in expenditures for items and services covered under parts A and B for each participating independence at home medical practice based upon the size of the practice, characteristics of the enrolled individuals, and other factors the Secretary would determine to be appropriate. The Secretary would annually designate the total amount of savings achieved for beneficiaries enrolled in independence at home practices.

The Secretary would be required to establish how savings beyond the first five percent are to be apportioned among practices, taking into account the number of beneficiaries served by each practice, the characteristics of the individuals enrolled in each practice, the practices' performance on quality performance measures, and other factors as the Secretary determines appropriate. The Secretary must limit payments for shared savings to each practice so that aggregate expenditures for applicable beneficiaries would not exceed the amount that the Secretary estimates, less five percent, would be expended for such services for such beneficiaries enrolled in an independence at home medical practice if the pilot program had not been implemented.

An applicable beneficiary would be defined as an individual who the independence at home practice has determined:

(A) is entitled to, or enrolled for, benefits under part A and enrolled for benefits under Part B;

(B) is not enrolled in a Medicare Advantage plan C, a Program for All-Inclusive Care for the Elderly program, or an accountable care organization under section 1899 or any other shared savings program under Medicare;

(C) has two or more chronic illnesses, such as congestive heart failure, diabetes, dementias designated by the Secretary, chronic obstructive pulmonary disease, ischemic heart disease, stroke, Alzheimer's Disease and neurodegenerative diseases, and other diseases and conditions designated by the Secretary which result in high costs under this title;

(D) within the past 12 months has had a nonelective hospital admission and received acute or subacute rehabilitation services or skilled home care services;

(E) has two or more functional dependencies requiring the assistance of another person (e.g., bathing, dressing, toileting, walking, or feeding); and

(F) fulfills other criteria as the Secretary determines appropriate.

The Secretary would be required to determine a method to ensure that beneficiaries' have agreed to participate in an independence at home practice and that their agreement to participate is voluntary. Physicians or nurse practitioners must not take any elements of this proposed legislation as encouraging them to limit applicable beneficiary access to services covered under this title. Beneficiaries who do agree to participate do not relinquish access to any Medicare benefits as a condition of receiving services from a practice.

Agreements with practices under the program could cover a 3-year period. No independence at home practice participating in the accountable care organization pilot program or the medical home pilot program would be eligible to participate in this pilot program.

The Secretary would be required to give preference, in selecting practices, to medical practices in high costs areas of the country, that have experience in furnishing health care services to applicable beneficiaries in the home, and that use electronic medical records, health information technology, and individualized plans of care. The Secretary could waive certain provisions in the Social Security Act to implement this pilot program.

The Secretary would be required to enter into agreements with as many qualified independence at home practices as practicable to test the independence at home medical practice model to achieve cost reductions and improve health outcomes for applicable beneficiaries. When selecting qualified practices, the Secretary is required to limit to 10,000 the number of applicable beneficiaries allowed to participate in the pilot program.

The Secretary must evaluate each independence at home medical practice under the pilot program to assess whether the practice reduced preventable hospitalizations and hospital readmissions, reduced emergency room visits, improved health outcomes, improved the efficiency of care, reduced the costs of health care services, and achieved beneficiary and family caregiver satisfaction.

The Secretary must also conduct an independent evaluation of the pilot program and submit to Congress an interim and a final report. These reports would be required to include an analysis of best practices under the pilot program and the impact of the pilot program on coordination of care, expenditures under this title, access to services, and the quality of health care services provided to applicable beneficiaries, in addition to other areas as determined by the Secretary.

Subject to the evaluation of the pilot program contained in the interim and final reports to Congress, the Secretary may enter into additional agreements with practices to further test and refine models with respect to qualifying practices. If, and to the extent that, the practice models are beneficial to this pilot program and the Chief Actuary of the CMS certifies that the model would result in estimated spending that would be less than without the expansion, then the Secretary may issue regulations to implement, on a permanent basis, the independence at home practice model. In so doing, the Secretary, would take into account the evaluation of each independence at home practice and the evaluation of the pilot program contained in the interim and final reports.

For purposes of administering and carrying out the pilot program (other than for payments for items and services furnished under Medicare, shared savings and monthly fees, or other related payments such as interim payments), the provision would appropriate to the Secretary for CMS Program Management Account $5 million (from out of either general revenues or out of part A or B of the Medicare Trust Fund) for each of fiscal years 2010 through 2015. Amounts appropriated for a fiscal year would be available until expended.

Sec. 3025. Hospital Readmissions Reduction Program.

Present Law

Medicare pays for inpatient care provided by acute care hospitals using a prospectively determined payment for each discharge under section 1886(d) of the Social Security Act. Payment also depends on the relative resource use associated with a patient classification group, referred to as the Medicare Severity diagnosis related groups (MS-DRGs), to which the patient is assigned. Under Medicare's inpatient prospective payment system (IPPS), each MS-DRG is paid based on an estimate of the average resources needed to care for a patient with a specific diagnosis and set of care needs.

The Medicare program currently has payment policies in place related to how the Medicare program must reimburse hospitals in cases where Medicare beneficiaries are transferred between two hospitals through the course of their acute care episodes. Under the current transfer payment policy, the sending acute care hospital (the hospital that transfers the patient to another acute care hospital) is paid on a per diem basis at a level that can be no greater than the otherwise applicable full MS-DRG payment amount if the transfer meets certain conditions. The final discharging acute care hospital (the hospital that receives the patient) receives the full MS-DRG payment amount. Payment changes resulting from such transfers are implemented via Medicare's claims processing systems.

The Balanced Budget Act of 1997 (BBA, P.L. 105-33) directed the Secretary to apply the acute care transfer policy to a broader set of circumstances. Specifically, BBA directed the Secretary to select ten MS-DRGs with high volumes of discharges to post-acute care or disproportionate use

of post-acute services and pay these cases as transfers beginning in FY 1999. Post-acute care includes long-term care hospitals, inpatient rehabilitation facilities or distinct part units, psychiatric hospitals or units, skilled nursing facilities, and clinically related home health care provided within three days after the date of discharge. After FY 2000, the Secretary was authorized to expand this post acute care (PAC) transfer policy to additional MS-DRGs.

According to the Medicare Payment Advisory Commission's (MedPAC) *June 2007 Report to Congress*, analysis of 2005 Medicare data showed that 6.2 percent of hospitalizations of Medicare beneficiaries resulted in readmission within 7 days and 17.6 percent of hospitalizations resulted in readmission within 30 days. The 17.6 percent of hospital readmission accounts for $15 billion in Medicare spending. These readmission rates reflect the total number of readmissions, including those that may not have been related to the initial diagnosis and may not have been preventable. MedPAC, the Centers for Medicare and Medicaid Services (CMS), and others have expressed concern that providers do not have financial incentives to reduce potentially preventable readmissions. In addition, MedPAC, in its June 2008 report, recommended that Medicare's payments to hospitals with relatively high readmission rates for select conditions be reduced.

Committee Bill

Starting for discharges on October 1, 2012, the Secretary would establish a hospital readmissions reduction program for subsection(d) hospitals for certain potentially preventable Medicare inpatient hospital readmissions covering eight conditions with high volume or high rate (or both). Starting in FY2016 and in subsequent years, the list of conditions could be expanded, taking into account whether the condition has a high volume or high rate (or both) of potentially preventable inpatient readmissions or results in high Medicare spending.

Before the beginning of the fiscal year, the national average readmission rate related to each condition would be calculated. The rate would be the weighted average of all MS-DRGs related to the condition, risk-adjusted for patient severity and other appropriate patient characteristics. A hospital-specific readmission rate related to each condition would also be calculated with the same risk and other adjustments.

A readmission would be an individual who is discharged from a subsection (d) (or an acute care) hospital and admitted to the same or another hospital or critical access hospital within 30 days from the date of such discharge. A readmission would not include a planned readmission; a readmission related to major or metastatic malignancies, burn care or trauma care; a readmission of a patient where the original admission had discharge status of "left against medical advice"; and a transfer from another hospital.

For each fiscal year, all acute care hospitals would be ranked based on the national average and hospital-specific readmission rate for each selected condition for a specific period as determined by the Secretary. The quartile of hospitals with the highest readmission rates for each condition would be identified. Starting for discharges on October 1, 2013, if an individual is readmitted and the prior discharge is related to a condition selected for that fiscal year, the Medicare payment for the prior discharge would be reduced by an applicable percentage. The payment

adjustment for a discharge in a fiscal year would only apply to an acute care hospital in the highest readmission quartile for the condition for the fiscal year. Any payment reductions would only apply for the fiscal year involved and would not be taken into account in subsequent fiscal years. The applicable percentage reduction would be 20 percent for a readmission that occurs within 7 days of the prior discharge and would be 10 percent for a readmission that occurs within 15 days of the prior discharge.

Information on the readmission rates for each acute care hospital would be made publicly available after the hospital has the opportunity to review and submit corrections to the information. The information would be posted on the Hospital Compare website in an easily understandable format.

There would be no administrative or judicial review of the determination of the payment amount for the prior discharge; the methodology for selecting conditions, determining ranks**,** and making payment adjustments; the readmission reports provided to acute care hospitals; or the publicly available hospital readmission information.

Sec. 3026. Community-Based Care Transitions Program.

Present Law

No provision.

Committee Bill

Beginning in 2011, the Committee Bill would establish a five-year Community Care Transitions Program under Medicare. Under this program, the Secretary would fund eligible hospitals and community-based organizations to provide transition services to certain Medicare beneficiaries at risk of re-hospitalization or a substandard transition into post-hospitalization care. High-risk Medicare beneficiaries would include those beneficiaries who have attained a minimum hierarchical condition category score (specified by the Secretary) based on a diagnosis of multiple chronic conditions, including one of the following conditions: cognitive impairment, depression, a history of multiple hospital readmissions, and any other chronic disease or risk factor as determined by the Secretary.

Eligible hospitals would be those identified by the Secretary as having high readmission rates, such as above the 75th percentile for selected conditions. The Secretary would give priority for participation in the Community-Based Care Transitions Program to eligible community-based organizations and hospitals (that partner with community-based organizations) that provide services to medically underserved populations, small communities and rural areas. Applications by community-based organizations and hospitals to participate in this program would be required to propose at least one care transition intervention (this intervention could not include the discharge planning activities already required of Medicare-participating hospitals under Medicare's Conditions of Participation). Examples of such interventions 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. Arranging timely post-discharge follow-up to educate patients and, as appropriate, the primary caregiver, about responding to health symptoms that may indicate additional health problems or a deteriorating condition;

3. Assisting patients and caregivers in ensuring productive and timely interactions with post-acute and outpatient providers;

4. Assessing and actively engaging with a beneficiary and caregiver through the provision of self-management support and relevant information that is specific to the beneficiary's conditions; and

5. Conducting comprehensive medication review and management, including self-management support, if appropriate.

A total of $500 million would be transferred by the Secretary from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund for this program and would be required to remain available until expended. The Secretary would have the authority to continue or expand the scope and duration of the program if the Secretary determined that expansion would improve quality of care and the CMS Office of the Actuary certifies that expansion would reduce projected Medicare spending.

Sec. 3027. Extension of Gainsharing Demonstration.

Present Law

Section 5007 of the Deficit Reduction Act of 2005 (DRA, P.L.109-171) authorizes a gainsharing demonstration to evaluate arrangements between hospitals and physicians designed to improve the quality and the efficiency of care provided to beneficiaries. In the absence of this DRA authority, gainsharing arrangements are restricted by the Civil Monetary Penalty law. CMS is currently operating two projects, each consisting of one hospital in New York and West Virginia. Although authorized to begin on January 1, 2007, the project began on October 1, 2008 and will end as mandated on December 31, 2009. The Secretary was required to submit a report on quality improvement and achieved savings as a result of the demonstration no later than December 1, 2008. The final report on these issues was due on May 1, 2010. The project was appropriated $6 million in FY2006 to be available for expenditure through FY2010.

Committee Bill

The authority to conduct the gainsharing demonstration project in operation as of October 1, 2008 would be extended until September 30, 2011. The due date of the quality improvement and achieved savings report would be extended from December 1, 2008, to March 31, 2011. The final report would be due March 31, 2013, instead of May 1, 2010. An additional $1.6 million

would be appropriated in FY2010. All appropriations would be available for expenditure through FY2014 or until expended.

PART IV – Strengthening Primary Care And Other Workforce Investments

Sec. 3031. Expanding Access to Primary Care Services and General Surgery Services.

Present Law

Medicare uses a fee schedule to reimburse physicians for the services they provide. In certain circumstances, physicians receive an additional payment to encourage targeted activities. These bonuses, typically a percentage increase above the Medicare fee schedule amounts, can be awarded for a number of activities including demonstrating quality achievements, participating in electronic prescribing, or practicing in underserved areas.

Section 1833(m) of the Social Security Act provides bonus payments for physicians who furnish medical care services in geographic areas that are designated by the Health Resources and Services Administration (HRSA) as primary medical care health professional shortage areas (HPSAs) under section 332 (a)(1)(A) of the Public Health Service (PHS) Act. In addition, for claims with dates of service on or after July 1, 2004, psychiatrists furnishing services in mental health HPSAs are also eligible to receive bonus payments.

The bonus payment equals ten percent of what would otherwise be paid under the fee schedule. HPSAs may be designated as having a shortage of primary medical care, dental or mental health providers. They may be urban or rural areas, population groups or medical or other public facilities.

Committee Bill

The Committee Bill would establish a new 10 percent bonus on select evaluation & management codes under the Medicare fee schedule for five years, beginning January 1, 2011. The groups of codes to which this bonus would apply would be office visits, home visits, nursing facility visits, and domiciliary, rest home (e.g. boarding home), or 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 nurse practitioners, clinical nurse specialists or physician assistants; and (2) furnish 60 percent of their services in the select primary care service codes. The following healthcare common procedure coding system (HCPCS) services, identified as of January 1, 2009, would be considered primary care services: (i) 99201 through 99215 (office visits); (ii) 99304 through 99340 (nursing facility care, domiciliary, rest, or home visits and custodial care); and (iii) 99341 through 99350 (home visits and services). The Secretary could subsequently modify this list. The bonus payments under this subsection and under the physician quality reporting program would each be determined independently.

In addition, general surgeons (physicians who have designated general surgery as their primary specialty code in their application for the submission of Medicare claims) who provide care in a HPSA 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 (by modifying the conversion factor for all codes), except for physicians who primarily provide services in a HPSA zip code.

Sec. 3031A. Medicare Federally Qualified Health Center Improvements.

Present Law

A Federally qualified health center (FQHC) is a type of provider defined by the Medicare and Medicaid statutes. FQHCs include all organizations receiving grants under section 330 of the Public Health Service Act (PHSA), clinics that have been certified as meeting such requirements (called FQHC Look-Alikes) or outpatient facilities that are operated by tribal organization or urban Indian organizations.

FQHC services are defined by Medicare statute as rural health clinic services (such as physician services, those provided by physician assistants, nurse practitioners, nurse midwives, visiting nurses, clinical psychologist or social workers and related services and supplies), diabetes outpatient self-management training services, medical nutrition therapy services and preventive primary health services required under section 330 of the PHSA. The preventive services as defined by the PHSA include prenatal and perinatal services; appropriate cancer screening; well-child services; immunizations against vaccine-preventable diseases; screenings for elevated blood lead levels, communicable diseases, and cholesterol; pediatric eye, ear, and dental screenings to determine the need for vision and hearing correction and dental care; voluntary family planning services; preventive dental services.

FQHCs receive cost-based reimbursement from Medicare, subject to a per-visit payment limit and certain productivity standards. Medicare pays FQHCs on an interim basis for covered services furnished to beneficiaries using an all-inclusive rate for each visit (except for certain vaccines which are paid on a cost basis). Generally, the FQHC's final payment rate is calculated by dividing the FQHC's total allowable cost for such services by the total visits which is subject to the maximum per-visit payment limit. The payment limits are increased each year by the Medicare Economic Index (MEI) and are different for urban and rural FQHCs. The upper payment limit per visit for urban FQHCs is $119.29 starting January 1, 2009, through December 31, 2009 and per visit limit for rural FQHCs is $102.58 effective January 1, 2009.

As established by the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA, P.L. 108-173) the Centers for Medicare & Medicaid Services (CMS) provides supplemental payments to FQHCs that contract with Medicare Advantage (MA) organizations to cover the difference, if any, between the payment received by the FQHC for treating MA enrollees and the payment to which the FQHC would be entitled to receive under the cost-based all-inclusive payment rate. An FQHC is only eligible to receive this supplemental payment when FQHC services are provided during a face-to-face encounter between an MA enrollee and one or more of the following FQHC covered core practitioners: physicians, nurse practitioners,

physician assistants, certified nurse midwives, clinical psychologists, or clinical social workers. The supplemental payment is made directly to each qualified FQHC by the Medicare contractor.

Committee Bill

Effective for services starting on January 1, 2011, the Committee Bill would expand the statutory definition of FQHC services to include the Medicare definition of preventive services at 1861(ddd)(3) that would be established in Sec. 2002 of this legislation. These services would include screening and preventive services (other than electrocardiograms), an initial preventive physical examination, and personalized prevention plan services.

The Committee Bill would also change Medicare's payments to FQHCs. For services starting January 1, 2012, during the fiscal year that ends in 2012), an FQHC would be paid a rate based on the average of its reasonable costs of providing services during 2010 and 2011, subject to appropriate tests of reasonableness, but not per visit payment limits or productivity screens. These payments, except for certain vaccine services, would not exceed 80 percent of the costs. Services furnished during the FQHC's fiscal year during 2013 (and succeeding years) would be paid on an amount calculated on a per visit basis (without application of productivity screens or per visit limits) increased by the MEI applicable to primary care services. The update amount for an FQHC's fiscal year during 2014 (and succeeding years) would be the percentage increase in a market basket index of FQHC costs as developed by the Secretary and established during the rule making process. FQHC payments would be adjusted to account for any increase or decrease in the scope of services, including a change in the type, intensity, duration, or amount of services furnished by the center during the fiscal year less any applicable copayment amounts. Other than certain vaccine services, Medicare's payment for FQHC services would not exceed 80 percent of the established payment amount (without regard to coinsurance amounts which are established at 20 percent charges.) Payment rules would be established for entities that first qualify as FQHCs in fiscal years after 2011. Medicare's supplemental payments to FQHC services provided to a beneficiary enrolled in a MA plan would continue at 100 percent of the established FQHC payment amount**.**

Sec. 3032. Distribution of Additional Residency Positions.

Present Law

Medicare pays for the costs of graduate medical education (GME) in teaching hospitals through an indirect medical education (IME) adjustment within its inpatient prospective payment system (IPPS) and direct graduate medical education (DGME) payments made outside of the IPPS. With certain exceptions, the Balanced Budget Act of 1997 (BBA, P.L. 105-33) limited the number of allopathic and osteopathic residents that Medicare would reimburse a teaching hospital at the level reported in its cost report ending on or before December 31, 1996. The limit does not include dental or podiatry residents.

The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA, P.L. 108-173) authorized the redistribution of up to 75 percent of each teaching hospital's unused resident positions to hospitals seeking to increase their medical residency training programs.

Any adjustments made to teaching hospitals' resident limits would be permanent. Rural teaching hospitals with less than 250 beds were exempt from the redistribution of any of their unfilled positions. Under the redistribution program, teaching hospitals were allowed to request up to an additional 25 full time equivalent (FTE) positions for DGME and IME payments. Hospitals were required to demonstrate the likelihood that the redistributed positions would be filled within three cost reporting periods beginning July 1, 2005. MMA required that the unused slots be redistributed according to specific priorities: rural hospitals, urban hospitals located in areas with a population of one million or less, specialty training programs that are the only specialty program in a state, and all other hospitals. The redistribution was effective for portions of cost reporting periods starting July 1, 2005. The redistributed resident slots have different IME and DGME payment formulas from those used to reimburse hospitals' previous residents.

Committee Bill

The Secretary would reduce the otherwise applicable resident limit for a teaching hospital that has residency positions that are unused. Unused positions would be established when a hospital's reference residence level is less than its otherwise applicable resident limit. The reduction would be effective for portions of cost reporting periods occurring on or after July 1, 2011 and would equal 65 percent of the difference between a hospital's reference level and its limit. Rural teaching hospitals with less than 250 beds would be exempt from the redistribution of any of their unfilled positions. Hospitals who had an approved voluntary reduction plan under Section 1886 (h)(6) would also be exempt from the redistribution policy if they demonstrate that they have a specified plan in place for filling the unused residency positions within two years of enactment of this legislation.

A hospital's reference residence level would be established as determined appropriate by the Secretary.

The Secretary would be required to increase the otherwise applicable resident limit for each qualifying hospital that submits a timely application by such number determined by the Secretary. The aggregate number of increases in resident limits would be equal to the estimated aggregate reduction in resident limits. A hospital that receives an increase in its otherwise applicable resident limit would be required to ensure during a five year period beginning on the date of the increase that (1) the number of FTE primary care residents as determined by the Secretary is not less than the average number of FTE primary care residents during the three most recent cost reporting periods ending prior to the date of enactment; and (2) that not less than 75 percent of the positions attributable to such an increase are in a primary care or general surgery residency as determined by the Secretary.

The Secretary would determine whether a hospital has met the requirements during the five year period in an appropriate manner and time, including at the end of the period.

A hospital that does not meet these requirements would have its otherwise applicable resident limit reduced by the amount of the increase authorized under this provision. Those positions would be subsequently distributed according to the priorities established in this provision.

When determining the increase in a hospital's otherwise applicable resident limit, the Secretary would take into account: (1) the demonstrated likelihood that a hospital would fill the positions within the first three cost reporting periods beginning on or after July 1, 2011; (2) whether a hospital would take part in an innovative delivery model that promotes quality and care coordination; and (3) whether a hospital would have an accredited rural training track residency program.

The Secretary would distribute the increase in the otherwise applicable resident limit based on the following factors: (1) to hospitals located in states with resident-to-population ratios in the lowest quartile; (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 (HPSA) determined by the Department of Health and Human Services as of the date of enactment compared to total population of the state based on the most recent state population projections by the Census Bureau; and (3) to hospitals located in rural areas.

From the pool of available slots, 70 percent of such slots would be reserved and distributed to hospitals in states meeting the first criteria, (those with low resident-to-population ratios). The remaining 30 percent of slots would be reserved and distributed to those hospitals in states meeting the second and third criteria (to hospitals in the ten states with highest proportion of population living in health professional shortage areas and hospitals located in rural states). Any resident positions that are not allocated within one year from the date of enactment from a given category may be distributed to hospitals in the other category in accordance with the above considerations and priorities.

Hospitals would not receive more than 75 additional FTE residency positions under this provision. The increase in resident positions would be distributed no later than three years after the date of enactment.

The per resident amounts (PRAs) for the resident positions distributed under this provision would equal the hospitals PRAs for primary and non-primary care positions for the purposes of calculating direct graduate medical payments. The indirect medical education adjustment for these resident positions distributed under this provision would be reimbursed at the full IME adjustment factor.

Sec. 3033. Counting Resident Time in Outpatient Settings and Allowing Flexibility for Jointly Operated Residency Training Programs.

Present Law

Medicare currently reimburses the direct costs of graduate medical education (DGME) for approved residency training programs in a non-hospital setting where the residents' activities relating to patient care are performed as long as the hospital incurs all, or substantially all, of the costs for the training program in that setting. Through regulation, CMS has defined all, or substantially all costs, as 90 percent of resident stipends and fringe benefits and costs associated with a supervising physician. However, as presently administered, a hospital that jointly operates a residency program with another hospital cannot include the time spent by residents

working at a non-hospital site if it incurs, all or substantially all of the costs, for only a portion of the residents in that program at the non-hospital site.

Committee Bill

Effective for cost reporting periods beginning on or after July 1, 2010, all time spent by a resident would count toward Medicare's DGME 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.

Effective for discharges on or after July 1, 2010, all the time spent by a resident in patient care activities in a non-hospital setting would be counted towards Medicare's IME 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.

An eligible training site would be an ambulatory or non-hospital training site. A jointly operated residency training program means an approved medical residency training program that is jointly operated by one or more hospitals or by one or more eligible training sites under a written agreement which specifies a method for an equitable distribution of time spent by the resident in activities relating to patient care.

Each hospital or eligible training site participating in the operation of a jointly operated residency training program would submit the written agreement to the Secretary. In the case of a jointly operated residency training program, the direct graduate medical education and the indirect medical education payments would not exceed the aggregate payments that would have been made to the hospitals and the eligible training sites if the training program had been independently operated.

The provisions would not be implemented in a manner that would require reopening of any settled hospital cost reports where there is not a jurisdictionally proper appeal pending on IME and DGME payments as of the date of enactment.

Sec. 3034. Rules for Counting Resident Time for Didactic and Scholarly Activities and Other Activities.

Present Law

Medicare pays teaching hospitals the costs of approved medical residency training programs through two mechanisms: an indirect medical education (IME) adjustment within the inpatient prospective payment system (IPPS) and direct graduate medical education (DGME) payments made outside of the IPPS. Certain non-patient care activities that are part of an approved training program are not allowable for DGME or IME payment purposes. With respect to training that occurs in hospital settings, Medicare would not include the time that residents spend in non-patient care activities, including didactic activities, when calculating IME payments; these

activities would be included when calculating DGME payments in hospital settings. With respect to training that occurs in non-hospital settings, Medicare would not count the time that residents spend in non-patient care activities, including didactic activities, when calculating DGME or IME payments.

Committee Bill

When calculating DGME payments, Medicare would count the time that residents in approved training programs spend in certain non-patient care activities in a non-hospital setting that is primarily engaged in furnishing patient care. The term "non-hospital setting that is primarily engaged in furnishing patient care" would be a non-hospital setting in which the primary activity is the care and treatment of patients as defined by the Secretary. 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 approved leave spent by resident in an approved training program as long as the leave time does not extend the program's duration.

When calculating IME 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 and seminars, but not in certain research activities that are not associated with the treatment or diagnosis of an particular patient) if the hospital is an IPPS hospital, a hospital paid under the IPPS for Puerto Rico, is a hospital paid under a state specific hospital reimbursement system, or is a provider-based hospital outpatient department.

These provisions would be effective as of dates determined appropriate by the Secretary, but would not be applied in a manner that would require reopening of any settled hospital cost reports where there is not a jurisdictionally proper appeal pending on IME and DGME payments as of the date of enactment.

Sec. 3035. Preservation of Resident Cap Positions from Closed and Acquired Hospitals.

Present Law

The Centers for Medicare and Medicaid Services (CMS) has established certain regulations governing Medicare's provider enrollment requirements that determine under which circumstances providers can bill the Medicare program including those involved in change of ownership transactions. Very generally, in order to acquire a teaching hospital's resident cap under a change of ownership transaction, the acquiring entity must retain the original provider number. However, the acquiring entity would also assume all liabilities associated with that provider number.

Starting August 29, 2005 (the day after Hurricane Katrina), hospitals were permitted to form emergency affiliation agreements if located in Federally declared disaster areas starting the first day of a Section 1135 emergency period. Under 42 Code of Federal Regulations (CFR) 413.79, a

home hospital located in such an area that experiences at least a 20 percent decline in inpatient occupancy can temporarily transfer its resident cap to a host hospital.

Committee Bill

The Secretary would promulgate regulations to establish a process where the residency allotments in a hospital with an approved medical residency program that closes on or after the enactment date for Balanced Budget Act of 1997 (BBA, P.L. 105-33) 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. First priority would be given to hospitals located in the same or contiguous core-based statistical area as the hospital that closed; second priority would be given to hospitals located in the same State as the hospital that closed; third priority would be given to hospitals located in the same region of the country as the hospital that closed; and fourth priority, to be used only if the residents are not distributed under the other priorities, would be the priorities established for the distribution of additional residency positions established previously in this legislation. Preference would be given within each category to hospitals that are members of the same affiliated group. The residency positions would be distributed to those hospitals that demonstrate a likelihood of filling the position within three years. The aggregate increase in hospitals' applicable resident limits would equal the number of resident positions in applicable approved medical programs that closed.

A special rule for acquired hospitals would be established. Specifically, when a hospital is acquired through any mechanism by another entity with approval of a bankruptcy court during a period determined by the Secretary, but not less than within three years, the applicable resident limit of the acquired hospital would be the limit of the acquired hospital as of the date immediately before the acquisition. The acquiring entity would be required to continue operation of the hospital that was acquired and to furnish services, medical residency programs, and the volume of patients similar to those of the hospital that was acquired during such period. This provision would apply only to instances where the acquiring entity waives the right to establish a resident limit as a new teaching program.

The provisions would not be implemented in a manner that would require reopening of any settled hospital cost report where there is not a jurisdictionally proper appeal pending on Medicare's IME and DGME payments as of the date of enactment.

The Secretary would give consideration to the effects of these provisions on the temporary adjustment to a hospital's FTE resident cap established under 42 CFR 413.79 as in effect on the date of enactment in order to assure that there is no duplication of FTE slots. These provisions would have no affect on resident reference limit for the replacement hospital for the former Martin Luther King Jr. Hospital.

Sec. 3036. Workforce Advisory Committee.

Present Law

No provision.

Committee Bill

The provisions would require the Secretary of HHS to establish a Workforce Advisory Committee (the "Committee") comprised of members appointed by the Secretary among specified groups. No later than a date determined appropriate by the Secretary, the Committee would be required to develop and submit to Congress and the heads of relevant Federal agencies a national workforce strategy to recruit, train, and retain a health care workforce that meets the current and projected health care needs of the United States. The Committee would be required to consult with the heads of relevant Federal agencies, as specified, and with State and local entities in developing such national workforce strategy.

The Committee would be required to conduct a study on the U.S. health care workforce. Such study shall include an analysis of, at minimum: the current and projected health care workforce supply; the current and projected demand for health professionals; the capacity of education and training for the health care workforce; the implications of current and proposed Federal laws and regulations affecting the health care workforce; and the health care workforce needs of specific populations, including minorities, rural and urban populations and medically underserved populations.

On a biannual basis, the Committee would be required to submit to Congress and the heads of relevant Federal agencies a report containing results from this study with recommendations for legislation and administrative action, as determined appropriate.

The Committee would also be required to conduct studies on specific high-priority topics, as described, and submit to Congress and the heads of relevant Federal agencies a report containing the results of each study with recommendations for such legislation and administrative action, as determined appropriate. The Committee would be required to make the biannual report and each study of high-priority topics available to the public.

Sec. 3037. Demonstration Projects to Address Health Professions Workforce Needs; Extension of Family-to-Family Health Information Centers.

Present Law

Existing health professions education and training programs authorized under Title VII of the PHSA provide funding to medical schools and other facilities to promote community-based and rural practice, primary care, and opportunities for minorities and disadvantaged students. Title VIII of the PHSA authorizes a comparable set of programs to promote nursing education and training. Appropriations authority for most Title VII and VIII programs has expired, though many of them continue to receive funding.

There are no Federal requirements related to training personal or home care aides. The Medicare program does not cover personal care attendant services. States may choose to offer personal

care services through their Medicaid state plan and/or Medicaid waiver programs. For states that offer Medicaid-funded personal care services, the State Medicaid Manual requires them to develop provider qualifications for personal care aides. The manual does not list specific qualifications, but rather offers examples of areas where states may establish requirements including: criminal background checks or screens for attendants before they are employed; training for attendants; use of case managers to monitor the competency of personal care providers; and/or establishment of minimum requirements related to age, health status, and/or education.

Section 501(c)(1)(A)(iii) of the SSA authorizes sums to be appropriated for the purpose of enabling the Secretary (through grants, contracts, or otherwise) to provide for special projects of regional and national significance for the development and support of family-to-family health information centers. Specifically, there is appropriated to the Secretary, out of any money in the Treasury not otherwise appropriated: $3 million for FY2007; $4 million for FY2008; and $5 million for FY2009.

Committee Bill

The Committee Bill establishes demonstration grants to address needs in the health professions workforce. It would establish a demonstration grant program through competitive grants to provide aid and supportive services to low-income individuals with the opportunity to obtain education and training for occupations in the health care field that pay well and are expected to experience labor shortages or be in high demand. These grants would be made by the Secretary of Health and Human Services, in consultation with the Secretary of Labor, to states, Indian tribes, tribal organizations, institutions of higher education, local workforce investment boards under the Workforce Investment Act, or community-based organizations. At least three grants must be awarded to an Indian tribe, Tribal organization, or Tribal College or University. Grantees must consult with the state agency administering the Temporary Assistance for Needy Families (TANF) block grant, and, if the grantee is not a local workforce investment board, consult with local and state workforce investment boards. The demonstration grant is to serve low-income persons, including recipients of assistance under state Temporary Assistance for Needy Families (TANF) programs. The demonstration program shall provide eligible individuals, if appropriate, with financial aid; child care, case management; and supportive services. Financial aid, services, or incentives received from the demonstration program shall not be considered income, and shall be disregarded in determining eligibility for TANF, Medicaid, the Supplemental Nutrition Assistance Program (SNAP), Low Income Home Energy Assistance Program, and any program administered by the Department of Housing and Urban Development. Grantees must submit interim reports and a final report to the Secretary of HHS on their activities, which will assess the project's effectiveness in improving outcomes for participants and address health professions workforce needs in the project areas. The Secretary of HHS must evaluate the demonstration project. The evaluation will identify successful activities for creating and sustaining a health professions workforce that has accessible entry meets, meets high standards for education, training, certification and professional development; and provides increased wages, health care coverage, and other benefits for the workers. The Secretary of HHS shall submit interim and final reports on the demonstration to Congress.

The Committee Bill also establishes a demonstration program to competitively award grants to up to six states for three years to develop core training competencies and certification programs for personal and home care aides. In selecting states to participate, the Secretary will establish criteria to ensure geographic and demographic diversity. In addition, a state must offer medical assistance for personal care services under its Medicaid state plan, not reduce the number of hours of training from pre-demonstration levels or below levels required by state or Federal law; and recruit a minimum number of health and long term care providers to participate in the project. Participating states must demonstrate that their existing training standards are different from other states and different from the competencies described in the demonstration.

The demonstration will determine the efficacy of developing core training competencies in the following areas: the role of the personal or home care aid; consumer rights, ethics, and confidentiality; communication, cultural, and linguistic competence and sensitivity, problem solving, behavior management, and relationship skills; personal care skills; health care support; nutritional support; infection control; safety and emergency training; training specific to an individual consumer‘s needs; and self-care. The project will also evaluate the methods used to implement these competencies including: length of training; appropriate student to trainer ratio; time spent in the classroom compared to on-site; trainer qualifications; content for hands-on training and written certification exam; and continuing education requirements. The Secretary of Health and Human Services will develop an experimental or control group testing protocol, in consultation with an independent evaluation contactor, to evaluate the impact of core training competencies on: job satisfaction; mastery of job skills; beneficiary and family satisfaction with services; and on existing training infrastructure and resources of the States. The evaluation must also address whether a minimum number of hours of initial training should be required for personal or home care aides. The Secretary will make an interim report to Congress within two years after enactment and a final report within a year of completion of the demonstration project.

The Committee Bill appropriates $85 million per year for five years (FY2010-FY2014) for these demonstrations, with no more than $5 million per year for three years (FY 2010-FY2012) allowed for the personal and home care aid demonstration.

Extension of Family-to-Family Health Information Centers

Present Law

The Deficit Reduction Act of 2005 (DRA, P.L. 109-171) provided dedicated funding for the development and support of family-to-family health information centers. The centers 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; provide information regarding the health care needs of children with disabilities or special health care needs; identify successful health delivery models for such children; develop models of collaboration between families of such children and health professionals; provide training and guidance with regard to the care of such children; and conduct outreach activities to families of such children, health care providers, schools, and other appropriate entities and individuals. Family-to-family health information centers are staffed by members of families with expertise in Federal, State and private health systems and health

professionals. In Fiscal Year 2009, family-to-family health information centers are funded at $5 million. No funds are appropriated for years after FY2009.

Committee Bill

The Chairman‘s Mark would extend funding for family-to-family health information centers at $5 million per year for FY2010 through FY2012.

Sec. 3038. Increasing Teaching Capacity.

Present Law

Under Section 747 of the Public Health Service Act (PHSA), the Secretary may, among other things, make grants to or enter into contracts with hospitals, medical and osteopathic schools, and other nonprofit entities for health professions training programs in family medicine, general internal medicine, or general pediatrics, and comparable programs in dentistry. When making awards under this section the Secretary is required to give preference to programs that would establish or expand training programs and to entities that collaborate with departments of primary care. It also specifies that for programs that propose to train residents, the Secretary is required to give priority to programs that have a high or recently improved record of training graduates who remain in primary care practice and who have a record of training individuals from disadvantaged backgrounds. Authority for appropriations for these grants or contracts expired at the end of FY2002.

Sections 751 and 752 of the PHSA authorizes the Area Health Education Centers (AHEC) program that may fund community-based residency training. The AHEC program provides grant funding to schools of medicine and schools of osteopathic medicine, and consortia of such schools, or the parent institutions of such schools for the planning, development and operation of the AHEC program. AHECs aim to improve the supply, diversity, quality and distribution of health personnel. Among other activities, AHEC funds may be used to support community-based primary care residency programs, but are currently not connected to Medicare GME payments. The appropriations authority for the AHEC program expired at the end of FY2002.

Sections 331, 338A, 338B, and 338I of the PHSA authorize the National Health Service Corps (NHSC), administered by the Health Resources and Services Administration. The NHSC provides scholarship and loan repayment programs for medical school students, nurse practitioners, nurse midwives, physician assistants, dental school students, and allied health professionals who enter primary care in health professional shortage areas (HPSAs). NHSC clinicians may fulfill their service commitments in health centers, rural health clinics, public or nonprofit medical facilities, Federal or state correctional facilities, or within other community-based systems of care. Section 338D specifies the conditions by which NHSC clinicians can obtain a waiver from their NHSC commitment in order to fulfill their service obligation in a private practice located in HPSA.

With respect to the Medicare law, the costs of approved residency training programs in teaching hospitals are recognized under two payment mechanisms: an indirect medical education (IME)

adjustment within the inpatient prospective payment system (IPPS) and direct graduate medical education (DGME) payments made outside of the IPPS. With certain exceptions, the Balanced Budget Act of 1997 (BBA; P.L. 105-33) limited the number of allopathic and osteopathic residents that Medicare will reimburse at the level reported by the hospital in its most recent cost report ending on or before December 31, 1996. Rural teaching hospitals, hospitals that established new training programs before August 5, 1997, and urban teaching hospitals that operate certain rural residency training programs are partially exempt from the cap. Other restrictions apply to hospitals with new programs established after that date.

BBA permitted the Secretary to make Medicare payments directly to "qualified nonhospital providers" who incur direct teaching costs in the operation of an approved medical residency training program. Prior to this, only hospitals could receive Medicare teaching payments for residents training in nonhospital sites. BBA stated that the definition of a qualified nonhospital provider must include Federally Qualified Health Centers (FQHCs), Rural Health Centers (RHCs), Medicare Advantage organizations and "other such entities as the Secretary deems to be appropriate." Any qualified nonhospital provider would only receive direct graduate medical education payment and not indirect medical education payments.

The Health Care Financing Administration (HCFA), now CMS, promulgated a final rule in 1998 that designated FQHCs, RHCs, and Medicare+Choice organizations as "qualified nonhospital providers" that are eligible to receive direct teaching payments. These payments became effective for portions of cost reporting periods occurring on or after January 1, 1999. The payments are made only if the nonhospital provider incurs "all or substantially all" of the costs of the training program in the nonhospital setting. The definition of "all or substantially all" is the same as used for determining when a hospital is eligible for payment.

Committee Bill

The provision would amend the Public Health Service Act (PHSA) to insert a new section.

Sec. 749. Teaching Health Centers Development Grants.

The new section would authorize the Secretary to establish a grant program to award funds to teaching health centers to establish newly accredited or expanded primary care residency training programs. The provision would require that grants be awarded for not more than 2 years with the maximum award of $500,000. Grantees would be required to use funds for: costs associated with curriculum development; recruitment, training and retention of residents and faculty; accreditation (by either the Accreditation Council for Graduate Medical Education or the American Osteopathic Association); and faculty salaries during the development phase. Funds for technical assistance provided by an eligible entity would be required to be used for materials development; staff salaries; travel; and administrative costs.

Entities would be required to submit an application to the Secretary in such time, in such manner, and containing such information as the Secretary may require. The Secretary would be required to give priority to funding training programs at FQHCs, RHCs, Indian health centers, and to newly established residency programs, integrated rural training programs, rural training tracks,

and to residencies with a mission to train physicians for rural and underserved practice. The Secretary would be required to give further preference to applications that document an existing affiliation agreement with an AHEC as defined in PHSA Sec. 751 and 799B.

The provision would define "eligible entity" to mean an organization capable of providing technical assistance including an AHEC as defined in PHSA Sec. 751 and 799B; and "primary care residency program" to mean an approved medical residency program under SSA Sec. 1886(h)(5)(A) in the fields of family medicine, general pediatrics, general internal medicine, or obstetrics and gynecology.

It would also define "teaching health center" to mean a facility that is a community-based, ambulatory patient care center; and is establishing or expanding a primary care residency program as defined by SSA Sec.1886(h)(5)(A) in a high-need specialty as determined by the Secretary. The definition also includes FQHCs, community health centers, health care for the homeless centers, RHCs, migrant health centers, Native American health centers operated by the Indian Health Service, an Indian tribe or tribal organization, and other not-for-profit community-based clinical entities.

There would be authorized to be appropriated $25 million for FY2010, $50 million for FY2011 and FY2012, and such sums as may be necessary for each fiscal year thereafter. No more than $5 million annually may be used for technical assistance program grants.

The provision would also amend PHSA Sec. 338C(a) to allow up to 50 percent of the time spent teaching to count as full-time service for the purpose of fulfilling the contractual NHSC service obligation for scholarship or loan repayment. This provision would not apply to individuals who are fulfilling their NHSC service requirement through work in private practice.

The Medicare statute would also be modified to permit payments to qualified teaching health centers for direct and other indirect expenses associated with operating approved graduate medical residency training programs. Such programs are operated by a qualified teaching health center that meets criteria for accreditation as established by 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. These payments would be in addition to any indirect or direct graduate medical education payments made to teaching hospitals and would not count against the limitation on the number of total full time equivalent residents paid for by Medicare in teaching hospitals. A total of $230 million would be transferred from the Medicare Part A Hospital Insurance trust fund for purposes of the program and would be available until expended from FY2011 to FY2015.

Both "approved graduate medical residency training programs" and "direct medical education costs" would be defined according to the Medicare statute. A primary care residency program would be an approved medical residency program in family medicine, internal medicine, pediatrics, medicine-pediatrics, obstetrics and gynecology, psychiatry and geriatrics. A qualified

teaching health center would be an entity that is a community based, ambulatory patient care center and operates a primary care residency program. These would include Federally qualified health centers, community mental health centers, a community health center, health care for the homeless centers, rural health centers, migrant health centers, health centers operated by the Indian Health Service, Indian tribes and tribal organizations, or urban Indian organizations, and Title X clinics.

Sec. 3039. Graduate Nurse Education Demonstration Program.

Present Law

Title VIII of the Public Health Service Act (PHSA) contains several provisions on nursing workforce development, including programs to support graduate nurse education and training. Section 811 of the PHSA authorizes the Secretary to provide Advanced Education Nursing Grants to qualified entities to fund projects that support the enhancement of advanced nursing and practice, and traineeships for individuals in advanced nursing programs. Section 831 authorizes the Secretary to provide Nurse Education, Practice, and Retention Grants to qualified entities to expand nursing education, practice and retention.

Section 801 of the PHSA defines a school of nursing to mean a collegiate, associate degree, or diploma school of nursing. The section defines "accredited" to mean a program, hospital, school, college or university or unit thereof, accredited by a recognized body or bodies, or by a State agency, approved for such purpose by the Secretary of Education that is included on the list that the Secretary is required to publish of such accrediting bodies.

Medicare will pay hospitals for the costs associated with provider-operated nursing or allied health education programs on a pass-through basis. To be eligible for these payments, the training program must be recognized by a nationally approved body or state licensing organization. Also, the provider must directly incur the training costs, directly control the program curriculum; control the administration of the program; employ the teaching staff; and provide and control both the necessary classroom instruction and clinical training. In some circumstances, hospitals that do not directly operate a health training program may receive payments for the net costs of training they incur if they received payment for these services in 1989 and if other requirements are met. Net costs are determined by deducting tuition, student fees, and state and local grants from a provider's total education costs. In 2001, MedPAC reported that Medicare spends about $300 million for the costs associated with training nurses and allied health professionals,.

Committee Bill

Fifty million dollars would be appropriated from the Hospital Insurance Trust Fund each fiscal year from 2012 through 2015 for the establishment of a graduate nurse education demonstration program in Medicare. These funds would be available until spent. The Secretary would assure that only those appropriated funds are used for the conduct of this demonstration.

Starting January 1, 2012, the Secretary would establish a demonstration program to increase the supply of highly skilled advanced practice nurses. Participating hospitals would receive reasonable costs reimbursement from Medicare for the educational costs (including faculty salaries, any student stipends, clinical instruction costs, and other direct and indirect costs) of a hospital and affiliated schools attributable to the training of advanced practice nurses. Costs would be limited to those associated with an increase in the enrollment and the number of advanced practice nurse graduates in each education or training program over the comparable average number from 2006 to 2010.

The demonstration program would provide these nurses with the necessary skills to provide primary and preventive care, transitional care, chronic care management, and other appropriate nursing services through affiliation with one or more accredited nursing schools and in partnership with two or more non-hospital community-based patient care settings where at least half of all clinical training occurs. The Secretary would be able to waive the requirement for affiliation with accredited nursing schools for clinical training of advanced practice registered nurses in rural and medically underserved areas.

No payment would be made to a hospital unless the hospital has in effect an enforceable legal agreement with the schools of nursing and non-hospital settings. These hospitals would also be required to make timely, complete payments to such a school or setting (through the school when the setting is arranged through the school).

For purposes of the demonstration program, the term `advanced practice nurse' would include a clinical nurse specialist, nurse practitioner, certified registered nurse anesthetist, and certified nurse midwife.

PART V – Health Information Technology

Sec. 3041 – Clarification Regarding Inclusion of Free Clinics as Providers Eligible for Incentives for Adoption and Meaningful Use of Certified EHR Technology.
Present Law

Present Law

The HITECH Act authorized bonus payments for eligible professionals and hospitals participating in Medicare and Medicaid as an incentive to become meaningful users of certified EHR systems: see Present Law description for Sec. 1102. For the Medicare incentives, an eligible professional means a physician, as defined under SSA Section 1861(r). For the Medicaid incentives, an eligible professional is defined as (1) a non-hospital physician, dentist, certified nurse mid-wife or nurse practitioner with at least a 30 percent Medicaid patient volume (pediatricians must have at least a 20 percent Medicaid patient volume); (2) physician assistants that meet certain specified requirements; and (3) Federally qualified health centers and rural health clinics with at least a 30 percent patient volume made up of needy individuals, as defined.

Free clinics are safety-net health care organizations, staffed by volunteers, that provide a range of medical, dental, pharmacy, and/or behavioral health services to economically disadvantaged

individuals who are predominately uninsured. Facilities that otherwise meet the above definition, but charge a nominal fee to patients, may still be considered free clinics provided essential services are delivered regardless of the patient's ability to pay. Free clinics are 501(c)(3) tax-exempt organizations. They do not bill Medicare, Medicaid, or private payers for the health care services they provide.

Committee Bill

The Committee Bill would amend the definition of a professional that is eligible to receive Medicare EHR incentives (and subject to Medicare penalties for failure to become a meaningful EHR user) by clarifying that nothing in the provision would prevent a physician furnishing items and services in a free clinic (as defined above) from being considered so eligible.

The Committee Bill would further amend the definition of a professional eligible to receive Medicaid EHR incentives, by clarifying that nothing in the provision would prevent a physician, dentist, certified nurse mid-wife, nurse practitioner, or physician assistant furnishing items and services in a free clinic (as defined above) from being considered so eligible.

Subtitle B – Improving Medicare for Patients and Providers

PART I – Ensuring Beneficiary Access to Physician Care and Other Services

Sec. 3101. Increase In The Physician Payment Update.

Present Law

Medicare payments for services of physicians and certain non-physician practitioners are made on the basis of a fee schedule. The fee schedule assigns relative values to services that reflect physician work (i.e., time, skill, and intensity it takes to provide the service), practice expenses, and malpractice costs. The relative values are adjusted for geographic variation in costs. The adjusted relative values are then converted into a dollar payment amounts by a conversion factor. The law specifies a formula, commonly referred to as the sustainable growth rate formula (SGR), for calculating the annual update to the conversion factors and the resultant fees. Section 101 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA, P.L. 110-173) increased the update to the conversion factor for Medicare physician payment by 0.5 percent compared with 2007 rates for the first six months of 2008. The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA, P.L. 110-275) extended the 0.5 percent increase in the physician fee schedule that was set to expire on June 30, 2008, through the end of 2008 and set the update to the conversion factor to 1.1 percent for 2009. The conversion factor for 2010 and subsequent years will be computed as if this modification had never applied, so unless further legislation is passed, the update formula will require a 21 percent reduction in physician fees beginning January 1, 2010 and by additional amounts annually for at least several years thereafter.

Committee Bill

The Committee Bill would set the annual update to the conversion factor used in the determination of the Medicare fee schedule at 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.

Sec. 3102. Extension Of The Work Geographic Index Floor And Revisions To The Practice Expense Geographic Adjustment Under The Medicare Physician Fee Schedule.

Present Law

The Medicare fee schedule is adjusted geographically for three factors to reflect differences in the cost of resources needed to produce physician services: physician work, practice expense, and medical malpractice insurance. The geographic adjustments are indices that reflect how each area compares to the national average in a "market basket" of goods. A geographic practice cost index (GPCI) with a value of 1.00 represents an average across all areas. A series of laws sets a temporary floor value of 1.00 on the physician work index beginning January 2004; most recently, Section 134 of the MIPPA extended the application of this floor when calculating Medicare physician reimbursement through December 2009. The other geographic indices (for practice expense and medical malpractice) were not modified by these acts.

Committee Bill

The Committee Bill would extend the 1.00 floor for the geographic index for physician work for an additional three years through December 31, 2012.

The Committee Bill would also direct the Secretary to adjust the practice expense geographic practice cost index (PE GPCI) for 2010 and in subsequent years. For 2010, the PE GPCI would reflect 3/4 of the difference between the relative costs of employee wages and rents in each of the different fee schedule areas and the national averages. For 2011, the adjustment would reflect 1/2 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 1/2 local and 1/2 national). The Committee Bill includes a hold harmless provision that would protect any areas adversely affected by the adjustment in 2010 or 2011.

The Secretary would analyze current methods of establishing practice expense geographic adjustments under the Medicare 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. This analysis would include an evaluation of the following: (1) the feasibility of using actual data or reliable survey data developed by recognized medical organizations, such as the American Medical Association, on the costs of operating a medical practice, including office rents and non-physician staff wages, in the different Medicare payment localities; (2) the office expense portion of the PE GPCI, including the extent to which types of office expenses are determined in local markets instead of national markets; and (3) the weights assigned to each of the categories within the practice expense GPCI.

For 2012 and in subsequent years, the Secretary would make appropriate adjustments to the PE GPCI no later than January 1, 2012 to ensure accurate geographic adjustments across payment areas. These adjustments would include the following: (1) basing the office rents component and its weight on office expenses that vary among fee schedule areas; and (2) considering a representative range of professional and non-professional personnel employed in a medical office based on the use of the American Community Survey data or other reliable data for wage adjustments. The adjustments made in 2012 and for subsequent years would be made without regard to the adjustments made in 2010 and 2011 and would be made in a budget neutral manner.

If the Secretary does not complete the required analysis as described above and does not make appropriate adjustments in the Medicare Physician Fee Schedule rule for 2012 or for a subsequent year, the 2011 payment rule (including the hold harmless) would remain in effect.

Sec. 3103. Extension Of Exceptions Process For Medicare Therapy Caps.

Present Law

Present Law places two annual per beneficiary payment limits for all outpatient therapy services provided by non-hospital providers. For 2009, the annual limit on the allowed amount for outpatient physical therapy and speech-language pathology combined is $1,840, and there is a separate limit for occupational therapy of $1,840. The Secretary was required to implement an exceptions process for 2006, 2007, and the first half of 2008 for cases in which the provision of additional therapy services was determined to be medically necessary. Section 141 of the MIPPA extended the exceptions process for therapy caps through December 31, 2009.

Committee Bill

The Committee Bill would extend the exceptions process for therapy caps for 2 years, through December 31, 2011.

Sec. 3104. Extension of Payment for the Technical Component of Certain Physician Pathology Services.

Present Law

In 1999, the Health Care Financing Administration, (now the Centers for Medicare and Medicaid Services or CMS), proposed terminating an exception to a payment rule that had permitted laboratories to receive direct payment from Medicare when providing technical pathology services that had been outsourced by certain hospitals. The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA, P.L. 106-554) extended this exception for 2 years until January, 1 2003. The Medicare Prescription Drug, Improvement and Modernization Act (MMA, P.L.108-173) extended the exception for 2005 and 2006 to permit independent laboratories to receive direct payments for the technical component for certain inpatient pathology services. The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA, P.L. 110-275) extended the provision until January 1, 2010.

Committee Bill

The Committee Bill would extend the direct payments provision until January 1, 2012.

Sec. 3105. Extension of Ambulance Add-ons.

Present Law

The Medicare Prescription Drug, Improvement and Modernization Act (MMA, P.L.108-173) established bonus payments for ground ambulance services furnished on or after July 1, 2004 and before January 1, 2010 that originate in a qualified rural area. The qualified rural areas are those with the lowest population densities that collectively represent a total of 25 percent of the population.

The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA, P.L. 110-275) 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 for the period July 1, 2008 through December 31, 2009. Areas designated as rural on December 31, 2006 are treated as rural for purposes of payments for air ambulance services during this period as well.

Committee Bill

The Committee Bill would extend the bonus payments and the increased ground ambulance payments until January 1, 2012. The provision to pay certain urban air ambulance services as rural would be extended until January 1, 2012 as well.

Sec. 3106. Extension of Certain Payment Rules for Long-term Care Hospital Services and of Moratorium on the Establishment of Certain Hospitals and Facilities.

Present Law

Long-term care hospitals (LTCHs) are designed to provide extended medical and rehabilitative care for patients who are clinically complex and have multiple acute or chronic conditions. LTCHs that are distinct part units of other hospitals are not explicitly permitted by the Medicare statute. Over time, however, the LTCH industry has evolved to include co-located hospitals-within-hospitals (HwHs) or satellite facilities in addition to traditional freestanding facilities. CMS has implemented additional organizational requirements on these LTCHs, in an attempt to ensure that these are separate entities. Certain LTCHs (grandfathered HwHs) have been exempted from the requirements. Starting October 1, 2004, CMS established limits on the number of discharged Medicare patients that an HwHs and satellite LTCHs (except grandfathered LTCHs) can admit and be paid as independent LTCHs; after that threshold has been reached, generally, the LTCH will receive a substantially lower payment for subsequent patient admissions who have been discharged from the host hospital. Starting July 1, 2007, CMS extended this payment policy to other types of LTCHs, including grandfathered entities. Among other LTCH changes, the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA, P.L.

110-173), as modified by the American Recovery and Reinvestment Act of 2009 (ARRA, P.L. 111-5), provided for a three year moratorium on the application of this payment policy for certain LTCHs starting December 29, 2007.

Effective for the first cost reporting period beginning on or after October 1, 2002, LTCHs are paid according to a prospective payment system (PPS), subject to a five year transition period. Under this PPS, Medicare pays a LTCH a predetermined amount per discharge, depending upon the patient's assignment into one of the Medicare-severity long term diagnosis related groups (MS-LTC-DRGs). The LTCH patient classification system, MS-LTC-DRGs, is based on Medicare severity diagnosis related groups (MS-DRGs) used in the inpatient prospective payment system (IPPS) to pay acute care hospitals. By statute, total payments under LTCH-PPS must be equal to the amount that would have been paid if the PPS had not been implemented in the initial year of implementation. CMS proposed to review LTCH payments and make a one-time prospective adjustment to the LTCH PPS to correct for any errors in the original budget neutrality calculations. MMSEA established a three year moratorium on that one-time budget neutrality adjustment starting December 29, 2007 (the enactment date of MMSEA).

The LTCH-PPS includes certain case level adjustments for short stay and interrupted stay cases. CMS adopted a very short-stay outlier payment policy starting July 1, 2007 to reduce payments for patients who have lengths of stay that are less than or equal to one standard deviation from the geometric average length of stay (ALOS) of the same MS-DRG under the IPPS. This very short stay outlier policy is subject to the three year moratorium established by MMSEA.

Finally, MMSEA, as modified by ARRA, also established a three year moratorium on the establishment of new LTCHS, including HwHs and satellite facilities, and on the increase of hospital beds in existing LTCHs.

Committee Bill

The provisions would extend the three year moratorium established by MMSEA for certain LTCH payment rules concerning HwHs and satellite facilities, the very short stay outlier policy, and the budget neutrality adjustment for two years until December 29, 2012. The existing three year moratorium on the establishment of new LTCHs and on the increase in hospital beds in LTCHs would be extended for two years as well.

Sec. 3107. Extension Of Physician Fee Schedule Mental Health Add-On.

Present Law

The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA, P.L. 110-275) increased payments for certain Medicare mental health services by five percent.

Committee Bill

The Committee Bill would extend the add-on payment provision through December 31, 2011.

Sec. 3108. Permitting Physician Assistants to Order Post-Hospital Extended Care Services and to Provide for Recognition of Attending Physician Assistants as Attending Physicians to Serve Hospice Patients.

(a) Ordering Post-Hospital Extended Care Services.

Present Law

In a skilled nursing facility (SNF), Medicare law allows physicians, as well as nurse practitioners and clinical nurse specialists who do not have a direct or indirect employment relationship with a SNF, but who are working in collaboration with a physician, to certify the need for post-hospital extended care services for purposes of Medicare payment. Section 20.2.1 of Chapter 8 of the Medicare Benefit Policy Manual defines post-hospital extended care services as services provided as an extension of care for a condition for which the individual received inpatient hospital services. Extended care services are considered "post-hospital" if they are initiated within 30 days after discharge from a hospital stay that included at least three consecutive days of medically necessary inpatient hospital care.

Committee Bill

The Committee Bill would allow a physician assistant who does not have a direct or indirect employment relationship with a SNF, but who is working in collaboration with a physician, to certify the need for post-hospital extended care services for Medicare payment purposes.

This provision would apply to items and services furnished on or after January 1, 2011.

(b) Recognition of Attending Physician Assistants as Attending Physicians to Serve Hospice Patients.

Present Law

Under the Medicare program, hospice services may only be provided to terminally ill individuals under a written plan of care established and periodically reviewed by the individual's attending physician and the medical director (and by the interdisciplinary group of the hospice program). For purposes of a hospice written plan of care, Medicare defines an attending physician as a physician or nurse practitioner who may be employed by a hospice program and who the individual identifies as having the most significant role in the determination and delivery of medical care to the individual at the time the individual makes an election to receive hospice care.

For an individual to be eligible for Medicare-covered hospice services, the individual's attending physician (not including a nurse practitioner) and the medical director (or physician member of the interdisciplinary group of the hospice program) must each certify in writing that the individual is terminally ill at the beginning of the first 90-day period of hospice.

Committee Bill

For purposes of a hospice written plan of care, the Committee Bill would include a physician assistant in the definition of an attending physician. The provision would continue to exclude physician assistants from the authority to certify an individual as terminally ill.

Sec. 3109. Recognition of Certified Diabetes Educators as Certified Providers for Purposes of Medicare Diabetes Outpatient Self-Management Training Services.

Present Law

Medicare covers diabetes self-management training (DMST), under certain conditions, to help a beneficiary learn how to successfully manage their diabetes. When Congress passed the DMST benefit in 1997, it did not include Certified Diabetes Educators (CDEs) as providers. At the time the DSMT benefit took effect, most CDEs worked in hospital outpatient clinics where diabetes education and care was generally covered by Medicare.

Many hospital DSMT programs have now closed, thus limiting access to DSMT programs. Because CDEs in private practice are not recognized under Medicare as providers of DSMT, many beneficiaries are unable to receive self management training outside the hospital setting to help treat and control their diabetes.

Committee Bill

The Committee Bill would define CDEs, set certain qualifying conditions for CDE certification, and recognize CDEs as Medicare providers of DSMT services. CDEs would still provide DSMT following a physician referral, but they would be able to work in appropriate, non-hospital locations and bill Medicare for these services as appropriate.

The proposed change would take effect on January 1, 2011.

Sec. 3110. Exemption of Certain Pharmacies from Accreditation Requirements

Present Law

MMA required the Secretary to establish and implement quality standards for suppliers of durable medical equipment, prosthetics and supplies (DMEPOS) under Part B of Medicare. MIPPA requires DMEPOS suppliers to prove their compliance with the quality standards by being accredited by October 1, 2009. MIPPA, however, exempted eligible professionals from having to comply with the accreditation requirement unless the standards and accreditation requirements being applied were specifically designed to be applied to those professionals. The statutes defines the following as eligible professionals: physicians, physical or occupational therapists, qualified speech-language pathologists, qualified audiologists, physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, certified nurse-midwives, clinical social workers, clinical psychologists, or registered dietitians or nutrition professionals. The Secretary was given authority to exempt additional professionals

from the accreditation requirements. Pharmacists and pharmacies were not listed as exempt from the accreditation requirements.

Committee Bill

Effective January 1, 2010, the Committee Bill would make certain pharmacies eligible for an exemption from the accreditation requirements. A pharmacy would be exempt from the accreditation requirements under the following circumstances: (1) the pharmacy submits an attestation that its total Medicare DMEPOS billings are, and continue to be, less than a rolling three year average of five percent of total pharmacy sales; (2) the pharmacy submits an attestation that it is enrolled as a provider of durable medical equipment, prosthetics, orthotics, and supplies under the Medicare program for at least 5 years and has had no adverse determination against it for the last five years due to fraud; 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 (1) and (2). The documentation submitted for (3) would be required to consist of an accountant certification or filing of tax returns by the pharmacy.

The provision would also allow the Secretary to determine accreditation standards that are more appropriate for pharmacies. The Secretary would have the authority to implement this amendment by program instruction or otherwise.

Section 3111. Medicare Part B Special Enrollment Period for Disabled TRICARE Beneficiaries.

Present Law

TRICARE is the health care plan under the Department of Defense (DoD) that covers members of the uniformed services, their families and survivors. TRICARE coverage was extended to Medicare-eligible military retirees, their Medicare-eligible spouses and dependent children and Medicare- eligible widow/widowers by the Floyd D. Spence National Defense Authorization Act of 2001 (P.L. 106-398). This law authorized a program known as TRICARE For Life (TFL) which acts as a secondary payer to Medicare and provides supplemental coverage to TRICARE-eligible beneficiaries who are entitled to Medicare Part A based on age, disability or end stage renal disease (ESRD). In order to participate in TFL, these TRICARE-eligible beneficiaries must enroll in and pay premiums for Medicare Part B.

Under Present Law (10 U.S.C. 1086(d)), TRICARE-eligible beneficiaries who are entitled to Medicare Part A based on age, disability or ESRD, but decline Part B, lose eligibility for TRICARE benefits. Veterans' advocacy groups have reported that many beneficiaries are not aware that their TRICARE coverage is dependent upon Part B enrollment. Individuals who choose not to initially enroll in Medicare Part B upon becoming eligible may elect to do so later during a January 1 through March 31 annual enrollment period. However, Medicare Part B coverage is effective July 1 of the year during which enrollment occurs and the Medicare Part B late enrollment penalty, (ten percent for each 12 month period in which the individual could have

been enrolled but did not) would apply. In addition to the late-enrollment penalty, late-enrollers are liable for all medical expenses incurred during the period they are not enrolled in Part B.

Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA, P.L. 108-173) provided enrollment incentives to TRICARE beneficiaries who were entitled to Medicare Part A, but were not enrolled in Medicare Part B during their initial eligibility period. Further, the law directed the Secretary to provide a Part B special enrollment period for TRICARE beneficiaries who had not enrolled in Part B as of the date of MMA's enactment—December 8, 2003. The law mandated that this special enrollment period begin as soon as possible after MMA's enactment and end on December 31, 2004. In addition the MMA waived premium surcharges for TRICARE beneficiaries who enrolled in Medicare Part B from 2001 through 2004.

Committee Bill

The Committee Bill creates a twelve-month special enrollment period (SEP) for military retirees, their spouses (including widows/widowers) and dependent children, who are otherwise eligible for TRICARE and entitled to Medicare Part A based on disability or ESRD, but who have declined Part B. This twelve-month special enrollment period (SEP) would be available to an individual once in their lifetime and begin on the day after the last day of the initial enrollment period. If the individual was notified of retroactive Medicare Part A and Part B entitlement, the twelve-month period would begin with the month in which the individual was notified of Medicare Part B entitlement. For this population, the Part B coverage period would begin on the first day of the month in which the individual enrolls during the SEP. The individual would also have the option of choosing Part B coverage retroactive to the first month after the initial enrollment period. The late enrollment penalty would not apply to individuals who enroll during the SEP. The Secretary of Defense would be required to identify and notify individuals of their eligibility for the SEP; the Secretary of Health and Human Services and the Commissioner for Social Security would support these efforts. The provision would become effective on the date of enactment.

Sec. 3112. Payment for Bone Density Tests

Present Law

Dual energy X-ray absorptiometry (DXA) machines are used to measure bone mass to identify individuals who may have or are at risk of having osteoporosis. For those individuals who are eligible, Medicare will pay for a bone density study once every two years, or more frequently if the procedure is determined to be medically necessary.

Medicare reimburses for imaging procedures, including DXA, differently based on where the test is performed. Medicare reimbursement for bone density procedures is comprised of a professional component, the amount paid for the physician's interpretation of the results of the scan, and a technical component, the amount paid for all other services including technician and equipment costs. Procedures performed in an Independent Diagnostic Testing Facility (IDTF) or a physician office are reimbursed under the Medicare Physician Fee schedule. In a hospital

outpatient department (HOPPS), the technical component is reimbursed under an Ambulatory Payment Classification under Medicare's hospital outpatient department prospective payment system.

Under the physician fee schedule, relative values are assigned to services. These relative values reflect physician work (based on time, skill, and intensity involved), practice expenses (including the cost of nurses and other staff), and malpractice expenses. The relative values are adjusted for geographic variations in the costs of practicing medicine. These geographically adjusted relative values are converted into a dollar payment amount by a conversion factor.

As reported by CMS and MedPAC, spending for imaging services reimbursed under the Medicare physician fee schedule grew rapidly between 2003 and 2005. The Deficit Reduction Act of 2005 (DRA; P.L. 109-171) capped reimbursement of the technical component for x-ray and imaging services at the lesser rate of the hospital outpatient rate or the physician fee schedule. Specifically, designated imaging services with a Medicare physician fee schedule technical payment (prior to geographic adjustment) that exceeds the comparable hospital outpatient prospective payment system (HOPPS) technical payment (prior to geographic adjustment), are capped at the 2007 HOPPS payment amount. (The professional component is not affected by the DRA provision.) Bone density procedures are subject to the DRA provisions.

Payments for imaging services have also been affected by revisions to payments for practice expense in the 2007 physician fee schedule rule. CMS implemented a new methodology for determining resource-based practice expense payments for all services that has led to reductions in the professional component reimbursement. The new formula is being phased in over four years from 2007 to 2010.

It is estimated that reimbursement rates for DXA services have been reduced by more than half since 2006.

Committee Bill

This Committee Bill would change the payment amounts for CPT codes 76075 and 76077 (relating to dual energy x-ray absorptiometry (DXA)), and any successor to such codes furnished during 2010 and 2011. The payments would be set at 70 percent of the 2006 reimbursement rates for these services.

The Committee Bill would also direct the Secretary to arrange with the Institute of Medicine of the National Academies to study and report to the Secretary and Congress on the ramifications of Medicare reimbursement reductions for DXA on beneficiary access to bone mass measurement benefits.

Sec. 3113. Revision To The Medicare Improvement Fund.

Present Law

Section 188 of MIPPA established the Medicare Improvement Fund (MIF), available to the Secretary to make improvements under the original fee-for-service program under Parts A and B for Medicare beneficiaries. Under Present Law, $22.29 billion are available for services provided in years 2014 through 2017.

Committee Bill

The Committee Bill would eliminate the funding in the MIF.

Sec. 3114. Treatment Of Certain Complex Diagnostic Laboratory Tests.

Present Law

In general, clinical laboratory services are billed to Medicare on the date when the specimen is collected, not necessarily on the date when the service is ordered or performed. A test ordered on a specimen collected from a patient during an inpatient stay or outpatient visit would be considered for billing purposes as being provided by the hospital. The hospital would bear financial responsibility for the test, even if the test is performed after the patient has left the hospital. The laboratory services are bundled as part of the hospital's Medicare payment and the laboratory would receive payment from the hospital rather than directly from Medicare.

Committee Bill

The Committee Bill would allow laboratories to bill the Medicare program separately for certain complex diagnostic tests during a two-year period beginning July 1, 2011. If a laboratory were to perform a covered complex diagnostic laboratory test (see below) on a specimen collected from an individual while a patient of a hospital and if such test were performed after such period, the specimen would be considered as if it had been collected directly by the laboratory and the laboratory would be able to bill for direct payment.

The term "covered complex diagnostic laboratory test" would mean a diagnostic laboratory test that (a) is an analysis of gene or protein expression, topographic genotyping, or a cancer chemotherapy sensitivity assay, (b) is described in the section that defines diagnostic laboratory and other diagnostic tests under current Medicare statute (section 1861(s)(3) of the Social Security Act (42 U.S.C. 1395x(s)(3)), (c) is performed only by the laboratory offering the test, and (d) is not furnished by the hospital where the specimen was collected to a patient of such hospital, directly or under arrangements with the hospital.

This modification would apply to tests furnished on or after July 1, 2011, and before the earlier of (a) July 1, 2013 and (b) the date that the CMS Chief Actuary submits the spending report described below to the Committee on Ways and Means and the Committee on Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate and to the Secretary of Health and Human Services.

The CMS Chief Actuary would monitor Medicare expenditures as a result of the modifications of this section during the two-year period beginning on July 1, 2011. If the Chief Actuary were

to determine that, during the two-year period, either of the following conditions have been met, the Chief Actuary would submit a report to the Committee on Ways and Means and the Committee on Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate and to the Secretary of Health and Human Services that includes a statement regarding this determination.

The conditions that would trigger the CMS Chief Actuary's report would be the following: (i) Medicare expenditures during the two-year period as a result of the provisions of this subsection were to reach $100 million; or (ii) Medicare payments to laboratories during the two-year period as a result of these provisions were to reach $100 million.

Sec. 3115. Improved Access for Certified-Midwife Services.

Present Law

Sec. 1833 of the SSA provides for payments from the Medicare Part B Trust Fund for services received by covered individuals. With respect to certified nurse-midwife services, the amount required to be paid is 80 percent of the lesser of the either (1) the actual charge for the services, or (2) the amount determined by a fee schedule established by the Secretary. The fee schedule is not allowed to exceed 65 percent of the prevailing charge that would be allowed for same services performed by a physician.

Committee Bill

The Committee Bill would amend Sec. 1833(a)(1)(K) by adding that for services provided after January 1, 2011, the fee schedule for certified-midwife services would not be allowed to exceed 100 percent of the fee schedule amount provided under Sec. 1848 for the same service performed by a physician.

Sec. 3116. Working Group on Access to Emergency Medical Care.

Present Law

Title XXVIII, Subtitle B of the Public Health Service Act established the Office of the Assistant Secretary for Preparedness and Response (ASPR). The Office advises the HHS Secretary on matters related to bioterrorism and other public health emergencies, and coordinates medical incident response assets and activities, among other functions. The Emergency Care Coordination Center, located within ASPR, was established in January 2009.

The Emergency Medical Treatment and Labor Act (EMTALA, Section 1867 of the SSA) requires hospital emergency departments to examine and treat any individual who comes to the hospital with an emergency medical condition, and any woman who is in labor. EMTALA further requires hospitals to offer treatment, within their capacity and with the individual's consent, to stabilize the emergency condition, or transfer the individual to another medical facility, subject to certain restrictions. EMTALA does not preempt state or local laws unless they directly conflict with its specific requirements. In addition, the Act prohibits discrimination and

delay in examining or treating emergency patients, and provides protections to whistleblowers who report violations of its provisions.

Committee Bill

The Committee Bill would require the Secretary, within 60 days of enactment, to establish a Working Group on Access to Emergency Medical Care. Membership of the Working Group would include at least two individuals from each of the following: (1) representatives of emergency medical personnel; (2) appropriate elected or appointed officials; (3) health care consumer advocates; and (4) representatives of emergency care hospitals and health systems. Working Group members would be required to serve without compensation. HHS would be required to provide administrative support, technical assistance and the use of facilities for the Working Group.

Duties of the Working Group would include identifying and examining: (1) barriers causing delays in timely inpatient admission of certain patients who present at emergency departments; (2) factors in the health care delivery, financing, and legal systems that impede or prevent the effective delivery of emergency department services, as required under EMTALA; and (3) best practices to improve patient flow within hospitals. The Working Group would be required to develop recommendations for admission, boarding and diversion standards. It would also be required to develop guidelines, measures and incentives to ensure proper implementation, monitoring and enforcement of the standards.

The Working Group would be required to submit a report to Congress and the Secretary containing their recommendations for admission, boarding, and diversion standards for hospital emergency departments, including guidelines and incentives for enforcing those standards, as well as recommendations for legislative and administrative actions regarding (1) Federal programs, policies and financing needed to assure the availability of emergency services, and (2) coordination of Federal, state and local programs for disaster response and emergencies. The Working Group would terminate upon submission of their report.

PART II – Rural Protections

Sec. 3121. Extension of Outpatient Hold Harmless Provision.

Present Law

Small rural hospitals (with no more than 100 beds) that are not sole community hospitals (SCHs) can receive additional Medicare payments if their outpatient payments under the prospective payment system are less than under the prior hospital outpatient department (HOPD) reimbursement system. For calendar year (CY) 2006, these hospitals received 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 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 receive 85 percent of the payment difference for covered HOPD services furnished on or after January 1, 2009, and before January 1, 2010.

Committee Bill

The provision would establish that small rural hospitals would receive 85 percent of the payment difference in CY2010 and CY2011. SCHs with not more than 100 beds would receive 85 percent of the payment difference in CY2010 and CY2011. The 100-bed limitation for SCHs would be removed so that all SCHs would receive 85 percent of the payment difference in CY2010 and CY2011.

Sec. 3122. Extension of Medicare Reasonable Costs Payments for Certain Clinical Diagnostic Laboratory Tests Furnished to Hospital Patients in Certain Rural Areas.

Present Law

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 Part B that are provided as outpatient hospital services. Reasonable cost reimbursement for laboratory services provided by these hospitals ended July 1, 2008.

Committee Bill

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.

Sec. 3123. Extension of the Rural Community Hospital Demonstration Program.

Present Law

As required by Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA, PL 108-173), 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) in low population density areas. No more than 15 hospitals can participate in the demonstration. Currently, there are ten hospitals participating in the program.

Committee Bill

This provision would extend the demonstration program for an additional two years, expand the maximum number of participating hospitals to 30 for that period, and expand the eligible sites to rural areas in all states until January 1, 2012. The Secretary would provide for the continued participation for those hospitals that are in the demonstration at the end of the initial five-year period during the two year extension unless the hospital elects to discontinue such participation.

Sec. 3124. Extension of the Medicare-dependent Hospital Program.

Present Law

Medicare dependent hospitals (MDHs) 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 FY1987 or in two of the three most recently audited cost reporting periods. As specified in regulation, they cannot be a sole community hospital and must have 100 or fewer beds. MDHs receive special treatment, including higher payments, under Medicare's inpatient prospective payment system. The sunset date for the MDH classification has been periodically extended by legislation. As established by the Deficit Reduction Act of 2005 (DRA, P.L. 109-171), the MDH classification would expire September 30, 2011.

Committee Bill

The MDH classification would be extended two years, until September 30, 2013.

Sec. 3125. Temporary Improvements to the Medicare Inpatient Hospital Payment Adjustment for Low-volume Hospitals.

Present Law

Under Medicare's inpatient prospective payment system (IPPS), certain low-volume hospitals receive a payment adjustment to account for their higher costs per discharge. A low-volume hospital is defined as an acute care hospital that is located more than 25 road miles from another comparable hospital and that has less than 800 total discharges during the fiscal year. Under Present Law, the Secretary is required to determine an appropriate percentage increase for these low-volume hospitals based on the empirical relationship between the standardized cost-per-case for such hospitals and their total discharges to account for the additional incremental costs (if any) that are associated with such number of discharges. The low-volume adjustment is limited to no more than 25 percent. Accordingly, under regulations, qualifying hospitals (those located more than 25 road miles from another comparable hospital) with less than 200 total discharges receive a 25 percent payment increase for every Medicare discharge.

Committee Bill

A temporary adjustment that would increase payment in FY2011 and FY2012 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.

Sec. 3126. Improvements to the Demonstration Project on Community Health Integration Models in Certain Rural Counties.

Present Law

Section 123 of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA, P.L. 110-275), 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.

Those eligible to participate in the demonstration project are limited to a Rural Hospital Flexibility Program grantee under section 1820(g) of the Social Security Act that are located in States with at least 65 percent of its counties with six or fewer residents per square mile. Based on these criteria, the Secretary is instructed to select up to four states to participate in the demonstration program, and within those states, up to six counties. For a county to be eligible to participate, it must have 6 or fewer residents per square mile and contain a critical access hospital (CAH) that furnished one or more of specified services (home health, hospice, or rural health clinic) and had a daily inpatient census of five or less as of date of enactment; skilled nursing facility services must be available in the eligible county.

The 3-year demonstration project is to begin on October 1, 2009 and be done in a budget neutral manner.

Committee Bill

The limit of six eligible counties that may participate in the demonstration project within the qualifying states would be eliminated. Rural health clinic services would no longer be a required CAH service for entities participating in the demonstration program. Rural health clinic services would be removed from the definition of other essential services and replaced with physician services.

Sec. 3127. MedPAC Study on Adequacy of Medicare Payments for Health Care Providers Serving in Rural Areas.

Present Law

No provision.

Committee Bill

The Medicare Payment Advisory Commission (MedPAC) would be required to review payment adequacy for rural health care providers and suppliers serving the Medicare program and provide a report to Congress by January 1, 2011. MedPAC would analyze rural payment adjustments; beneficiaries' access to care in rural communities; adequacy of Medicare payments to rural

providers and suppliers; and quality of care in rural areas. MedPAC would submit a report to Congress including recommendations no later than January 1, 2011.

Sec. 3128. Technical Correction Related to Critical Access Hospital Services.

Present Law

Critical Access Hospitals (CAHs) are limited-service rural facilities that are located more than 35 miles from another hospital (15 miles in certain circumstances) or designated by the state as a necessary provider of health care; offer 24-hour emergency care; have no more than 25 acute care inpatient beds and have a 96-hour average length of stay. Generally, a rural hospital designated as a CAH receives 101 percent reasonable, cost based reimbursement for inpatient and outpatient care rendered to Medicare beneficiaries. A CAH may elect an all-inclusive outpatient payment which is equal to a 101 percent of reasonable costs for facility services plus 115 percent of the Medicare physician fee schedule payment for professional services when the physician or practitioner has reassigned his or her billing rights to the CAH. As part of its FY2010 rulemaking process, starting October 1, 2009, CMS will lower the facility component of the all-inclusive, elective payment method to 100 percent of the CAH's reasonable costs; the payment for professional services will remain at 115 percent of the fee schedule amount.

Medicare will pay for ambulance services provided by a CAH or by an entity owned and operated by a CAH at 100 percent of reasonable costs, but only if CAH or the entity is the only supplier or provider of ambulance services with a 35-mile drive of the CAH or the entity.

Committee Bill

Medicare would pay the facility component of the all-inclusive elective CAH payment for outpatient services at 101 percent of reasonable costs. Medicare would pay for qualifying ambulance services provided by a CAH or by an entity owned and operated by a CAH at 101 percent of reasonable cost. These provisions would take effect as if they were included in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA, P.L. 108-173).

Sec. 3129. Extension of and Revisions to Medicare Rural Hospital Flexibility Program.

Present Law

The Balanced Budget Act of 1997 (BBA, P.L. 105-33) established the Medicare Rural Hospital Flexibility Program, which created the critical access hospital (CAH) designation under Medicare and authorized a grant program (FLEX grants) that is administered by the Health Resources and Services Administration (HRSA). 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 Medicare Rural Hospital Flexibility Program also authorized up to $50,000 for the Small Rural Hospital Improvement (SHIP) Grant Program. This program provides funding to small rural hospitals to provide assistance with any or all of the following: (1) to pay for costs related to the implementation of Medicare's prospective payment systems; (2) to comply with provisions of Health Insurance Portability and Accountability Act; and (3) to reduce medical errors and support quality improvement. To be eligible for these grants, a hospital must have less than 50 beds and be located in a rural area and may include critical access hospitals (CAHs).

As established by the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA, P.L. 110-275), the Secretary may also award grants to States to increase the delivery of mental health services or other health services deemed necessary to meet the needs of veterans and other residents of rural areas, including rural census tracks. There are certain limitations imposed on the use of grant funds for administrative expenses, both at the state and Federal level. The FLEX grant program is authorized at $55 million for each fiscal year from 2009 and 2010 and the new rural mental health and other services grants would be authorized at $55 million for each of fiscal years 2009 and 2010.

Committee Bill

The FLEX grant program would be extended two years until 2012 authorized at such sums as may be necessary in each year to be available until expended. Starting January 1, 2010, SHIP funding may also be used to assist small rural hospitals in participating in the delivery system reforms included this legislation, such as value-based purchasing programs, accountable care organizations, bundling and other programs deemed appropriate by the Secretary.

PART III – Improving Payment Accuracy

Sec. 3131. Payment Adjustments for Home Health Care.

Present Law

Home health agencies (HHAs) are paid under a prospective payment system (PPS) that provides payments based on 60-day episodes of care for beneficiaries, subject to several adjustments. The home health (HH) base payment amount is increased annually by an update factor that is determined, in part, by the projected increase in the HH market basket (MB) index (a measure of changes in the costs of goods and services purchased by HHAs to provide HH services). HHAs that submit quality data to the Secretary receive a full MB increase, while HHAs that do not submit quality data receive a reduced update equivalent to the MB minus two percentage points. For CY 2010, the HH MB update is 2.2 percent. The base payment amount is adjusted for differences in the care needs of patients (case mix) using "HH resource groups" (HHRGs) and outlier adjustments (to account for extraordinarily costly patients), among other adjustments. Presently, there is no difference between urban and rural base payment amounts.

In CY2008, refinements to the Medicare HH PPS included, among other changes, a reduction in the payment rate for four years (to continue through CY2011) to adjust for increases in case mix that are related to changes in coding instead of increased patient severity of illness. The

proposed CMS rule for CY 2010 would continue with the 2.75 reduction to the HH PPS rates for CY 2010. Among other things, the proposed rule would also implement a cap on outlier payments to be no more than 2.5 percent of total HH PPS payments.

In its March 2009 Report *to Congress: Medicare Payment Policy*, MedPAC reported that most HHAs continued to be paid above costs. Accounting for the payment refinements in CY2008 and the MB update under Present Law, MedPAC estimates that HHAs would have margins of 12.2 percent in CY2009. In this report, MedPAC recommends that the CY2010 HH payment update be eliminated in CY2010. MedPAC also recommends that the planned coding reductions for CY2011 be advanced to CY2010 and HH payments be rebased in CY2011 to more closely reflect the cost of visits and other services delivered in the average HH episode.

Committee Bill

Updating Home Health Payments through Rebasing. Starting in CY2013, the Secretary would be directed to rebase payments by a percentage considered appropriate by the Secretary to, among other things, reflect the number, mix and level of intensity of HH services in an episode, and the average cost of providing care. In doing so, the Secretary would be required to consider the differences between HH agencies in regards to hospital-based and freestanding providers; for-profit and non-profit providers; and resource costs between urban and rural providers. In addition, the Secretary would be directed to phase in the new reimbursement system according to the following schedule: in CY2013, 25 percent of current payment rates would be rebased and 75 percent would be based on amounts calculated under the prior payment system; in CY2014, 50 percent would be rebased and 50 percent would be based on the prior payment system; in CY2015, 75 percent would be rebased and 25 percent would be based on the prior payment system; and in CY2016, 100 percent of the payments would be rebased.

As part of the rebasing proposal, the Secretary would be directed to 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.

MedPAC would be directed to report to Congress on the implementation of the new system, with particular emphasis on how rebasing changes impact: access to care for beneficiaries, quality outcomes, supply of HH providers; and any differential financial impacts on rural, urban, non-profit and for-profit providers. No later than January 1, 2015, MedPAC would be required to submit to Congress a report on this study, together with recommendations for legislative and administrative action.

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 HH agency may be reimbursed in a given year from outlier payments. The Secretary would continue to withhold 5 percent from episode payments for the outlier pool, with payouts capped at 2.5 percent.

Reinstatement of Rural Home Health Payment Adjustment. For visits ending on or after January 1, 2010 and before January 1, 2016, the Secretary would be directed to provide for a three percent add-on payment for HH providers serving rural areas.

Study Regarding the Development of Home Health Payment Reforms to Ensure Access to Care and Quality Services

1. 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.

2. In conducting the study, the Secretary shall consider whether certain factors should be used to measure patient severity of illness and access to care. Factors to consider in this analysis may include, but are not limited to, population density and relative patient access to care; variations in service costs for providing care to Medicare-Medicaid dual eligible beneficiaries; presence of severe and/or chronic diseases as evidenced by multiple, discontinuous home health episodes; poverty status as evidenced by the receipt of a Supplemental Security Income; absence of caregivers; language barriers; atypical transportation costs; and security costs.

3. The study may include recommendations on:

    a. Methods to revise the home health payment system to more accurately account for the costs related to patient severity of illness or to improving beneficiary access to care, including payment adjustments for services that may be under or over-valued; necessary changes to reflect the resource use relative to providing home health care to low-income beneficiaries or beneficiaries living in medically underserved areas; ways the outlier payment may be improved to more accurately reflect the cost of treating beneficiaries with high severity levels of illness; the role of quality of care incentives and penalties in driving provider and patient behavior; and improvements in the application of a wage index;

    b. An assessment of the validity and reliability of responses on the OASIS instrument with particular emphasis on questions that relate to higher PPS payment and higher outcome scores under “Home Care Compare;

    c. 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 to improve beneficiary access to care; and

    d. Other areas deemed appropriate by the Secretary.

4. In conducting the study, the Secretary shall seek input from stakeholders representing home health providers and beneficiaries. The Secretary shall also seek input from the

Medicare Payment Advisory Commission, the HHS Inspector General and the Government Accountability Office in its development and design of the study.

5. The Secretary shall issue a report on its findings and recommendations to the Congress by no later than March 1, 2011. The report shall include a timetable for the potential implementation of the recommendations and a statement as to which recommendations require a change in statute and those that can be implemented under the regulatory authority of the Secretary.

6. In addition, no later than January 1, 2012, based on the findings of this report and if the Secretary deems appropriate, the Secretary shall establish a temporary Medicare payment adjustment targeted toward ensuring access to care for beneficiaries with high severity of illness or to improve access to care for low-income or underserved beneficiaries. This temporary Medicare add-on payment may be no greater than three percent of the base PPS payment amount for any covered home health service furnished to an eligible beneficiary based on the findings of this report. Payments made under this section shall not exceed $500 million in total from 2011-2019.

Sec. 3132. Hospice Reform.

Present Law

Medicare covers hospice care for terminally ill beneficiaries instead of most other Medicare services related to the curative treatment of their illness. Using an interdisciplinary team, Medicare's hospice benefit provides care that specializes in the relief of the pain and symptoms associated with a terminal illness and the provision of supportive and counseling services to patients and their families during the final stages of a patient's illness and death. For a person to be considered terminally ill and eligible for Medicare's hospice benefit, the beneficiary's attending physician and the medical director of the hospice (or physician member of the hospice team) must certify that the individual has a life expectancy of six months or less. Beneficiaries electing hospice are covered for two 90-day periods, followed by an unlimited number of 60-day periods. The medical director or physician member of the hospice team must recertify at the beginning of each period that the beneficiary is terminally ill. Services must be provided under a written plan of care established and periodically reviewed by the individual's attending physician and the medical director of the hospice.

Medicare payments to hospices are predetermined fixed amounts for each case, according to the general type of care provided to a beneficiary on a daily basis. Such payments are intended to pay for the costs of care for a hospice beneficiary, on average. Payments for hospice care are based on one of four prospectively determined units of payment, which correspond to four different levels of care (i.e., routine home care, continuous home care, inpatient respite care, and general inpatient care) for each day a beneficiary is under the care of the hospice. Payment would thus vary by the length of the patient's period in the hospice program as well as by the characteristics of the services (intensity and site) furnished to the beneficiary. Hospices bill separately for additional physician services not covered under the payment categories described above.

The hospice cost report data collected by CMS contain provider-reported cost and statistical data for free-standing hospice providers. The data set is normally updated quarterly and is available on the last day of the month following the quarter's end.

Committee Bill

The Secretary would be required to collect additional data and information to revise payments for hospice care after consulting with hospice providers and the Medicare Payment Advisory Commission. Collection of the additional data and information would be required to begin by January 1, 2011. The Secretary would be required to collect the additional data and information on: (1) charges and payments, (2) the number of days of hospice care attributable to Medicare beneficiaries, (3) with respect to each type of hospice service, the number of days, cost, and payment of hospice care attributable to the type of service; charitable contributions and other revenue of the hospice program, the number of hospice visits, the type of practitioner providing visits, and the length of the visit and other information regarding the visit.

No later than October 1, 2013, the Secretary would be required to, by regulation, implement revisions to the methodology for determining payment rates for routine home care and other services included in hospice. Such revisions could be based on an analysis of data and information described above. Such adjustments could reflect changes in resource intensity in providing such care and services during the course of the entire episode of hospice care.

Payment revisions would be required to be budget neutral in that they would result in the same estimated amount of aggregate Medicare expenditures for hospice care furnished in the fiscal year in which such revisions in payment would be implemented as would have been under Medicare for such care if such revisions had not been implemented.

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. These changes would be implemented in FY2014 through rulemaking and would be budget neutral.

The Secretary would impose certain requirements on hospice providers as follows: (1) that a hospice physician or advanced practice nurse have a face-to-face encounter with the individual 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.

Sec. 3133. Improvement to Medicare Disproportionate Share Hospital (DSH) Payments.

Present Law

The Medicare disproportionate share hospital (DSH) adjustment was included in the inpatient prospective payment system (IPPS) in 1986 on the premise that low-income patients are more costly to treat and those acute care hospitals (referred to as subsection (d) hospitals) serving a large number of such patients would be likely to have higher costs for their Medicare patients than would otherwise similar institutions. Over time, as the formulas for Medicare's DSH adjustment have been changed, the justification for the higher payments has evolved and the adjustment is viewed as a way to insure access to hospital care.

Medicare's DSH payments are distributed through a hospital-specific percentage increase to its prospective payment rate. In most instances, the size of a hospital's DSH adjustment would depend upon the number of patient days provided to low-income Medicare patients or Medicaid patients. However, small urban hospitals and many rural hospitals have their DSH adjustment capped at 12 percent.

In its March 2007 *Report to Congress*, MedPAC found that about three-quarters of the Medicare DSH payments (accounting for about $5.5 billion in FY2004) was not empirically justified in terms of higher patient care costs. Also, Medicare's DSH payments were poorly targeted to hospitals' shares of uncompensated care

Committee Bill

Starting in FY2015 and for subsequent fiscal years, the Secretary would make DSH payments equal to 25 percent of what otherwise would 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, the Secretary would pay to such acute care hospitals an additional amount using a formula that is the product of three factors: the difference in hospitals' DSH payments after reducing DSH payments to empirically justified levels as compared to Present Law; the difference in the percentage change in the uninsured under-65 population from 2012; and the percentage of uncompensated care provided by a hospital (relative to all acute care hospitals).

The measure to establish the percentage change in the uninsured under-65 population would be one minus the difference of percent of individuals under 65 who are uninsured in 2012 minus those who are uninsured in the most recent period for which data is available (divided by 100). For FY2015 through FY2017, the data would be estimated by the Secretary based on the most recent estimates from the Director of the Congressional Budget Office. Starting in FY2018 and in subsequent years, the data would be estimated by the Secretary based on data from the Census Bureau or other appropriate sources as certified by the Chief Actuary of the Centers for Medicare and Medicaid Services.

The factor related to uncompensated care shall be based on the amount of uncompensated care provided by a hospital as a percentage of the aggregate amount of uncompensated care for all such hospitals. The Secretary will be directed to use appropriate data on uncompensated care, or alternative data if it serves as a better proxy for the costs of treating the uninsured.

There would be no administrative or judicial review of any estimate that is used in determining any of the three factors; any period of time for that formula; or any alternative DSH percentage.

Sec. 3134. Misvalued Codes Under The Physician Fee Schedule.

Present Law

The Medicare physician fee schedule is based on assigning relative weights to each of the approximately 7,500 physician service codes used to bill Medicare. The relative value for a service compares the relative work involved in performing one service with the work involved in providing other physicians' services. The scale used to compare the value of one service with another is known as a resource-based relative value scale (RBRVS).

The Center for Medicare and Medicaid Services (CMS), which is responsible for maintaining and updating the fee schedule, continually modifies and refines the methodology for estimating relative value units (RVUs). CMS relies on advice and recommendations from the American Medical Association/Specialty Society Relative Value Scale Update Committee (RUC) in its assessments. In general, as currently implemented, increases in RVUs for a service or number of services lowers the resultant fees for other physician services. One consequence has been that the payments for evaluation and management codes, whose RVUs typically are not increased over time, have fallen relative to other codes whose RVUs have increased and as a consequence of new technologies that have been introduced into coverage with relatively high RVUs. CMS is required to review the RVUs no less than every five years.

In determining adjustments to the relative value units (RVUs) used as the basis for calculating Medicare physician reimbursement under the fee schedule, the Secretary has authority to adjust the number of RVUs for any service code to take into account changes in medical practice, coding changes, new data on relative value components, or the addition of new procedures. The Secretary is required publish an explanation of the basis for such adjustments.

These adjustments are subject to a budget neutrality condition. With the exception of certain expenditures that are exempt by statute, the adjustments may not cause the amount of expenditures made under the Medicare physician fee schedule to differ from year to year by more than $20,000,000 from the expenditures that would have been incurred without such an adjustment.

Committee Bill

The Committee Bill would require the Secretary to 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 codes for which there has been the fastest growth; codes that have experienced substantial changes in practice expenses; codes for new technologies or services after the relative values are initially established for such codes; multiple codes that are frequently billed in conjunction with furnishing a single service; codes with low relative values, particularly those that are often billed multiple times for a single treatment; codes

which have not been subject to review since the implementation of the RBRVS; and such other codes determined to be appropriate by the Secretary. Adjustments to misvalued procedures would be subject to budget neutrality requirements.

Sec. 3135. Modification Of Equipment Utilization Factor For Advanced Imaging Services.

Present Law

Under the Medicare fee schedule, some services have separate payments for the technical component and the professional component. For example, imaging procedures generally have two parts: the actual taking of the image (the technical component), and the interpretation of the image (the professional component). Medicare pays for each of these components separately when the technical component is furnished by one provider and the professional component by another. When both components are furnished by one provider, Medicare makes a single global payment that is equal to the sum of the payment for each of the components.

CMS's method for calculating the Medicare fee schedule reimbursement rate for advanced imaging services assumes that imaging machines are operated 25 hours per week, or 50 percent of the time that practices are open for business. Setting the equipment use factor at a lower — rather than at a higher—rate has led to higher payment for these services. Citing evidence showing that the utilization rate is 90 percent, rather than the 50 percent previously assumed, MedPAC is urging CMS to use the higher utilization rate in the calculation of fee schedule payments for advanced imaging services.

According to MedPAC and the Government Accountability Office (GAO), there are opportunities to improve the efficiency of the Medicare fee schedule. In 2005, MedPAC recommended reducing certain fees to account for efficiencies and savings from the technical preparation and supplies achieved when multiple imaging services are furnished sequentially on contiguous body parts during the same visit. Starting January 1, 2006, physicians receive the full technical component fee for the highest paid imaging service in a visit, but technical component fees for additional imaging services are reduced by 25 percent.

Committee Bill

The Committee Bill would increase 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.

In addition, the Committee Bill would increase the technical component payment reduction for sequential imaging services on contiguous body parts during the same visit from 25 percent to 50 percent.

The Comptroller General would conduct a study on the estimated impact of the adjustment in practice expense to reflect higher presumed utilization under the amendments made by this subsection on the following: (1) Medicare beneficiary access to advanced diagnostic imaging services (as defined in section 1834(e)(1)(B) of the Social Security Act (42 U.S.C.

1395m(e)(1)(B)), including such access in rural areas; (2) utilization of advanced diagnostic imaging services (as so defined); and (3) the estimated savings to the Medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) during the period of 2010 through 2019 as a result of such adjustment.

The Comptroller General would report to Congress by January 1, 2013, on the results of the study, together with recommendations for such legislation and administrative action as the Comptroller General determines appropriate.

Sec. 3136. Revision of Payment for Power-Driven Wheelchairs.

Present Law

Wheelchairs, including power-driven wheelchairs, are covered by Medicare under the capped-rental category of the durable medical equipment (DME) benefit. Medicare pays for power-driven wheelchairs in one of two ways: either Medicare will pay the supplier a monthly rental amount during the beneficiary's period of medical need (though payments are not to exceed 13 continuous months), or the payment is made on a lump-sum basis at the time the supplier furnishes the chair if the beneficiary chooses the lump-sum payment option. If the reasonable lifetime of a power-driven wheelchair is reached, or the wheelchair is lost or irreparably damaged, Medicare will pay for a replacement. The beneficiary may elect to have the replacement purchased through either monthly rental payments not to exceed 13 months, or a lump-sum payment.

Rental payments for wheelchairs are statutorily determined as ten percent of the purchase price of the chair for each of the first three months of rental and 7.5 percent of the purchase price for each of the remaining ten months of the rental period.

Medicare pays for most DME on the basis of a fee schedule. However, the Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA, 108-173) required the Secretary to establish a competitive acquisition program for specified durable medical equipment; the competitive acquisition program would replace the Medicare fee schedule payments. The program is to be phased-in, starting in nine of the largest metropolitan statistical areas (MSAs) in 2009; expanding to 80 of the largest MSAs in 2011 and remaining areas after 2011.

Committee Bill

Starting January 1, 2011, the Committee Bill would limit the option to purchase a power-driven wheelchair with a lump-sum payment only to complex, rehabilitative power wheelchairs. The lump-sum payment option would be eliminated for all other wheelchairs. The provision would also eliminate the lump-sum purchase option for replacing a wheelchair for all chairs except complex, rehabilitative power wheelchairs. This provision would not apply to competitive acquisition areas prior to January 1, 2011.

Also starting January 1, 2011, the Committee Bill would change the calculation of the rental payment for power-driven wheel chairs. The rental payment for power-driven wheelchairs would be 15 percent of the purchase price for each of the first three months (instead of ten percent), and six percent of the purchase price for each of the remaining ten months of the rental period (instead of 7.5 percent).

Sec. 3137. Hospital Wage Index Improvement.

Present Law

A hospital wage index is used to adjust the standardized amount to account for the local wage variation or cost of labor in the hospital's area. Medicare defines hospital labor market areas using definitions of statistical areas established by the Office of Management and Budget (OMB). The wage index is intended to measure the average wage level for hospital workers in each urban area (a modified core based statistical area or CBSA) or rural area (comprised of counties that have not been assigned to any CBSA) relative to the national average wage level. Some states where every county is included in an urban area have no rural wage index. There is a statutory requirement that the wage index for any urban area in a state cannot be less than the rural wage index of that state (often referred to as the rural floor).

Hospitals submit data on their hours, wages, and labor-related costs annually in their Medicare cost report. There is a four-year lag in the data used to calculate the wage index; the FY2008 wage index was calculated using data submitted by hospitals for cost reporting periods beginning in FY2004. Generally, CMS calculates an area's average hourly wage (AHW) using the data on compensation and hours submitted by every hospital in the area. Starting in FY2005, CMS has adjusted this data to account for the relative skill mix of the hospitals in the area. This occupationally mix adjusted average hourly wage is then divided by the same measure calculated using data from all hospitals in the nation to establish the area's adjusted wage index.

The Tax Relief and Health Care Act of 2006 (TRHCA, P.L. 109-432) required that MedPAC submit a report to Congress on wage index revisions, including recommendations on alternatives by June 30, 2007. The Secretary was directed to consider MedPAC's recommendations and include in the fiscal year 2009 inpatient prospective payment proposed rule one or more proposals to revise the wage index. TRHCA also requires that CMS consider specific issues of Congressional concern such as eliminating exceptions, minimizing variation in the wage index across county borders and using the hospital wage index in different settings. MedPAC issued its mandated report by June 2007. CMS did consider the report's recommendations in its FY2009 rulemaking process and has hired an independent consulting firm to further evaluate the impact of making the recommended changes.

Unlike other providers, acute care hospitals may apply to the Medicare Geographic Classification Review Board (MGCRB) for a change in classification from a rural area to an urban area, or reassignment from one urban area to another urban area. If reclassification is granted, the new wage index will be used to calculate the hospital's Medicare payment for inpatient and outpatient services. Other services offered by the hospital such as rehabilitation services in a distinct part unit will be paid using the wage index from the hospital's original area.

Generally, for an individual hospital to qualify for reclassification, it must demonstrate a close proximity to the area where the hospital seeks to be reclassified. After establishing appropriate proximity, a hospital may qualify for the wage index of another area if it proves that its incurred costs are comparable to those of hospitals in that area. To use an area's wage index, a hospital must demonstrate that its own AHW is within a certain percentage of the AHW of the area to which it seeks redesignation. Until recently, in order to reclassify to a different area, a rural hospital had to demonstrate that its AHW is equal to at least 82 percent of the area's AHW; an urban hospital's AHW had to be 84 percent of the area's AHW. Starting in FY2010, the reclassification threshold has been raised two percentage points to 84 percent for rural hospitals and 86 percent for urban hospitals. MGCRB hospital reclassifications are established on a budget neutral basis so aggregate inpatient payments will not increase as a result of reclassified hospitals' higher payments.

Section 508 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA, P.L. 108-173) 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. These reclassifications were extended from March 31, 2006 to September 30, 2007 by the Tax Relief and Health Care Act of 2006 (TRHCA, P.L. 109-432). The Medicare, Medicaid and SCHIP Extension Act (MMSEA, P.L. 110-173) extended the reclassifications to September 30, 2008. The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA, P.L. 110-275) extended the reclassifications until September 30, 2009. These extensions were exempt from any budget neutrality requirements.

Committee Bill

The Section 508 reclassifications would be extended until September 30, 2011. The Secretary would be required to use the wage index data that was promulgated by the Secretary in the Federal Register on August 27, 2009 (74 Fed. Reg. 43754), and any subsequent corrections, for purposes of the extension.

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. This plan would be required to take into account the goals set forth in the MedPAC June 2007 report including establishing a new hospital compensation index system that: (1) uses Bureau of Labor Statistics data, or other data or methodologies, to calculate relative wages for each geographic area involved; (2) minimizes wage index adjustments between and within CBSA and statewide rural areas; (3) includes methods to minimize the volatility of wage index adjustments that result from implementation of policy, while maintaining budget neutrality in applying such adjustments; (4) takes into account the effect that implementation of the proposal would have on health care providers and on each region of the country; (5) addresses issues related to occupational mix, such as staffing practices and ratios, and any evidence on the effect on quality of care or patient safety as a result of implementation of policy in this section; and (6) provides for a transition period. The Secretary would be required to consult with relevant affected parties in developing the plan.

The Secretary would also be required to restore the reclassifications thresholds used in determine hospital reclassifications to the percentages used for FY2009 MGCRB decisions, starting FY2011. This change would be in effect until the first fiscal year one year after the Secretary submits the plan to reform the Medicare wage index system as referenced above. This provision would be implemented in a budget neutral fashion.

Sec. 3138. Treatment of Certain Cancer Hospitals.

Present Law

Eleven cancer hospitals are exempt from the inpatient prospective payment system (IPPS) used to pay inpatient hospital services provided by acute care hospitals. As part of this exemption, these facilities are paid on a reasonable cost basis, subject to certain payment limitations and incentives. These hospitals are also held harmless under the outpatient prospective payment system (OPPS) and will not receive less from Medicare under this payment system than under the prior outpatient payment system. Under OPPS, Medicare pays for outpatient services using ambulatory payment classification (APC) groups.

Committee Bill

The Secretary would be required to conduct a study determine if the outpatient costs incurred by IPPS-exempt cancer hospitals with respect to Medicare's APCs exceed those costs incurred by other hospitals reimbursed under OPPS. If the costs in the IPPS-exempt cancer hospitals are excessive, the Secretary would be required to provide for an appropriate adjustment under Section 1833(t) of the Social Security Act for services furnished starting January 1, 2011.

Sec. 3139. Payment for Biosimilar Biological Products.

Present Law

A biologic is a preparation, such as a therapeutic product or a vaccine, that is made from living organisms. The legislative proposal assumes the enactment of legislation that would expand the regulatory activities of FDA by opening a pathway for the approval of biosimilars, also referred to as follow-on biologics. The new regulatory pathway would be analogous to the FDA's existing authority for approving generic chemical drugs under the Drug Price Competition and Patent Term Restoration Act of 1984 (P.L. 98-417). Often referred to as the Hatch-Waxman Act, this law allows the generic company to establish that its drug product is chemically the same as the already approved innovator drug, and thereby its application for FDA approval relies on FDA's previous finding of safety and effectiveness for the approved drug.

Medicare Part B pays for a limited number of drugs for beneficiaries in several different ways, depending on the setting in which the drug is administered, the type of drug, and the patient's eligibility for Medicare. Part B covers certain drugs administered to patients in physician offices and hospital outpatient departments, or those administered through durable medical equipment (DME) and billed by pharmacy suppliers. In certain limited instances, Part B will pay for drugs billed as supplies and self-administered by the patient.

CMS assigns a Healthcare Common Procedure Coding System (HCPCS) code to each drug. Medicare payments for Part B drugs are based on average sales price (ASP) for each HCPCS code. CMS uses the same HCPCS code for all drug products listed as therapeutically equivalent in FDA's *Orange Book*. Therefore, a brand-name drug and any generic versions of the same drug would have the same HCPCS code and the prices would be averaged together for ASP determinations.

Committee Bill

The Committee Bill would allow a Part B biosimilar product approved by the Food and Drug Administration and assigned a separate billing code to be reimbursed at the ASP of the biosimilar plus six percent of the ASP of the reference product. A biosimilar biological product would mean a product approved under an abbreviated application for a license of a biological product that relies in part on data or information in an application for another biological product licensed under the Public Health Service Act. The term reference biological product means the licensed biological product that is referred to in the application for the biosimilar product.

Sec. 3140. Public Meeting And Report On Payment Systems For New Clinical Laboratory Diagnostic Tests.

Present Law

No Present Law.

Committee Bill

The Committee Bill would require the Secretary to convene a public meeting on mechanisms of payment for new clinical laboratory diagnostic tests under the Medicare program. The public meeting would include a discussion of how to reform Medicare payment mechanisms for such tests. The Secretary would submit a report to Congress containing a summary of the public meeting, together with recommendations for such legislation and administrative action that the Secretary would determine to be appropriate.

Sec. 3141. Medicare Hospice Concurrent Care Demonstration Program.

Present Law

No provision.

Committee Bill

The Committee Bill would require 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 relative to such funds that would otherwise be paid to hospice programs in a given year.

Sec. 3142. Application of Budget Neutrality on a National Basis in the Calculation of the Medicare Hospital Wage Index Floor for Each All-urban and Rural State.

Present Law

A hospital wage index is used to adjust the standardized amount to account for the local wage variation or cost of labor in a hospital's area. The wage index is intended to measure the average wage level for hospital workers in each urban area (a modified core based statistical area or CBSA) or rural area (comprised of counties that have not been assigned to any CBSA) relative to the national average wage level As established by Section 4410 of the Balanced Budget Act of 1997 (BBA, P.L. 105-33), the wage index for any urban area in a state cannot be less than the rural wage index of that state (often referred to as the rural floor). In some states, every county is included in an urban area; as a result, there is no rural wage index for that state and no rural floor. Beginning in FY2006, the Centers for Medicare and Medicaid Services (CMS) established an "imputed" rural floor for states that did not have any acute care hospitals in rural areas.

The effect of the rural floor (that is, raising the wage index for urban areas in a state to that state's rural wage index) is required to be implemented on a budget neutral basis. BBA established that the budget neutrality requirement for the rural floor be achieved by adjusting the wage index of all other hospitals not affected by the rural floor. Until FY2009, CMS funded the budget neutrality requirement associated with the impact of the rural and imputed rural floor though a nationwide adjustment. Starting in FY2009, CMS began a transition to fund the budget neutrality requirement through a state-specific adjustment; the statewide adjustment would be fully implemented in FY2011. States with no hospitals receiving the rural floor wage index would not experience reduced payments; those hospitals within each state with urban areas paid at the higher rural wage index would fund the higher payments for the affected hospitals.

Committee Bill

The Committee Bill would require application of budget neutrality requirement associated with the effect of the imputed rural and rural floor on a national, rather than state-specific adjustment (through a uniform, national adjustment to the area wage index).

Sec. 3143. HHS Study on Urban Medicare-dependent Hospitals.

Present Law

Medicare dependent hospitals (MDHs) are small rural hospitals with a high proportion of patients who are Medicare beneficiaries. Specifically, the hospitals in rural areas have at least 60 percent of acute inpatient days or discharges attributable to Medicare in FY1987 or in two of the three most recently audited cost reporting periods. As specified in regulation, they cannot be a

sole community hospital (SCH) and must have 100 or fewer beds. MDHs receive special treatment, including higher payments, under Medicare's inpatient prospective payment system (IPPS).

IPPS includes certain payment adjustments, such as the indirect medical education (IME) adjustment for teaching hospitals, to compensate hospitals for higher average costs which might not be in their control. The disproportionate share hospital (DSH) adjustment increases payments for hospitals that serve a relatively high proportion of low-income Medicare and Medicaid patients. Certain hospitals, such as rural referral centers, SCHs, and MDHs, receive special treatment under IPPS. Other small, limited service critical access hospitals (CAHs) are exempt from IPPS and paid 101 percent of their reasonable costs.

Committee Bill

The Secretary would conduct a study on the need for additional Medicare payments for urban Medicare-dependent hospitals paid under IPPS which receive no additional payments through either an IME or a DSH adjustment or who are not classified as an RRC, SCH, or MDH. CAHs would be excluded as well. For the purposes of the study, urban Medicare-dependent hospitals would be defined as those hospitals with more than 60 percent of their inpatient days or discharges paid by Medicare. The study will examine the Medicare inpatient margins of these hospitals compared to other IPPS hospitals that receive one or more of the additional payments or adjustments and would consider the applicability to these urban hospitals of the existing payment adjustment for Medicare-dependent rural hospitals. The Secretary would submit a report including recommendations for legislative and administrative actions to Congress no later than nine months from the date of enactment.

Subtitle C – Provisions Relating to Part C

Sec. 3201. Medicare Advantage Payment.

Present Law

Under the Medicare Advantage (MA) program, beneficiaries have the option to receive Medicare benefits through private health insurance plans. MA plans are paid a monthly per-capita amount to provide all Medicare-covered benefits (except hospice) to beneficiaries who enroll in their plan.

Section 1853 of the Social Security Act requires the Secretary each year to calculate monthly benchmark amounts for MA plans for each county of the country (and the territories). These benchmark amounts are administered prices—that is, they are set by statutory formula and used to determine how MA plans are paid under Medicare. Present Law also requires MA plans to submit bids to the Secretary on an annual basis that represent their average monthly revenue requirements for providing Medicare-covered benefits per enrollee for the following year. The monthly bid amounts reflect plans' estimated costs of delivering Medicare benefits per enrollee, as well as their administrative costs, such as profits and expenses for sales, marketing, and care

management activities. MA plans also submit separate monthly bids for benefits that they offer under Part D.

MA benchmarks are calculated differently for local plans and regional plans. The local benchmark is based solely on statutory county-level rates. The regional benchmark consists of two components: statutory county-level rates and a weighted average of regional plan bids. The latter component introduces an element of price competition among regional plans by basing a portion of the benchmark amount on bids submitted by the plans.

Medicare payments to MA plans are determined by comparing their bids to the benchmark rates. If an MA plan bid is equal to or above the benchmark, its payment is the benchmark, and it must charge an enrollee premium equal to the difference between its bid and the benchmark. If an MA plan bid is below the benchmark, its payment is its bid. MA plans that bid below the MA benchmarks are also paid a "rebate" amount in addition to their bid. Specifically, MA plans that bid below the benchmarks are paid 75 percent of the difference between their bids and the benchmarks. Thus, the Medicare payment to MA plans that bid below the statutory benchmark is equal to each plan's bid plus 75 percent of the difference between each bid and the benchmark rate.

The "rebate" paid to MA plans must be used to provide benefits that are not covered by Medicare. These extra benefits can take the form of lower Medicare cost sharing under Parts A, B or D, reduced or eliminated monthly Part B premium, or added benefits and services beyond those covered by statute. Rebate payments to MA plans vary widely across the country. Areas with high statutory benchmark rates—mainly areas with the highest levels of per capita Medicare spending—tend to have the highest rebates paid to MA plans. Consequently, MA plans in high cost areas can offer significantly more extra benefits than MA plans in areas with average or low per capita Medicare costs. Under Present Law, the average rebate amount is about $100 per month, or $1,200 per year. Rebate payments enable MA plans to compete on extra benefits rather than on the price or quality of care they offer.

In general, the MA benchmarks in each local area (county) are updated annually by the national per capita growth rate in Medicare expenditures, otherwise known as the national MA per capita growth percentage. In certain years (known as *rebasing years*), MA benchmarks are reset as the greater of the prior years' rate updated by the national MA per capita growth percentage or 100 percent of local fee-for-service (FFS) costs, with adjustments.

Determination of a plan's service area differs for local and regional MA plans. Local plans choose the counties they wish to serve. Regional plans must agree to serve an entire region defined by the Secretary, and may choose to serve more than one region. MA regions are made up of states or groups of states. If a local plan eliminates a service area, the plan may allow all or some of the former enrollees from the affected area to continue their enrollment if the enrollees agree to see providers designated by the plan and there are no other plans available in the area.

Current payments to MA plans (bids plus rebate payments) are risk adjusted. The Centers for Medicare and Medicaid Services (CMS) uses characteristics, such as age, sex, disability status and prior health history to estimate the relative risk of each beneficiary enrolled in a plan. MA

plans are paid their bids plus rebate payments adjusted by their enrollees' risk scores. If MA plans enroll beneficiaries with higher costs, their payments are adjusted upward to account for the costs of covering sicker enrollees. If MA plans enroll beneficiaries with lower costs, their payments are adjusted downward to account for the lower cost of covering healthier enrollees.

Other than risk adjusting payments, the statute does not contain explicit financial incentives for MA plans to manage or coordinate care for high cost, chronically ill beneficiaries.

Section 1854 of the Social Security Act gives the Secretary broad authority to set guidelines and review the actuarial soundness of the monthly bid amounts submitted by MA plans. The statute requires that the Secretary only accept bid amounts or proportions that reasonably reflect the revenue requirements of benefits provided under the plan. Present Law also allows the Secretary to negotiate with plans regarding the bid amounts and supplemental benefits, which is similar to the authority provided to the Director of the Office of Personnel Management with respect to the Federal Employee Health Benefits Program (FEHBP). There is one exception: the Secretary is not allowed to review the actuarial bases of the bid amounts or use negotiation authority with respect to private fee-for-service plans.

The Medicare Prescription Drug, Improvement and Modernization Act (MMA, P.L 108-173) required all MA organizations to have a quality improvement program. As part of this program, plans must collect, analyze, and report data that measure health outcomes and other indicators of performance. The quality measures reported by MA plans are summarized by CMS into a composite quality score for each plan. MA plan quality scores are published annually by CMS. MA plans are also required to annually assess the impact and effectiveness of their quality improvement programs and take timely action to correct any systemic problems that come to their attention.

Committee Bill

The Committee Bill would base the calculation of 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.

MA Benchmarks and Rebates. Beginning in 2011, the Committee Bill would transition MA benchmarks to reflect plan bids. In 2011, the national MA per capita growth percentage would be reduced by three percentage points. Starting in 2012, local MA benchmarks would be blended with plan bids. Specifically, local MA benchmarks would be based on 33 percent of the enrollment weighted average of plan bids for each payment area and 67 percent of the Present Law MA benchmarks. In 2013, a greater share of the benchmark rates would reflect actual plan bids. Specifically, 67 percent of the benchmark rates would be based on the enrollment weighted average of plan bids for each payment area, while the remaining 33 percent would be based on the Present Law MA benchmarks. The Secretary would use enrollment figures from the most recent month from which data is available. In addition, the coding intensity adjustment of MA

plan risk scores would be extended during the transition from statutory benchmarks to competitively bid benchmark rates from 2011 through 2013.

In 2014, the local MA benchmarks would be based on the actual plan bids from the prior year. That is, the 2014 MA benchmarks would be equal to 100 percent of the enrollment weighted average of the 2013 plan bids increased by the national MA growth percentage for 2014. Beginning in 2015, the MA local benchmarks would be determined by the enrollment weighted average of all MA bids in each payment area. In the case of a payment area where only a single plan is offered, the weight would be equal to one. In the case of a payment area where no MA plans were offered in a prior year and multiple plans bid in the following year, the Secretary would use a simple average to calculate the MA benchmark in that area. An upper bound would be established in each area so that local benchmarks could not exceed the levels that would have existed under Present Law. Bids from all local MA plans (except regional plans, PACE plans and 1876 cost plans) would be used to set the MA benchmarks.

Regional plan benchmarks would continue to be calculated as a weighted blend of the regional bids and local MA benchmarks. However, the statutory portion would be based on the new MA benchmarks instead of statutory rates.

In 2011, 2012, and 2013, local and regional MA plans would still receive 75 percent of the difference between their bids and the benchmark rates as a rebate payment. Beginning in 2014, MA plans that bid below the new benchmark rates would receive a rebate amount equal to 100 percent of the difference between their bids and the new benchmarks (rather than 75 percent of the difference as under Present Law). Just as required under Present Law, local and regional MA plans that bid equal to or above the new benchmark rates would be paid the benchmark amount and must charge an enrollee premium equal to the difference between their bids and the benchmarks.

The Committee Bill would also risk adjust bid and rebate payments to plans as under Present Law. Also, 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 Present Law.

Bidding Rules. The Committee Bill would require bid information submitted by MA plans to be certified by a member of the American Academy of Actuaries (MAAA) beginning with plan year 2012. 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. The Secretary, acting through the Chief Actuary, would be required to establish bidding rules that plans would follow in order to protect the integrity and fairness of the bidding process when the bids are used to set benchmarks amounts in payment areas. The Secretary would be required 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. The Chief Actuary would report plan actuaries who were found to repeatedly not comply with bidding rules and standards to the Actuarial Standards Board for Counseling and Discipline. In addition, the Secretary would have authority to refuse to accept additional bids from MA organizations that had submitted bids with consistent misrepresentations.

Payment Areas. The Committee Bill would require 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 "Core-Based Statistical Areas" as determined by the Office of Management and Budget. The Secretary would be required to divide CBSAs that cover more than one state. Beginning in 2015, the Secretary would be allowed to adjust CBSA payment areas to reflect patterns of actual health care use. The Secretary would be required to base the adjustments on recent analyses of patterns of care. In 2012, payments areas for rural or non-urban areas would be counties, as under Present Law. Beginning in 2015, the Secretary would be allowed to combine one or more rural counties in a state into a single service area. The Committee Bill would require that new payment areas established by the Secretary in rural areas also reflect recent research on actual patterns of care.

The Committee Bill would provide additional authority to the Secretary to make limited exceptions to payment area requirements for plans that have historical agreements with other plans 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 as a result of their delivery model.

Under the Committee Bill, bidding and service areas would be the same as payment areas beginning in 2012. MA plans would be allowed to choose which payment areas they would like to serve, but they must bid and serve the entire payment area, and would no longer be allowed to apply different premiums to different segments of their service area.

Bonus Payments. The Committee Bill would establish two new bonus payments for local and regional MA plans. When added together, the two bonus payments would equal a maximum of six percent of the national adjusted average per capita Medicare cost for the year on a per member per month basis. These bonus payments would be available to MA plans, beginning in 2014, regardless of plan type or service area (except not for enrollees under the grandfather policy as described below). Unlike rebate payments, bonus payments would be available to plans that meet certain performance criteria and would not depend on benchmark rates.

The Committee Bill would create a new bonus payment for care coordination and management activities that are conducted by MA plans. Up to two percent of the national adjusted average per capita Medicare cost for the year would be available to MA plans that demonstrate to the Secretary that they conduct activities in four of eight areas. A plan would be eligible to earn ½ percent for each of the following separate areas in which they conduct activities:

1. Care management programs that target individuals with one or more chronic conditions, identify gaps in care, and facilitate improved care by using additional resources like nurses, nurse practitioners, and physician assistants.

2. Programs that focus on patient education and self-management of health conditions, including interventions that help manage chronic conditions, reduce declines in health status and foster patient/provider collaboration.

3. Transitional care interventions that focus on care provided around a hospital inpatient episode, including programs that target post-discharge patient care in order to reduce unnecessary health complications and re-admissions.

4. Patient safety programs, including provisions for hospital-based patient safety programs in their contracts with hospitals.

5. Financial policies that promote systematic coordination of care by primary care physicians across the full spectrum of specialties and sites of care, such as medical homes, capitation arrangements or pay-for-performance programs.

6. Medication therapy management programs that are more extensive than those required under Present Law.

7. Health information technology programs, including electronic health records, clinical decision support and other tools to facilitate data collection and ensure patient-centered, appropriate care.

8. Programs that address identify and ameliorate health care disparities among principal at-risk subpopulations

The Secretary would be authorized to add care management and coordination programs as appropriate. MA plans would be allowed to implement care managements and coordination programs in ways that are appropriate for urban and rural areas.

The Committee Bill would create a second bonus for prior year achievement or improvement in plan quality performance. Performance would be measured based on a ranking system that measures clinical quality and enrollee satisfaction at the contract or plan level as feasible. MA plans would be eligible to receive two percent of the national adjusted average per capita Medicare cost for the year if they achieve a three-star rating on a five-star ranking system or four percent if they achieve between four-and five-stars on a five-star ranking system. Plans that do not achieve at least a three-star rating would be eligible for a one percent quality bonus if their ratings improve over a prior year. If the Secretary does not use a five-star ranking system to measure quality under the MA program, bonus payments would continue to be available to plans at levels that reflect similar levels of achievement and improvement as the five-star ranking system. In making quality bonus payments to plans, the Secretary would use quality ratings from the preceding year. Plans that failed to report data used to determine the quality ratings would be counted as having the lowest performance and improvement ratings.

The Committee Bill would make accommodations for the quality bonus for new and low-enrollment plans for limited time frames. New MA plans would be eligible for a two percent bonus for the first three years of operation. In the fourth year of operation, new plans would be evaluated in the same manner as other plans with comparable enrollment.

For plans with low enrollment, the Secretary would use the regional or local mean for any quality measure that precludes a plan with insufficient data from being evaluated for quality

performance using a five-star ranking system. The Secretary would have authority to create alternative mechanisms of measuring quality for purposes of the quality bonus for plans with persistently low enrollment.

The performance bonuses—both care coordination and quality bonus payments—would be risk adjusted to reflect the demographics and actual health status of each enrollee in the same manner as rebate payments are risk adjusted under the Committee Bill and Present Law. MA plans would be required to use 100 percent of the performance bonus payment amounts to cover the costs of additional benefits offered to their enrollees as specified in Section 3202 below. Plans would still be allowed to offer supplemental benefits for which they charge beneficiaries an added premium, as under Present Law.

Grandfather Policy. MA plans would be allowed to grandfather the extra benefits for their current enrollees (defined as those who are enrolled in MA plans on the date of enactment of the Committee Bill) in certain areas of the country where average plan bids are not greater than 75 percent of local per capita fee-for-service costs. Plans would be able to grandfather enrollees beginning in 2012. The amount of extra benefits in 2012 would be the amount that was available though the plan in 2011; the amount would be reduced by 5 percent each year beginning 2013.

Plans that choose to retain or "grandfather" their current enrollees would also be required to submit bids under competitive bidding in those areas. The bids for covered Medicare benefits under competitive bidding would be used as the base payment to plans for grandfathered enrollees in 2012 and 2013. In 2014, the base payment to plans for grandfathered enrollees would be the new competitive benchmark amounts applicable to the grandfathered area. Plans would be paid additional amounts for extra benefits: in 2012 and 2013, non-grandfathered enrollees would receive their plans' rebate, whereas enrollees under the grandfather would receive the grandfathered amount; in 2014, non-grandfathered enrollees would receive their plans' performance bonus and rebate payments under competitive bidding, whereas enrollees under the grandfather would receive only the grandfathered amount. Performance bonus and rebate payments would not be available to enrollees in grandfathered plans. The base payment and extra benefits for grandfathered enrollees would be risk adjusted in the same manner as for non-grandfathered enrollees. Upon approval by the Secretary, the bid payments (e.g., base payment) for enrollees in grandfathered plans may be adjusted up to ½ percent per year to reflect differences in utilization of care for Medicare covered services by grandfathered enrollees that are not reflected in the competitive bid and that could result from the larger amount of extra benefits under the grandfather policy. MA plans would submit information to substantiate the need for the adjustment.

Transitional Benefits. Beginning in 2012, the Secretary would be required to provide for transitional extra benefits to beneficiaries who enroll in Medicare Advantage plans and would experience a significant reduction in extra benefits under competitive bidding. The Secretary would provide for 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 Medicare Advantage enrollment penetration is greater than 30 percent, and the MA plans bid below local per capita fee-for-service costs. The Secretary could also provide transitional

benefits in counties contiguous to these areas. In addition, the Secretary would be required to review plan bids to ensure transitional benefits made available are passed on to beneficiaries. The total amount available for transitional benefits would be $5 billion through 2019.

PACE Plans. The Committee Bill would exempt PACE plans authorized under Section 1894 of the Social Security Act from provisions of Section 3201, except the provision that would reduce the national MA per capita growth percentage by three percentage points in 2011.

CMS Actuary Certification. The Committee Bill would strike the MA provisions of the Committee Bill related to competitive benchmarks and performance bonus payments if the Chief Actuary of CMS certifies that beneficiaries participating in MA on the date of enactment would lose Medicare-covered benefits when the provisions of the Committee Bill are implemented. The Chief Actuary of CMS would be required to make this certification three months after the enactment of this legislation.

Sec. 3202. Benefit Protection and Simplification.

Present Law

Under the Medicare Advantage (MA) program, the cost sharing (i.e., coinsurance, copayments, and deductibles) that an enrollee must pay for covered health benefits is determined on a plan-by-plan basis. Cost sharing for any service offered by an MA plan may be greater than or less than cost sharing for the same service under the traditional Medicare program. However, the total value of cost sharing required by an MA plan is constrained by the estimated actuarial value of total cost sharing under original Medicare.

Payments to MA plans are based on the relation between the bid and the benchmark, as explained above. If a plan's bid is below the benchmark, the plan is paid its bid plus 75 percent of the difference in the form of a rebate. The rebate must be used to provide additional benefits to enrollees. MA plans have broad authority to determine how they use their rebates to cover the costs of additional benefits. They can reduce Medicare cost sharing expenses under Parts A, B or D. They can also reduce a beneficiary's monthly Part B premium or prescription drug premium. They may also use rebates to pay for benefits that are not covered by traditional Medicare. MA plans also have full discretion to determine how to apportion their rebates among these additional benefits. For this reason, the type and composition of additional benefits that are paid for by rebates varies widely among plans.

Regardless of whether a plan bids above or below the benchmark, a plan may choose to provide benefits not covered under original Medicare and charge a supplemental premium.

Committee Bill

The Committee Bill would include several protections for beneficiaries with respect to the cost sharing amounts charged by MA plans. The Committee Bill would also make additional benefits that are offered by MA plans and paid for by rebates and bonus payments more consistent across plans.

Beginning in 2011, The Committee Bill would prohibit MA plans from charging cost sharing that exceeds the cost sharing under the original Medicare program for certain services for which beneficiaries need the highest level of predictability and transparency, such as chemotherapy treatment, renal dialysis and skilled nursing care. The Secretary would be given authority to identify additional services for which this provision would apply. MA plans would be allowed to charge non-discriminatory levels of cost sharing for Medicare-covered services where there is no cost sharing under the original fee-for-service program.

The Committee Bill would also modify how plans can use their rebates and bonuses for additional benefits beginning with 2012. MA plans would have to apply the full amount of rebates and bonuses to cover the cost of additional benefits in the following priority order:

First, plans would use the most significant share to meaningfully reduce Part A, B, and D cost sharing relative to the traditional FFS program. Cost sharing would include copayments, co-insurance, deductibles, as well as out-of-pocket caps on total beneficiary spending. The Secretary could provide guidance on what constitutes meaningful cost sharing reductions, but could not set the amounts for each plan. The Committee Bill would remove authority of MA plans to reduce or eliminate the Part B premium as an additional benefit. In addition, any out-of-pocket spending limits that plans offer would be required to apply to all Part A and B benefits. In other words, MA plans would not be able to exclude certain services, like chemotherapy drugs, from out-of-pocket spending limits.

Second, plans would use the next largest share to add preventive and wellness benefits, such as preventive care visits, smoking cessation programs, and free flu shots.

Third, plans would be able to use the remainder to add non-covered benefits, such as eye examinations and dental coverage.

In addition, the Committee Bill would simplify information about additional benefits that are offered by MA plans. Beginning in 2011, the Secretary would categorize MA plans in each payment area into two or more distinct categories according to the share that rebates, bonuses and supplemental premiums are of each plan's bid. Any marketing materials used must reflect the plan's category. For example, the Secretary could decide to create three categories of plans: Bronze, Silver and Gold. The intent is to help beneficiaries compare and distinguish the additional benefits that MA plans offer above original fee-for-service Medicare.

Sec. 3203. Application of Coding Intensity Adjustment During MA Payment Transition

Present Law

Payments to Medicare Advantage plans are risk adjusted to reflect the actual health status of the beneficiaries that enroll in them, as required by the Balanced Budget Act of 1997 (P.L. 105-33). The Deficit Reduction Act (DRA) of 2005 (P.L. 109-171) included a provision to phase-out a budget neutrality adjustment that the Centers for Medicare and Medicaid Services (CMS) used in implementing risk adjusted payments to private plans. Also included in the DRA was a

provision that requires the Secretary to adjust risk scores for differences in coding patterns between Medicare Advantage plans and the original fee-for-service program. The Secretary is required to make the coding intensity adjustment through 2010.

Committee Bill

The Committee Bill would extend the coding intensity adjustment during the transition from statutorily defined benchmarks to competitively bid benchmarks from 2011 through 2013. It would also allow the Secretary to incorporate the adjustment into risk scores under competitive bidding, if appropriate, beginning in 2014.

Sec. 3204. Simplification of Annual Beneficiary Election Periods.

Present Law

According to the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA, P.L. 108-173), Medicare beneficiaries may enroll in or change their enrollment in Medicare Advantage (MA) and Part D plans from November 15 to December 31 each year in the annual coordinated election period. These changes become effective on January 1 of the next year. During a continuous enrollment and disenrollment period in the first three months of the new benefit year beneficiaries can enroll in an MA plan, and individuals enrolled in an MA plan can either switch to a different MA plan or return to original Medicare. However, during the three-month period, beneficiaries cannot change their drug coverage elections.

In a December 2008 report, the Government Accountability Office (GAO) found that about 15 percent of beneficiaries who chose to switch plans in the Part D annual coordinated election period for the 2008 benefit year were not fully enrolled in their new plan by January 1, primarily because of the volume of applications submitted late in the period. GAO recommended that Congress consider authorizing the Secretary of HHS to amend the current coordinated election period to include a sufficient processing interval to fully enroll beneficiaries prior to the effective date of their new coverage.

Committee Bill

The Committee Bill would shift the annual enrollment period dates for Medicare Advantage and Part D to October 15 to December 7. The change would be effective beginning in 2011. Also, beginning in 2011, the continuous enrollment and disenrollment period for MA and MA-PD plans that occurs between January 1 and March 31 each year would be eliminated. The Committee Bill would institute a limited disenrollment period from January 1 through February 15 in order for beneficiaries who enroll in Medicare Advantage or prescription drug plans during the annual enrollment period to disenroll during that period. These changes are intended to simplify the time frames under which beneficiaries would need to make enrollment decisions.

Sec. 3205. Extension for Specialized MA Plans for Special Need Individuals.

Present Law

Under the Medicare Modernization Act of 2003 (MMA, P. L. 108-173), Congress created a new type of Medicare Advantage coordinated care plan for individuals with special needs. Special needs plans (SNPs) are allowed to target enrollment to one or more types of individuals identified by Congress as: (1) institutionalized; (2) dually eligible for Medicare and Medicaid; and/or (3) individuals with severe or disabling chronic conditions.

Congress has since passed additional legislation affecting SNPs. The original SNP authority established by MMA was to expire in December 31, 2008. Passage of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA, P.L. 110-173) authorized the SNP program through December 31, 2009, but also established a moratorium on the creation of SNPs after January 1, 2008. More recently, the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA, P.L. 110-275), lifted the moratorium and authorized the SNP program through December 31, 2010. In addition to legislative changes affecting SNPs, CMS has issued regulatory guidance for the legislative changes. Most recently, the Centers for Medicare and Medicaid Services (CMS) issued a Final Rule in the January 12, 2009 *Federal Register*.

The number of SNPs has increased dramatically since 2004, the first year of operation. In 2004, CMS approved 11 SNPs, but by January 2008, CMS had approved 787 SNPs, including 442 dual-eligible SNPs, 256 chronic care SNPs, and 89 institutional SNPs. In September 2008, there were 1.2 million beneficiaries in SNPs.

Under MIPPA, the SNP program was authorized through December 31, 2010. MIPPA also required that new SNP enrollment be limited to individuals that meet the criteria for which the SNP is designated: dual-eligible, chronic care, and institutional care. Further, MIPPA required that dual-eligible SNPs contract with state Medicaid agencies to provide medical assistance services in order to serve new areas. Such contracts with states may include long-term care services. However, there is no requirement for state Medicaid agencies to contract with SNPs in order for SNPs to serve new areas.

MIPPA also modified the definition of a chronic care SNP to focus on beneficiaries who are at the greatest risk for hospitalizations and who may have the greatest need for care coordination. In addition, MIPPA required that all SNPs have models of care that are appropriate to their populations and include personalized care plans for each beneficiary that they enroll.

MIPPA further required SNPs to collect, analyze, and report data related to their model of care. These data are required to be reported for each plan sponsored by an organization. CMS provided additional guidance in an interim final rule that requires data that demonstrates compliance with 10 quality indicators. CMS coordinated with the National Committee on Quality Assurance to develop quality measures for SNPs. However, there is no statutory requirement that SNP participate in the NCQA quality measurement requirement or be approved by NCQA.

Present Law covering SNPs does not address requirements for the transition to other appropriate MA plans or FFS Medicare if beneficiaries fail to meet the target definition for the types of SNP plans in which they are enrolled. Further, the Secretary does not have the authority to adjust payment levels for dual-eligible SNP plans. Under the Program for All-inclusive Care for the

Elderly (PACE) program authority, CMS may provide for frailty adjustments for PACE organizations that treat a greater number of frail enrollees.

There is no requirement for the Secretary to assess how well the risk adjustment model functions with respect to plans, like SNPs, with high enrollment of chronically-ill and severely disabled beneficiaries or to make changes to address any deficiencies.

Committee Bill

The Committee Bill would extend the authority for MA SNPs to target their enrollment to certain populations through December 31, 2013. In addition, the MIPPA requirement for SNPs to restrict enrollment to individuals who are within the classes of special needs individuals would be made permanent and apply to all enrollees in SNPs. The Committee Bill would authorize the Secretary to transition beneficiaries enrolled in SNPs to other MA plans or original Medicare if the beneficiaries do not meet the definitions established for such plans. The Secretary also would be permitted to make time-limited exceptions to the transition for dual-eligible beneficiaries who may have temporarily lost their Medicaid status in order to give them time to reapply for Medicaid benefits.

The Committee Bill would create a new payment adjustment for fully-integrated dual-eligible SNPs beginning in 2011. Specifically, it would give the Secretary authority to provide a frailty adjustment for fully-integrated dual-eligible SNPs that have similar average levels of frail beneficiaries as PACE plans, as defined by the Secretary. The Secretary would only be able to adjust payments to dual-eligible SNPs that fully integrate benefits covered under Titles 18 and 19 of the Social Security Act. In order to qualify, dual-eligible SNPs would need to integrate Medicare and Medicaid benefits as well as payments through an MA contract with the Secretary and a contract with the state Medicaid agency that includes the provision of long-term care.

The Committee Bill would extend, until December 31, 2012, a provision in MIPPA that granted SNPs that serve dual-eligible beneficiaries temporary authority to continue to operate even though they have not established contracts with state Medicaid programs. By 2013, all dual-eligible SNPs would need to have contracts with states in order to operate as SNPs in any area of the country.

Beginning in 2012, the Secretary would require that SNPs be approved by the National Committee for Quality Assurance (NCQA) in order to serve targeted populations. Also beginning in 2011, the Secretary would use a risk score for new enrollees in chronic care SNPs that reflects the known underlying risk profile and chronic health status of similar individuals. The new risk score would be applied in lieu of the default risk score for new enrollees of non-SNP MA plans.

For 2011 and periodically thereafter, the Secretary would be required to evaluate and revise the methodology used to risk adjust MA plan payments in order to as accurately as possible account for higher medical and care coordination costs associated with frailty, individuals with multiple, co-morbid chronic conditions, enrollees with a mental illness diagnosis and also to account for costs that may be associated with higher concentrations of beneficiaries with these conditions.

The Secretary would be required to publish a description of its evaluations and any modifications with the announcement of final payment rates.

Sec. 3206. Extension of Reasonable Cost Contracts.

Present Law

Reasonable cost plans are Medicare Advantage (MA) plans that are reimbursed by Medicare for the actual cost of providing services to enrollees. Cost plans were created in the Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982. The Balanced Budget Act of 1997 included a provision to phase-out the reasonable cost contracts, however, the phase-out has been delayed over the years through Congressional action. These plans are allowed to operate indefinitely, unless two other plans of the same type (i.e., either two local or two regional plans) offered by different organizations operate for the entire year in the cost contract's service area. After January 1, 2010, the Secretary may not extend or renew a reasonable cost contract for a service area if: (a) during the entire previous year there were either two or more MA regional plans <u>or</u> two or more MA local plans in the service area offered by different MA organizations; <u>and</u> (b) these regional or local plans meet minimum enrollment requirements.

Committee Bill

The Committee Bill would extend for three years—from January 1, 2010, to January 1, 2013—the length of time reasonable cost plans may continue operating regardless of any other MA plans serving the area.

Sec. 3207. Technical Correction to MA Private Fee-for-Service Plans.

Present Law

Present Law allows different types of private plans to participate in the MA program, including coordinated care plans (CCPs, such as health maintenance organizations (HMOs) and preferred provider organizations (PPOs)), and private fee-for-service plans (PFFS). CCPs are required to meet medical access requirements by forming networks of contracted providers. Private fee-for-service plans (PFFS) can meet access requirements either by establishing payment rates for providers that are not less than rates paid under original Medicare or by developing contracts and agreements with a sufficient number and range of providers within a category to provide covered services under the terms of the plan. Beginning in 2011, the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA, P.L. 110-275) requires PFFS plans sponsored by employers or unions to establish contracted networks of providers to meet access requirements. PFFS plans that are not sponsored by employers are required to establish contracted networks of providers in areas defined as areas having at least two plans with networks (such as HMOs or PPOs). In areas without at least two network-based plans, PFFS plans retain the ability to establish access requirements through establishing payment rates that are not less than those under original Medicare. The Secretary has the authority to waive or modify requirements that hinder the design of, the offering of, or the enrollment in employer or union sponsored MA plans. The CMS Medicare Managed Care Manual for Employer/Union Sponsored Group Health Plans

specifies the circumstances under which the Secretary would exercise authority to waive some service-area network requirements for employer-sponsored coordinated care plans.

Committee Bill

The Committee Bill would clarify that, in defining areas in which PFFS 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. The Committee Bill would also allow the Secretary to grant employer-direct PFFS plans (as defined under 1857(i)(2)) a waiver from the network requirements in a manner similar to the Secretary's authority to waive or modify other MA requirements for employer-contracted coordinated care plans as specified in a 2008 service area extension waiver policy, as modified in an April 11, 2008 CMS memo entitled "2009 Employer Group Waiver-Modification of the 2008 Service Area Extension Waiver Granted to Certain MA Local Coordinated Care Plans." Only employer-direct PFFS plans that had enrollment as of October 1, 2009 would be eligible for the waiver.

Sec. 3208. Making Senior Housing Authority Demonstration Permanent.

Present Law

Erickson Advantage is a Medicare Advantage demonstration project administered by Evercare and available exclusively to Erickson Retirement Community residents. In general, Medicare Advantage plans are required to serve an area no smaller than a county, which prevents plans from targeting smaller areas of healthier, low-cost enrollees. The Erickson Advantage plan received a waiver of this requirement to be able to restrict enrollment to community residents.

Committee Bill

Effective January 1, 2010, the Committee Bill would allow Medicare Advantage plans that meet specific criteria to limit their service areas to a senior housing facility within a geographic area. MA plans would be eligible if they serve beneficiaries who reside in a continuing care retirement community, have a sufficient number of on-site primary care providers as determined by the Secretary, supply transportation benefits to other providers, and were in existence under a demonstration for at least one year by December 31, 2009.

Sec. 3209. Development of New Standards for Certain Medigap Plans.

Present Law

Many Medicare beneficiaries have individually purchased health insurance policies, commonly referred to as "Medigap" policies. Beneficiaries with Medigap insurance typically have coverage for Medicare's deductibles and coinsurance; they may also have coverage for some items and services not covered by Medicare. Individuals generally select from one of a set of standardized plans (Plan "A" through Plan "L", though not all plans are offered in all states). The law incorporates by reference, as part of the statutory requirements, certain minimum standards established by the National Association of Insurance Commissioners (NAIC) and

provides for modification where appropriate to reflect program changes. 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".

Beginning in 2010, two new packages may be offered -- Plan "M" and Plan "N." Plan "M" includes 50 percent coverage of the Part A deductible, and no coverage of the Part B deductible. Plan "N" includes 100 percent coverage of the Part A deductible but no coverage for the Part B deductible. In addition, coverage for the Part B coinsurance is limited to up to $20 for an office visit and up to $50 for an emergency room visit.

Committee Bill

The Committee Bill would request that NAIC create new model plans for C and F that include nominal cost sharing to encourage the use of appropriate 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 revisions would be required to be consistent with rules applicable to changes in NAIC Model Regulations. The new models C and F would be available in 2015.

Subtitle D – Medicare Part D Improvements

Sec. 3301. Medicare Prescription Drug Discount Program for Brand-Name Drugs.

Present Law

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA, P.L. 108-173) included a defined standard benefit structure under the Part D prescription drug benefit. In 2009, the standard benefit includes a $295 deductible and 25 percent coinsurance until the enrollee reaches the initial coverage limit ($2,700 in total covered drug spending). After the initial coverage limit, there is a gap in coverage, or "doughnut hole," in which the beneficiary is responsible for 100 percent of drug costs. Beneficiaries must spend $3,454.75 out-of-pocket before they reach the catastrophic benefit. Once they reach catastrophic coverage, they are responsible for five percent of drug costs. The plan pays 15 percent and the Medicare program pays 80 percent for the remainder of the benefit year.

Present Law allows Part D plan sponsors to offer benefit packages that differ from the standard benefit, as long as they are actuarially equivalent. Most plans offer actuarially equivalent benefit packages in lieu of the standard benefit design. Present Law also allows plans to offer "enhanced" benefit packages that provide more generous coverage (typically, enhanced benefit packages have higher premiums). Most enhanced packages have a reduced or $0 deductible and/or reduced cost-sharing in the initial coverage period. However, fewer plans choose to offer benefits during the coverage gap. Most plans that offer gap coverage only provide benefits for generic drugs and not brand-name drugs, and many times the coverage is limited to a subset of the generic drugs listed on plan formularies. Thus, if a beneficiary wants to purchase a plan that has both generic and brand-name coverage in the gap, they are not able to do so because insurers do not offer plans with those types of benefits. Insurers do not offer broad gap coverage because

it is voluntary and tends to attract sicker, more expensive beneficiaries with higher drug spending that would require them to set higher premiums overall.

Committee Bill

The Committee Bill would establish a discount program for beneficiaries who enroll in Part D and have drug spending that falls into the coverage gap. The Committee Bill would provide 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 until it 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 Present Law. The discount program would apply to Medicare beneficiaries who enroll in Part D, do not qualify for the low-income subsidy, are not enrolled in an employee–sponsored retiree drug plan, and do not have annual income that exceeds the Part B income thresholds as determined under Present Law ($85,000 for singles and $170,000 for couples in 2009). For beneficiaries with supplemental benefits that provide some savings during the doughnut hole, the discount would be applied to the costs remaining after the supplemental benefits have been applied.

Specifically, beginning July 1, 2010, eligible beneficiaries would automatically receive a 50 percent discount off the negotiated price for brand-name prescription drugs that are covered under Part D and covered by their plan's formulary or are treated as being on plan formularies through exceptions and appeals processes. For purposes of the discount, the negotiated price would be the same as defined in 42 CFR 423.100, which is the price that plans pay to pharmacies minus the amount of price concessions (i.e., rebates and discounts) that plans pass on to beneficiaries. Dispensing fees would be excluded from the negotiated price and the discount. That means beneficiaries who receive the discount would continue to pay pharmacy dispensing fees as under Present Law. The discount would be made at the point of sale and apply to sole-source and multiple-source brand-name drugs. Payment of the discount by manufactures would be made to pharmacies no later than 14 days after the date of dispensing a discounted drug.

The Committee Bill stipulates that drugs sold and marketed in the U.S. by a manufacturer would not be covered under Part D unless the manufacturer agrees to participate in the discount program described above. Manufacturers would be required to sign an agreement with the Secretary of Health and Human Services (HHS) in order to participate in the program and have their drugs covered under Part D. These conditions of coverage would not apply if the Secretary has made a determination that the availability of the drug would be essential to the health of beneficiaries or if the Secretary has determined that there are extenuating circumstances in the period between July 1, 2010 and September 30, 2010.

For an agreement with a manufacturer to be in effect by July 2010, the manufacturer would need to enter into an agreement with the Secretary by March 1, 2010. Initial agreements would be for 18 months (until December 31, 2011) and automatically renewed unless terminated by the Secretary or the manufacturer. The agreement would require manufacturers to discount drug

prices at the pharmacy or through a mail order service at the point of sale. The Secretary would be allowed to provide for manufacturer discount after the point-of-sale for a temporary period (July 1, 2010 through December 31, 2011) until the necessary data systems are in place to implement the discount at the point-of-sale. Manufacturers would be required to collect and have available appropriate data as determined by the Secretary to ensure that they can demonstrate compliance with the discount program.

The Secretary would be authorized to terminate an agreement within 30 days notice for violation of the requirements of the agreements or for other good cause. The Secretary would be required to provide, upon request, a hearing concerning such a termination, but such hearing would not delay the effective date of the termination. Manufacturers would be allowed to terminate an agreement for any reason. Such termination would not be effective until the end of the benefit year if terminated before January 30 and at the end of the following benefit year if terminated after January 30. Manufacturers could reenter the program for a benefit year if they reenter an agreement by January 30 of the preceding year.

The Committee Bill would also allow 100 percent of the negotiated price of discounted drugs (excluding dispensing fees) to count toward the annual out-of-pocket threshold that is used to define the coverage gap each year. This threshold is generally referred to as "true out-of-pocket" spending. In other words, the full negotiated price of discounted drugs would count as incurred costs of beneficiaries for purposes of Section 1860D-(2)(b)(4)(B) of the Social Security Act. The Committee Bill includes this provision so that the size of the coverage gap would not widen and beneficiaries with high prescription drug costs would not be held back from reaching the catastrophic benefit as a result of the discount program.

The Committee Bill would require the Secretary to contract with a third-party entity (or entities) to administer the drug discount program and would establish performance requirements and data standards for the third-party contractor(s). At a minimum, the third party would 1) receive and transmit information between plans, manufacturers and the Secretary and 2) receive and distribute, or facilitate the distribution of, the funds from manufactures in order to effect the discount to beneficiaries at the point of sale. Manufacturers would be required to contract with the same third party under terms specified by the Secretary in order to carry out their requirements under the discount program. The Secretary would not be authorized to receive or distribute funds from manufacturers under the discount program, except for the period between July 1, 2010, and December 31, 2010, if the Secretary determines it necessary to implement the discount program during that initial period of time.

The Committee Bill would also require manufacturers who participate in the Part D drug discount program to be audited for compliance. Manufacturers that do not comply with the discount would be subject to fines assessed and collected by the Secretary. Fines would be commensurate with the amount manufacturers would pay if they had adhered to the discount program, along with an additional penalty equal to 25 percent of the discount amount. The Committee Bill would also allow for a reasonable notice and dispute resolution mechanism before penalties could be assessed. The Secretary would be authorized to prohibit a manufacturer's drugs from being covered under Medicare Part D for repeated non-compliance.

Sec. 3302. Improvement in Determination of Part D Low-Income Benchmark Premium.

Present Law

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA, P.L. 108-173) created an outpatient prescription drug benefit in Medicare. Medicare beneficiaries who have limited income and resources may qualify for financial assistance to help pay for their prescription drug costs under the benefit. Those who qualify for the low-income subsidy (LIS) receive "extra help" paying for their monthly premiums, yearly deductibles, co-payments, and costs in the coverage gap. For example, the Federal government pays up to 100 percent of the Part D premiums for LIS beneficiaries who enroll in LIS-eligible plans.

A plan qualifies as an LIS-eligible plan if it offers standard coverage (or an equivalent) with a premium equal to or lower than a benchmark amount calculated for each region. The regional low-income benchmark amount, determined annually, is the weighted average of premiums in each of the 34 prescription drug plan (PDP) regions for standard prescription drug coverage, or the actuarial value of standard prescription drug coverage for plans that offer supplemental, or enhanced, coverage options. For Medicare Advantage prescription drug plans (MA-PD), the portion of the premium attributable to standard prescription drug benefits is used.

Under the Medicare Advantage (MA) program, private health plans bid to offer Medicare coverage to beneficiaries. The Secretary bases payment for an MA plan on the relationship between its bid and a statutorily defined benchmark. The MA benchmark represents the maximum amount the Federal government would pay a plan for providing Medicare benefits. If a plan's bid is less than the benchmark, its payment equals its bid plus a rebate of 75 percent of the difference between the benchmark and the bid. The rebate must be used to provide additional benefits to enrollees, reduce Medicare cost-sharing, or reduce a beneficiary's monthly Part B or Part D premiums.

MA plans offering prescription drug coverage must submit a separate bid for the Part D portion of the benefit. Payment for the portion of the premium attributable to standard prescription drug benefits is calculated in the same way as it is for stand-alone PDPs; however the MA plan may choose to apply some of its MA rebate payments to lower the Part D premium. If an MA plan uses rebate payments to reduce its Part D premium, the reduced premium amount, not the actual amount attributable to standard drug coverage, is factored into the regional low-income benchmark. This has the effect of lowering the LIS benchmark and therefore reducing the number of plans that can serve LIS beneficiaries at fully subsidized or $0 premium.

Committee Bill

The Committee Bill would require the Secretary to exclude Medicare Advantage rebates and performance bonus payments from the MA-PDP premium amount when calculating the regional 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.

Sec. 3303. Voluntary De Minimus Policy for Subsidy Eligible Individuals Under Prescription Drug Plans and MA-PD Plans.

Present Law

No provision.

Committee Bill

The Committee Bill would authorize a policy, beginning in 2011, through which plans that bid a nominal amount above the regional low-income subsidy (LIS) benchmark amount can choose to absorb the cost of the small difference between their bid and the LIS benchmark in order to qualify as a LIS-eligible plan. The Secretary would be given discretion to auto-enroll LIS beneficiaries into these plans in order to maintain 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.

Sec. 3304. Special Rule for Widows and Widowers Regarding Eligibility for Low-Income Assistance.

Present Law

To qualify for financial assistance under the Part D low-income subsidy (LIS) program, Medicare beneficiaries must have resources no greater than the income and resource limits established by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA, P.L.108-173). Individuals may qualify for the full subsidy in two ways: (1) if they are eligible for Medicaid or one of the Medicare Savings Programs (Qualified Medicare Beneficiary (QMB), Specified Low-Income Medicare Beneficiary (SLMB), or Qualifying Individual (QI)), or are recipients of Supplemental Security Income (SSI) benefits, they are deemed automatically eligible; or (2) if they apply for the benefit through their State Medicaid agency or through the Social Security Administration (SSA) and are determined to have an annual income below 135 percent of the Federal poverty level (FPL) and have resources below a certain limit (in 2009, $8,100 for an individual or $12,910 if married). Beneficiaries may qualify for a partial subsidy if they apply and are determined to have an annual income below 150 percent of FPL and their resources do not exceed a certain limit (in 2009, $12,510 for individuals or $25,010 if married). When determining whether a beneficiary qualifies for the low-income subsidy, $1,500 in resources per person is excluded from consideration if the beneficiary indicates that he/she expects to use resources for burial expenses.

If beneficiaries experience changes in their personal or financial circumstances during the year, they may be responsible for different levels of cost sharing or may no longer qualify for the low-income subsidy for the next plan year. Each year, the Secretary conducts a redeeming process to determine whether those who automatically qualified for the full subsidy in a given year continue to meet the criteria for eligibility in the following year. For those who have qualified for the full or partial subsidy through the application process, the agency that made the determination decision (SSA or an individual state) is responsible for monitoring a recipient's eligibility. For

example, for cases in which eligibility has been established through an application with SSA, a report of a subsidy-changing event, such as marriage, divorce, or death of a spouse, will trigger a redetermination of subsidy eligibility during the calendar year. This can result in changes to the individual's deductible, premium and cost sharing subsidy, or even termination of his or her LIS eligibility status. In the case of the death of a spouse, it is possible that the surviving spouse, as the sole owner of the previously combined resources, may exceed the resource limit for an individual and may no longer qualify for the LIS program.

Committee Bill

The Committee Bill would require 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 redetermined, as appropriate, for the LIS program on the same basis as other LIS-eligible beneficiaries.

Sec. 3305. Improved Information for Subsidy Eligible Individuals Reassigned to Prescription Drug Plans and MA-PD Plans.

Present Law

According to the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA, P.L. 108-173), low-income subsidy (LIS) beneficiaries who are enrolled in plans with premiums below the low-income regional benchmark amount receive assistance with premiums and cost sharing. LIS beneficiaries who are enrolled in LIS-eligible plans whose plan bids exceed the regional benchmark amount for the next benefit year are randomly reassigned by the Secretary of HHS to new plans whose bids are at or below the regional benchmark amount in order to ensure that these beneficiaries continue to receive a subsidy of plan premiums. It is possible that the new plan's exceptions, appeals and grievance mechanisms could differ from the old plan, and some covered drug(s) a beneficiary is currently taking would not be covered by the new plan.

Committee Bill

In the case of an LIS beneficiary who has been reassigned to another LIS plan, the Committee Bill would require the Secretary, beginning in 2011, to transmit, within 30 days of the reassignment, information to the beneficiary about formulary differences between the former plan and the new plan with respect to the beneficiary's drug regimen, as well as a description of the beneficiary's rights to request a coverage determination, exception or reconsideration, or resolve a grievance.

Sec. 3306. Funding Outreach and Assistance for Low-Income Programs.

Present Law

The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA, P.L. 110-275) provided $25 million for fiscal years 2008 and 2009 for beneficiary outreach and education activities related to low-income programs related to Medicare through State Health Insurance Programs (SHIPs), Area Agencies on Aging (AOAs), Aging and Disability Resource Centers (ADRCs), and the Administration on Aging.

SHIPs are state-based programs that provide Medicare beneficiaries with local, personalized assistance with Medicare benefits and other health insurance programs. MIPPA provided $7.5 million for grants to the states for SHIPs. Two-thirds is allocated based on the share of persons in each state with incomes below 150 percent of poverty and who have not enrolled in the Part D low-income subsidy program. One-third is allocated among states based on the share of Part D eligible beneficiaries residing in rural areas.

MIPPA also required the Secretary of HHS to provide $7.5 million to the Administration on Aging to make grants to Area Agencies on Aging. Additionally, MIPPA provided $5 million to the Administration on Aging to make grants to Aging and Disability Resource Centers under the Aging and Disability Resource Center grant program. Finally, MIPPA provided $5 million to the Administration on Aging to make a grant or enter into a contract with an entity to, among other things, maintain and update web-based decision support tools and integrated systems designed to inform older individuals about the full range of benefits for which the individuals may be eligible under Federal and state programs, and to develop and maintain an information clearinghouse on best practices and the most cost effective methods for finding such individuals.

Committee Bill

The Committee Bill would extend MIPPA Section 119 and provide $45 million for outreach and education activities related to Medicare low-income assistance programs, including the Part D low-income subsidy (LIS) program and the Medicare Savings Program (MSP). Funds would be allocated in the following manner: $15 million to State Health Insurance Programs, $15 million to the Administration on Aging for Area Agencies on Aging, $10 million to Aging Disability Resource Centers and $5 million for the contract for the National Center for Benefits Outreach and Enrollment. 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.

Sec. 3307. Improving Formulary Requirements for Prescription Drug Plans and MA-PD Plans with Respect to Certain Categories or Classes of Drugs.

Present Law

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA, P.L. 108-173) requires Part D plans to operate formularies that cover drugs within each therapeutic category and class of covered Part D drugs, although not necessarily all drugs within such categories and classes. The Secretary of HHS published a regulation (42 CFR Section 423.120) that requires Part D plans to have at least two drugs within each therapeutic category and class.

However, a higher standard of coverage has been established for six specific classes. Through sub-regulatory guidance, the Secretary protected access to certain classes of drugs by requiring Part D plans to cover all, or substantially all, of the drugs in the following six drug classes: immunosuppressant, antidepressant, antipsychotic, anticonvulsant, antiretroviral, and anti-neoplastic.

Section 176 of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA, P.L. 110-275) codified that, beginning in plan year 2010, the Secretary would identify the classes and categories of drugs that should be protected, or covered entirely by Part D plans, to ensure that beneficiaries have access to certain therapies and to a wide variety of therapy options for certain conditions. MIPPA included several clinical criteria that the Secretary would have to use in order to identify protected classes of drug. MIPPA also added a requirement that the Secretary promulgate regulations to identify the protected classes and make any subsequent changes to the classes through regulation.

Committee Bill

The Committee Bill would remove the criteria, specified in Section 176 of MIPPA, that would have been used by the Secretary to identify protected classes of drugs. The Committee Bill would give the Secretary authority to identify classes of clinical concern as defined by the Secretary. Part D plan sponsors would be required to include all drugs in these classes in their formularies; the Secretary would be allowed to establish exceptions if promulgated through a final rule. The Committee Bill would codify the current six classes of clinical concern as they are currently specified through sub-regulatory guidance until the Secretary issues a final rule regarding classes of clinical concern to be protected on plan formularies. The provision would be effective beginning in with plan year 2011.

Sec. 3308. Reducing Part D Premium Subsidy for High-Income Beneficiaries.

Present Law

According to the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, (MMA, P.L.108-173), Part D beneficiary premiums account for 25.5 percent of expected total Part D premium costs for standard coverage. Medicare pays the remaining 74.5 percent of Part D costs. The Medicare portion of average Part D costs is determined annually and paid directly to plans on a monthly basis for each beneficiary they enroll. However, beneficiaries pay different monthly premiums depending on the plan they select and whether or not they are entitled to low-income premium subsidies. If a beneficiary chooses a plan with lower than average premiums, then their share of their plan's premium will be lower than the 25.5 percent set nationally. Beneficiary premiums under Part D are not subject to income thresholds or means testing.

Beginning in 2007, as required by the MMA, high-income beneficiaries are required to pay higher premiums for Part B benefits. Beneficiaries with modified adjusted gross incomes that exceed a threshold amount are charged additional premiums based on a sliding scale that ranges from 35 percent to 80 percent of the value of Part B. In 2009, threshold levels started at $85,000 for an individual tax return and $170,000 for a joint return (based on 2007 returns). The

threshold amounts are specified in law, and are adjusted annually for inflation using the Consumer Price Index. The income thresholds are tied to specific premium shares. In 2008, approximately five percent of Part B enrollees paid the higher premiums.

Section 6103 provides that returns and return information are confidential and may not be disclosed by the Internal Revenue Service ("IRS"), other Federal employees, State employees, and certain others having access to such information except as provided in the Internal Revenue Code. Section 6103 contains a number of exceptions to the general rule of nondisclosure that authorize disclosure in specifically identified circumstances. For example, section 6103 provides for the disclosure of certain return information for purposes of establishing the appropriate amount of any Medicare Part B premium subsidy adjustment.

Specifically, upon written request from the Commissioner of Social Security, the IRS may disclose the following limited return information of a taxpayer whose premium, according to the records of the Secretary, may be subject to adjustment under section 1839(i) of the Social Security Act (relating to Medicare Part B): taxpayer identity information with respect to such taxpayer; the filing status of the taxpayer; the adjusted gross income of such taxpayer; the amounts excluded from such taxpayer's gross income under sections 135 and 911 to the extent such information is available; The interest received or accrued during the taxable year which is exempt from the tax imposed by chapter 1 to the extent such information is available; The amounts excluded from such taxpayer's gross income by sections 931 and 933 to the extent such information is available; Such other information relating to the liability of the taxpayer as is prescribed by the Secretary by regulation as might indicate that the amount of the premium of the taxpayer may be subject to an adjustment and the amount of such adjustment; and the taxable year with respect to which the preceding information relates.

This return information may be used by officers, employees, and contractors of the Social Security Administration only for the purposes of, and to the extent necessary in, establishing the appropriate amount of any Medicare Part B premium subsidy adjustment.

Section 6103(p)(4) requires, as a condition of receiving returns and return information, that Federal and State agencies (and certain other recipients) provide safeguards as prescribed by the Secretary of the Treasury by regulation to be necessary or appropriate to protect the confidentiality of returns or return information. Unauthorized disclosure of a return or return information is a felony punishable by a fine not exceeding $5,000 or imprisonment of not more than five years, or both, together with the costs of prosecution. The unauthorized inspection of a return or return information is punishable by a fine not exceeding $1,000 or imprisonment of not more than one year, or both, together with the costs of prosecution. An action for civil damages also may be brought for unauthorized disclosure or inspection.

Committee Bill

The Committee Bill would increase, beginning in 2011, the Medicare base premium amount for beneficiaries whose modified adjusted gross income (MAGI) exceeds the thresholds used under Part B ($85,000 for an individual and $170,000 per couple in 2009). This provision would be implemented in a manner that is similar to the current income-related reductions in Part B

premium subsidies. Instead of setting the base beneficiary premium at 25.5 percent of total Part D premiums, the Committee Bill would increase the base premium by a monthly amount calculated from the percentages used to decrease the Part B premium subsidy under Present Law. For individual MAGIs in 2007, the income-related share of total Part B costs were as follows: 35 percent for incomes between $80,000 and $100,000, 50 percent for incomes between $100,000 and $150,000, 65 percent for incomes between $150,000 and $200,000, and 80 percent for income greater than $200,000. Income thresholds for couples filing jointly are twice these dollar amounts. These income thresholds are per 2007 tax returns and have been inflated by the Consumer Price Index (CPI) for 2008 and 2009. Increases in base premium amounts would be deducted from beneficiaries' Social Security income in a manner similar to deductions for Part B premium increases.

The Committee Bill would also inflate the income thresholds by the CPI, except for the period between 2010 and 2019 when the income thresholds would not be updated. Under the Committee Bill, upon written request from the Commissioner of Social Security, the IRS may disclose the following limited return information of a taxpayer whose Medicare Part D premium subsidy, according to the records of the Secretary, may be subject to adjustment under the provisions of the Committee Bill: taxpayer identity information with respect to such taxpayer; the filing status of the taxpayer; the adjusted gross income of such taxpayer; the amounts excluded from such taxpayer's gross income under sections 135 and 911 to the extent such information is available; the interest received or accrued during the taxable year which is exempt from the tax imposed by chapter one to the extent such information is available; the amounts excluded from such taxpayer's gross income by sections 931 and 933 to the extent such information is available; other information relating to the liability of the taxpayer as is prescribed by the Secretary by regulation as might indicate that the amount of the Part D premium of the taxpayer may be subject to an adjustment and the amount of such adjustment; and the taxable year with respect to which the preceding information relates.

This return information may be used by officers, employees, and contractors of the Social Security Administration only for the purposes of, and to the extent necessary in, establishing the appropriate amount of any Medicare Part D premium subsidy adjustment.

For purposes of both the Medicare Part B premium subsidy adjustment and the Medicare Part D premium subsidy adjustment, the Committee Bill provides that the Social Security Administration may redisclose only taxpayer identity and the amount of premium subsidy adjustment to officers and employees and contractors of the Centers for Medicare and Medicaid Services, and officers and employees of the Office of Personnel Management and the Railroad Retirement Board. This redisclosure is permitted only to the extent necessary for the collection of the premium subsidy amount from the taxpayers under the jurisdiction of the respective agencies.

The Committtee Bill further provides that the Social Security Administration may redisclose the return information received under this provision to officers and employees the Department of Health and Human Services to the extent necessary to resolve administrative appeals of the Part B and Part D subsidy adjustments and to officers and employees of the Department of Justice to

the extent necessary for use in judicial proceedings related to establishing and collecting the appropriate amount of any Medicare Part B or Medicare Part D premium subsidy adjustments.

Sec. 3309. Simplification of Plan Information.

Present Law

According to the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, (MMA, P.L.108-173), Part D plans can design two general types of benefit packages: standard (or actuarially equivalent alternatives) and supplemental. The supplemental, or enhanced, benefit must be of higher actuarial value than the standard benefit. Enhanced plans may offer lower or $0 deductible, reduced cost sharing, an increased initial coverage limit, coverage of some drugs excluded from Part D and/or some coverage of drugs during the coverage gap. Plans must also offer a standard option in a region in order to offer enhanced benefit options.

Beneficiaries and persons assisting them can use the "Medicare Prescription Drug Plan Finder" on the Medicare.gov website to find and compare Part D plans in their area. The plan finder provides information on monthly premium and annual deductible amounts, whether there is coverage in the gap and estimated annual costs to the beneficiary. However, the plan finder does not indicate whether the benefits offered by a particular plan are standard, a standard alternative or enhanced. Additionally, marketing and enrollment materials provided by the plans may or may not include this information.

Committee Bill

The Committee Bill would require the Secretary to establish, beginning with the 2011 plan year, two or more categories of prescription drug plans offered by 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 and relevant marketing materials. The Secretary would also be required to ensure that there are meaningful differences between the benefit categories.

Sec. 3310. Limitation on Removal or Change of Coverage of Covered Part D Drugs Under a Formulary Under a Prescription Drug Plan or an MA-PD Plan.

Present Law

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003, (MMA, P.L.108-173) permits Part D plans to manage drug utilization and costs through formularies, or lists of drugs that a plan chooses to cover and the terms under which they are covered. The formulary must be developed by a Pharmacy and Therapeutics Committee, in which the majority of members are physicians and/or practicing pharmacists. A plan's formulary must include at least two drugs in each category or class used to treat the same medical condition. Drug plans are

also allowed to apply various utilization management (UM) restrictions to drugs on their formularies. These restrictions may include assignment of drugs to tiers that correspond to different levels of cost sharing; prior authorization, in which the beneficiary must obtain a plan's approval before it will cover a particular drug; and step therapy, in which a beneficiary must first try a generic or less expensive drug; and quantity limits.

Under Present Law, Part D plans may not change the therapeutic categories and classes in a formulary other than at the beginning of each plan year, except the Secretary may take into account new therapeutic uses and newly approved covered drugs. The law further stipulates that any removal of a covered drug from a formulary and any change in the preferred or tiered cost sharing status of such a drug shall take effect only after appropriate notice is made available to the Secretary, affected enrollees, physicians, pharmacies, and pharmacists.

The Secretary of HHS published regulations (42 CFR Section 423.120) that also require that, except under certain circumstances, for example when a covered drug has been deemed unsafe by the Food and Drug Administration (FDA) or removed from the market by its manufacturer, a Part D sponsor may not remove a covered drug from a plan formulary or make any change in the preferred or tiered cost sharing status of a covered drug on a plan's formulary between the beginning of the open enrollment period and 60 days after the beginning of the contract year associated with that open enrollment period. After March 1 of a given plan year, Part D sponsors may make maintenance changes to their formularies, such as replacing brand name drugs with new generic drugs or modifying formularies as a result of new information on drug safety or effectiveness. Part D sponsors can also currently make non-maintenance changes if they are approved by the Secretary.

According to guidance from the Secretary, if Part D sponsors remove drugs from their formularies, move covered drugs to a less preferred tier status, or add utilization management requirements, these changes must be approved in advance. Sponsors may make such changes only if enrollees currently taking the affected drug are exempt from the formulary change for the remainder of the contract year.

Regulation also allows Part D sponsors to expand formularies by adding drugs, reducing copayments or coinsurance by placing a drug on a lower cost sharing tier, or removing utilization management requirements at any time during the year.

Committee Bill

The Committee Bill would not allow Part D sponsors, beginning in 2011, to remove a covered drug from a plan formulary, apply 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 increase 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.

This provision would allow for exceptions if the change is in regard to a brand-name drug for which a generic drug was approved during the plan year, if the change is in regard to a safety issue determined by the plan's Pharmacy and Therapeutic Committee or by the FDA, or if the Secretary establishes a specific exemption through the promulgation of regulations relating to plan formularies. During the annual open enrollment period, Part D sponsors would be required to provide each enrollee a notice of any change in the formulary or other restrictions or limitations on coverage of a drug for the upcoming plan year. This notice would apply to the 2010 annual coordinated election period. Only the exception for FDA safety would apply to a drug in a protected category or class as determined under Section 3307.

Sec. 3311. Elimination of Cost Sharing for Certain Dual-Eligible Individuals.

Present Law

Cost-sharing subsidies for low-income subsidy (LIS) enrollees are linked to standard Part D prescription drug coverage. Full-subsidy eligibles have no deductible, nominal cost- sharing during the initial coverage limit and coverage gap, and no cost-sharing over the catastrophic threshold. Other full-benefit dual-eligible individuals with incomes up to 100 percent of the Federal poverty limit (FPL) have cost-sharing for all costs up to the catastrophic threshold of $1.10 in 2009 for a generic drug prescription or preferred multiple source drug prescription and $3.20 in 2009 for any other drug prescription. Full-subsidy-eligible individuals with incomes over 100 percent of FPL have cost-sharing for all costs up to the catastrophic threshold, of $2.40 in 2009 for a generic drug or preferred multiple source drug and $6.00 in 2009 for any other drug. Full-benefit dual eligibles who are residents of medical institutions or nursing facilities have no cost-sharing during any of the Part D coverage limits.

Committee Bill

Under the Committee Bill, cost sharing would not apply to persons who were full-benefit dual eligibles and for whom a determination was made that but for the provision of home and community-based care, the individual would require the level of care provided in an institutional setting. Such home and community-based care would be that provided under Section 1915 or 1932 of the Social Security Act or under a waiver under Section 1115 of the Act. The provision would be effective on a date specified by the Secretary, but not earlier than January 1, 2012.

Sec. 3312. Reducing Wasteful Dispensing of Outpatient Prescription Drugs in Long-Term Care Facilities Under Prescription Drug Plans and MA-PD Plans.

Present Law

Part D plans are required to offer a contract to any pharmacy willing to participate in its long-term care (LTC) pharmacy network so long as the pharmacy is capable of meeting certain minimum performance and service criteria and any other standard terms and conditions established by the plan for its network pharmacies. Each LTC facility selects at least one eligible LTC pharmacy to provide Medicare drug benefits to its residents. Plan formularies must be

structured so that they meet the needs of long-term care residents and provide coverage for all medically necessary medications at all levels of care.

Currently, the Part D program uses plan sponsors and pharmacy benefit managers (PBMs) to direct network pharmacies to dispense drugs in accordance with the State Board of pharmacy requirements and to conduct cost-effective drug utilization management. Both physician prescribing patterns and PBM payment practices result in most prescriptions being dispensed in 30- or 90-day quantities. In the situation where the full amount dispensed is not utilized by the patient due to death, discharge, adverse reactions, medication substitution, or other reason for discontinuation, the remaining unused medication become waste. Also, the unused medication could become an environmental hazard or diverted to illegal use.

Committee Bill

The Committee Bill would authorize the Secretary to establish dispensing technologies, such as weekly, daily or automated dose dispensing, that Part D plans would employ 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. This provision would apply to plan years starting January 1, 2012.

Sec. 3313. Improved Medicare Prescription Drug Plan and MA-PD Plan Complaint System.

Present Law

Under Medicare Part D and Medicare Advantage (MA), beneficiary complaints are processed and tracked in a variety of ways. Under Medicare Part D, Medicare beneficiaries who experience problems with their Part D plan may complain using one or both of two different processes. A beneficiary can file a complaint directly with CMS, which will generally forward it to the appropriate plan sponsor for resolution; or, a beneficiary can file a complaint directly with the plan sponsor (known as a grievance). A MA organization also must have procedures for hearing and resolving grievances between the organization and enrollees. MA organizations are required to provide written information to enrollees about these processes.

Part D and MA related complaints are tracked and resolved through CMS's centralized complaints system, while grievances are tracked and resolved by each plan sponsor using its own system. CMS maintains a central repository of Medicare Part C and Part D-related complaints received by its Regional Offices, Central Office, or through 1-800-MEDICARE. Complaints are assigned to various categories and subcategories, including but not limited to enrollment, disenrollment, benefits, access, pricing, co-insurance, marketing, fraud, waste, abuse, and customer service.

Section 1808(c) of the Social Security Act requires the Secretary of Health and Human Services to appoint a Medicare Beneficiary Ombudsman who is to receive complaints, grievances, and requests for information from Medicare beneficiaries with respect to any aspect of the Medicare Program.

Committee Bill

This Committee Bill would require the Secretary to develop and maintain a plan complaint system to handle complaints regarding Medicare Advantage (MA) and Part D plans or their sponsors. Such complaints may include complaints from MA or Part D eligible beneficiaries related to marketing, enrollment, covered drugs, premiums and cost-sharing, plan customer service, grievances and appeals, and participating providers. A plan complaint would be defined as a complaint that is received (including by telephone, letter, email, or any other means) by the Secretary (including by a regional office, the Medicare Beneficiary Ombudsman, a sub-contractor, a carrier, a fiscal intermediary, and a Medicare Administrative Contractor).

The Secretary would be required to develop a model electronic complaint form to be used for reporting complaints under the system that would be displayed on the Medicare.gov and Medicare Beneficiary Ombudsman websites.

The Medicare Ombudsman would conduct an annual report of the plan complaint system that would include an analysis of the numbers and types of complaints reported under the system; geographic variations in the complaints; the timeliness of agency or plan responses to such complaints; and the resolution of the complaints.

Sec. 3314. Uniform Exceptions and Appeals Process for Prescription Drug Plans and MA-PD Plans.

Present Law

Part D sponsors and Medicare Advantage organizations are required to have procedures in place for making timely coverage determinations and for handling appeals of coverage determinations. Under Part D, beneficiaries can use the coverage determination and appeals process to challenge a utilization management restriction on a drug on the sponsor's formulary or to request coverage for a Part D drug that is not on the sponsor's formulary (i.e. to allow exceptions). Similarly, MA beneficiaries can use the appeal process to request coverage of an item or service that the plan denied.

Section 1852(g) of the Social Security Act outlines general requirements regarding Medicare Advantage exceptions and appeals processes. The Part D program adapted many of the existing rules for appeals that apply to Medicare Advantage program. The coverage and determination and appeals processes may vary among MA and Part D plans as long as these general requirements are met.

Committee Bill

This Committee Bill would require prescription drug plan sponsors or MA organizations offering MA-PD plans to use a single, uniform exceptions and appeals process with respect to the determination of prescription drug coverage for an enrollee under the plan and to provide instant access to this process through a toll-free telephone number and an Internet website. To the

extent possible, Part D plan sponsors would be required to use the same form to carry out this process. This provision would apply to exceptions and appeals made on or after January 1, 2012.

Sec. 3315. Office of the Inspector General Studies and Reports.

Present Law

Special enrollment rules apply to individuals eligible for the Part D low-income subsidy. Generally, there is a two-step process for low-income persons to gain Part D coverage. First, a determination must be made that they qualify for the assistance; second, they must enroll, or be enrolled, in a specific Part D plan. According to Section 1860D-14 of the Social Security Act, full-benefit dual-eligible individuals who have not elected a Part D plan are to be auto-enrolled into one by CMS. If there is more than one plan available that has a monthly beneficiary premium that does not exceed the premium assistance amount under the low-income subsidy, the beneficiary is to be enrolled on a random basis among all such plans in the PDP region.

In a 2006 report, the Office of Inspector General of the Department of Health and Human Services (OIG) examined the extent to which Medicare prescription drug plan formularies include drugs commonly used by dual eligibles and found that inclusion of these drugs in Part D plan formularies varied. Because of this variation, some dual eligibles could find that they have been auto-enrolled in a plan that may not best meet their needs. For this reason, beneficiaries are able to change enrollment at any time, with the new coverage effective the following month.

When the Medicare prescription drug program was created, it was expected that drug plan sponsors would negotiate with drug manufacturers to obtain price concessions on drugs covered under Part D, and thus reduce total costs to the government and to beneficiaries. Some studies have suggested that Part D plans are not obtaining rebates equivalent to those required by statute under Medicaid, and therefore that the prices paid by Medicaid for prescription drugs are lower than the prices for the same drugs under Part D. Information on price concessions obtained by the private part D plans is considered proprietary; therefore it is difficult to make comparisons of the prices paid under Part D to those paid by other third party payers.

Committee Bill

The Committee Bill would require the OIG to report annually on the extent to which formularies used by prescription drug plans and MA-PD plans under Part D include drugs commonly used by full-benefit dual eligible individuals. The first report would be due to Congress not later than July 1st of each year, beginning with 2011.

The OIG would also be required to conduct a study comparing covered prescription drug prices paid under the Medicare Part D program to those negotiated by state Medicaid plans for the top 200 drugs determined by both volume and expenditures. The prices should include all rebates and discounts the Medicaid and Part D plans receive. As part of this study, the OIG would assess the financial impact of any price discrepancies on the Federal government and on beneficiaries, and provide recommendations for legislation and administrative action as appropriate. In conducting the study, the OIG would be given the authority to collect all necessary information

related to pricing necessary to produce comparisons of the Medicare and Medicaid drug benefits. The report would not disclose information that is deemed proprietary or likely to negatively impact a Medicaid program or Part D plan‘s ability to negotiate drug prices. The report would be submitted to Congress no later than October 1, 2011.

Sec. 3316. HHS Study and Annual Reports on Coverage for Dual Eligibles.

Present Law

Certain groups of Medicare beneficiaries automatically qualify (and are *deemed eligible*) for the full low-income subsidy under Part D. Dual eligibles who qualify for Medicaid based on their income and assets are automatically deemed eligible for Medicare prescription drug low-income subsidies. Additionally, those who receive premium and/or cost-sharing assistance from Medicaid through the Medicare savings program, plus those eligible for SSI cash assistance, are automatically deemed eligible for low-income subsidies and need not apply for them. CMS deems individuals automatically eligible for LIS effective as of the first day of the month that the individual attains the qualifying status (e.g., becomes eligible for Medicaid, MSP, or SSI). The end date is, at a minimum, through the end of the calendar year within which the individual becomes eligible.

For individuals who are newly full-benefit dual eligibles, Medicaid prescription drug coverage ceases as soon as the individual is eligible for part D, regardless of whether the individual is enrolled in a Part D plan. This creates the risk of coverage gaps for these individuals. To prevent coverage gaps between the end of Medicaid prescription drug coverage and the start of Medicare prescription drug coverage, CMS regulation specifies that auto-enrollment is effective the month in which the person becomes a full-benefit dual eligible. Because Medicaid eligibility is often retroactive, CMS randomly auto-enrolls new full-benefit dual eligibles into Part D plans retroactive to the start of their full dual status. If a beneficiary is already enrolled in a Part D plan, the Part D sponsor must take steps to ensure that the beneficiary has been reimbursed for any premiums or cost-sharing the member had paid that should have been covered by the subsidy.

Committee Bill

The Committee Bill would require the Secretary of Health and Human Services to monitor and track how many full-benefit dual eligibles enroll in a plan under Part D and receive retroactive drug coverage under the plan, the number of months of retroactive coverage provided, and the amount of reimbursements paid to individuals for costs incurred during the retroactive period. In conducting the study, the Secretary would be required to use drug utilization data reported by Part D plans. The Secretary would be required to submit a report to Congress on this study not later than January 1 of each year, beginning with 2012 and provide recommendations for legislation and administrative action as appropriate.

The Secretary would also be required to report annually on total annual expenditures for dual eligibles made under titles XVIII and XIX together with analyses of health outcomes for these beneficiaries and the extent to which they are able to access their benefits under both titles.

These reports would be submitted to Congress not later than January 1 of each year, beginning with 2013.

Sec. 3317. Including Costs Incurred By AIDS Drug Assistance Programs And Indian Health Service In Providing Prescription Drugs Toward The Annual Out-Of-Pocket Threshold Under Part D.

Present Law

Under the standard Medicare Part D benefit, beneficiaries must incur a certain level of out-of-pocket costs ($4,350 in 2009) before catastrophic protection begins. These include costs that are incurred for the deductible, cost-sharing, or benefits not paid in the coverage gap. Costs are counted as incurred, and thus treated as true out-of-pocket (TrOOP) costs only if they are paid by the individual (or by another family member on behalf of the individual), paid on behalf of a low-income individual under the subsidy provisions, or paid under a State Pharmaceutical Assistance Program. Incurred costs do not include amounts for which no benefits are provided—for example, because a drug is excluded under a particular plan's formulary. Additional payments that do not count toward TrOOP include Part D premiums and coverage by other insurance, including group health plans, workers' compensation, Part D plans' supplemental or enhanced benefits, or other third parties.

Committee Bill

The Committee Bill would allow costs paid by the Indian Health Service, Indian tribe or tribal organization or an urban Indian organization (as defined in Section 4 of the Indian Health Care Improvement Act) to count toward the out-of-pocket threshold. Costs paid under an AIDS Drug Assistance Program under Part B of Title XXVI of the Public Health Service Act would also count toward the out-of-pocket threshold. The provision would apply to costs incurred on or after January 1, 2011.

Subtitle E – Ensuring Medicare Sustainability

Sec. 3401. Revision of Certain Market Basket Updates and Incorporation of Productivity Improvements into Market Basket Updates That Do Not Already Incorporate Such Improvements.

Present Law

Currently, most fee-for-service Medicare providers receive predetermined payment amounts established under different, unique prospective payment systems. Each year, the base payment amounts in the different Medicare payment systems are increased by an update factor to reflect the increase in the unit costs associated with providing health care services. Generally, Medicare's annual updates are linked to either: (1) projected changes in specific market basket (MB) indices which are designed to measure the change in the price of goods and services (such as labor and equipment) that are purchased by the provider and intended to reflect the effect of

inflation on providers' costs per service; or (2) the Consumer Price Index for All Urban Consumers (CPI-U).

Each year, these updates are implemented assuming that the quantity, quality, and mix of inputs remain constant over time. According to the Congressional Budget Office, market basket updates overstate actual costs to providers because they do not assume increases in provider productivity that could reduce the actual cost of providing services (such as through new technology, fewer inputs, etc). Annual updates to the Medicare physician fee schedule are determined by a separate method that already incorporates adjustments for gains in physician productivity.

The Medicare Payment Advisory Commission (MedPAC) makes payment update recommendations for the different payment systems each year in its March report to Congress. In making these recommendations, MedPAC assesses adequacy of payments for efficient providers in the current year; how providers costs may change in the upcoming year; beneficiaries' access to care; changes in the capacity and supply of providers; changes in the volume of services; changes in the quality of care; providers' access to capital; and Medicare payment rates relative to provider costs' in the given year. Based on this analysis, in its March 2009 *Report to Congress: Medicare Payment Policy*, MedPAC recommended that a number of health care providers receive reduced or eliminated Medicare market basket updates in FY2010.

Committee Bill

Generally, the provision would provide for updates based on the MB or CPI minus full productivity estimates for all Parts A and B providers and suppliers who are subject to a MB or CPI update, except for annual inflationary adjustments to Graduate Medical Education payments. The productivity adjustment would equal the percentage change in the ten-year moving average of annual economy-wide private nonfarm business multi-factor productivity as projected by the Secretary for the relevant fiscal year or period.

Specifically, this change would implement a full productivity adjustment for inpatient and outpatient hospital services, inpatient psychiatric facilities, inpatient rehabilitation facilities, long term care hospital services and nursing homes beginning in FY2012. It would implement a full productivity adjustment for hospice providers beginning in FY2013. In addition, it would implement a full productivity adjustment for home health providers beginning in FY2015. For providers paid through the clinical laboratory test fee schedule, the Committee Bill would replace the scheduled 0.5 percent payment reduction for calendar years 2011 through 2013 with a full productivity adjustment for calendar year (CY) 2011 and subsequent years. The clinical laboratory productivity adjustment could not reduce the fee schedule update below zero. All other productivity adjustments for other Part B providers would begin in CY2011.

The update factors for Medicare providers and suppliers would be subject to the productivity adjustment and other adjustments as follows:

Inpatient acute care hospitals. The MB update for inpatient acute hospitals services would be reduced 0.25 percentage points in FY2010 and FY2011. This change would not apply to

discharges occurring before January 1, 2010. Beginning in FY2012, the full productivity adjustment would be applied. In addition, from FY2012 through FY2019, the MB update would be reduced 0.2 percentage points. However, for each of the fiscal years from FY2014 through FY2019, the reduction to the MB would be contingent upon the level of the non-elderly insured population relative to the projection of non-elderly insured population at time of enactment. Specifically, if the previous year's total percent of the non-elderly insured population is more than five percentage points below the projections at the date of enactment, the additional 0.2 percentage point MB reduction for the given year would be eliminated.

Skilled nursing facilities. The SNF MB update would be subject to the productivity adjustment beginning in FY2012.

Long term care hospitals. The MB update for long term care hospitals would be reduced 0.25 percentage points in rate year 2010 and rate year 2011. This change would not apply to discharges occurring before January 1, 2010. Beginning in rate year 2012, the full productivity adjustment would be applied. In addition, from rate year 2012 through rate year 2019, the MB update would be reduced 0.2 percentage points. However, for each of the rate years from 2014 through 2019, the reduction to the MB would be contingent upon the level of the non-elderly insured population relative to the projection of non-elderly insured population at time of enactment. Specifically, if the previous year's total percent of the non-elderly insured population is more than five percentage points below the projections at the date of enactment, the additional 0.2 percentage point MB reduction for the given year would be eliminated.

Inpatient rehabilitation facilities. The MB update for inpatient rehabilitation facilities would be reduced 0.25 percentage points in FY2010 and FY2011. This change would not apply to discharges occurring before January 1, 2010. Beginning in FY2012, the full productivity adjustment would be applied. In addition, from FY2012 through FY2019, the MB update would be reduced 0.2 percentage points. However, for each of the fiscal years from FY2014 through FY2019, the reduction to the MB would be contingent upon the level of the non-elderly insured population relative to the projection of non-elderly insured population at time of enactment. Specifically, if the previous year's total percent of the non-elderly insured population is more than five percentage points below the projections at the date of enactment, the additional 0.2 percentage point MB reduction for the given year would be eliminated.

Home health agencies. The MB update for home health services would be reduced by 1.0 percentage point in 2011 and 2012. Beginning in CY2015, the full productivity adjustment would be applied.

Inpatient Psychiatric facilities. The MB update for inpatient psychiatric facilities would be reduced 0.25 percentage points in rate year 2010 and rate year 2011. This change would not apply to discharges occurring before January 1, 2010. Beginning in rate year 2012, the full productivity adjustment would be applied. In addition, from rate year 2012 through rate year 2019, the MB update would be reduced 0.2 percentage points. However, for each of the rate years from 2014 through 2019, the reduction to the MB would be contingent upon the level of the non-elderly insured population relative to the projection of non-elderly insured population at time of enactment. Specifically, if the previous year's total percent of the non-elderly insured

population is more than five percentage points below the projections at the date of enactment, the additional 0.2 percentage point MB reduction for the given year would be eliminated.

Hospice care. The hospice MB update would be subject to the productivity adjustment beginning in FY2013. In addition, from FY2013 through FY2019, the MB update would be reduced 0.5 percentage points. However, for each of the fiscal years from FY2014 through FY2019, the reduction to the MB would be contingent upon the level of the non-elderly insured population relative to the projection of non-elderly insured population at time of enactment. Specifically, if the previous year's total percent of the non-elderly insured population is more than five percentage points below the projections at the date of enactment, the additional 0.5 percentage point MB reduction for the given year would be eliminated.

Dialysis. The ESRD MB would no longer be subject to a one percentage point reduction beginning in 2012, but would be subject to the productivity factor adjustments starting in 2012.

Outpatient hospitals. The MB update for hospital outpatient services would be reduced 0.25 percentage points in 2010 and 2011. This change would not apply to discharges occurring before January 1, 2010. Beginning in 2012, the full productivity adjustment would be applied. In addition, from 2012 through 2019, the MB update would be reduced 0.2 percentage points. However, for each of the fiscal years from FY2014 through FY2019, the reduction to the MB would be contingent upon the level of the non-elderly insured population relative to the projection of non-elderly insured population at time of enactment. Specifically, if the previous year's total percent of the non-elderly insured population is more than five percentage points below the projections at the date of enactment, the additional 0.2 percentage point MB reduction for the given year would be eliminated.

Ambulance services. The productive adjustment factor would be applied to the CPI-U used to increase the ambulance fee schedule starting in CY2011.

Ambulatory surgical services. The productive adjustment factor would be applied to the CPI-U used to update payments for ambulatory surgical services starting in CY2011.

Laboratory services. The existing 0.5 percentage point reduction to the CPI-U update to the fee schedule in CY2009 and CY2010 would be retained. The productivity adjustment factor would be applied to the CPI-U starting in CY2011, but the application of the adjustment could not reduce the increase to less than zero. A 1.75 percentage point additional reduction to the update in CY2011 through CY2014 would be established; for CY2015, such reduction would be1.95 percentage points.

Certain durable medical equipment. The productivity adjustment factor would be applied to the CPI-U used to increase the fee schedules for certain durable medical equipment (DME) beginning in CY2011. Under Present Law, certain DME are to receive a payment increase of CPI-U plus 2 percentage points in CY2014. The provision would eliminate the two percentage point increase.

Prosthetic devices, orthotics, and prosthetics. The productivity adjustment factor would be applied to the CPI-U update for the applicable fee schedule for this DME category starting in CY2011.

Other items. The productivity adjustment factor would be applied to the CPI-U update for this DME category starting in CY2011.

Sec. 3402. Temporary Adjustment To The Calculation Of Part B Premiums.

Present Law

Medicare beneficiaries have out-of-pocket cost-sharing requirements that differ according to the services they receive. Physician and outpatient services provided under Part B are financed through a combination of beneficiary premiums, deductibles, and Federal general revenues. In general, Part B beneficiary premiums equal 25 percent of estimated program costs for the aged, with Federal general revenues accounting for the remaining 75 percent. Beginning in 2007, higher-income enrollees pay a higher percentage of Part B costs − 35 percent, 50 percent, 65 percent, or 80 percent, depending on the enrollees' modified adjusted gross income. In 2009, the income thresholds for those premium shares are $85,000, $107,000, $160,000, and $213,000, respectively. (For married couples, the corresponding income thresholds are twice those values.) The income thresholds rise each year with changes in the consumer price index.

Committee Bill

The Committee Bill would freeze the current income thresholds for the period of 2011 through 2019.

Sec. 3403. Medicare Commission.

Present Law

No provision.

Committee Bill

The Committee Bill would establish an independent Medicare commission titled the "Medicare Commission." Specifically, the Commission would be required to develop and submit proposals to Congress aimed at extend the solvency of Medicare, lowering Medicare cost-growth, improving health outcomes for beneficiaries, promoting quality and efficiency, and expanding access to evidence-based care. A proposal would consist of a package of recommendations.

Requirements for Proposals .When developing its annual proposal for Congress, the Commission would be required to meet the following conditions: (1) reduce Medicare spending by targeted amounts (in certain years), (2) as appropriate, reduce spending under Medicare Parts C and D (such as premium subsidies and performance bonuses to Medicare Advantage and Prescription Drug Plans) and (3) include recommendations for any administrative funding necessary to implement the Commission's recommendations. The Commission would be

prohibited from making recommendations that would ration care, raise revenues, increase beneficiary premiums under Sections 1818, 1818A, or 1839, or modify Medicare benefits, eligibility, or cost-sharing requirements. The Commission would also be prohibited from developing proposals impacting providers scheduled to receive a reduction in their payment update in excess of a reduction due to productivity in a year prior to December 31, 2019, in which the Commission's proposals would take effect.

The Commission would also be required, to the extent feasible, to: (1) make recommendations that target reductions to sources of excess cost growth; (2) prioritize recommendations that extend Medicare solvency; (3) include only those recommendations that improve the health care delivery system, including the promotion of integrated care, care coordination, prevention and wellness and quality improvement and protect beneficiary access to care, including in rural and frontier areas; (4) consider the effects of changes in provider and supplier payments on beneficiaries; (5) consider the effects of proposals on any provider who has, or is projected to have, negative profit margins or payment updates; and (6) consider the unique needs of individuals dually eligible for Medicare and Medicaid.

Beginning January 1, 2014, the Commission would have the authority to submit to Congress advisory reports that include supplemental, non-binding recommendations regarding improvements to payment systems for providers who are otherwise not subject to the scope of the Commission's proposals. The provision would apply for reports prior to year 2020.

The Commission would be required to consult regularly with the Medicaid and CHIP Payment and Access Commission in carrying out its functions.

Establishment of Savings Targets. Beginning with the 2013 report of the Medicare Trustees, the provision would require the CMS Office of the Actuary (OACT) to determine whether the projected Medicare per-capita growth rate for the second succeeding year exceeds the average of the projected percentage increase in the Consumer Price Index (CPI) and the Consumer Price Index for medical care (CPI-M). The Medicare per-capita growth rate would be calculated as a five-year average of Medicare spending (Parts A, B, and D) per unduplicated enrollee, ending with the projection for the year in which the Commission's proposals would apply. This projection would be made without regard to the physician fee schedule update. The projection would also be required to take into account any delivery system reforms or payment changes either enacted or published in final rules and any recommendations made by the Commission to provide the Secretary with additional administrative funding to implement the proposal.

Prior to 2018, if the projected Medicare per-capita growth rate exceeds the average of CPI and CPI-M, the Commission would be required to submit a proposal to Congress by January 1, 2014 that would include recommendations for reducing the Medicare per-capita growth rate by 0.5 percentage points for 2015, 1.0 percentage points for 2016, 1.25 percentage points for 2017, and 1.5 percentage points for 2018 and subsequent years. After 2019, the Commission would be required to submit proposals to Congress if the projected Medicare per-capita growth rate exceeds the projected increase in the growth rate of real GDP per capita for the year plus 1.0 percentage point. The provision would also require that the Commission's proposals are certified by OACT to not increase spending within the following ten-year budget window.

Submission of Proposals. The Commission would be required to submit its proposals to Congress by January 1. The Commission would be required to submit a draft of its proposal to MedPAC by September 1 of the preceding year. Once the proposal is submitted to Congress, MedPAC would be required to review and present its analysis of the Commission's proposal no later than February 1. The Commission would also be required to submit a copy of the draft proposal to the Secretary by September 1st for the Secretary's review and comment by February 1st. If the Commission fails to submit a proposal by the January 1st deadline, the Secretary would be required to submit a proposal to Congress meeting the same requirements by no later than January 5, 2014.

Each proposal submitted to Congress would be required to include an explanation of each recommendation contained in the proposal and the reason for its inclusion. Each proposal would also be required to include an actuarial opinion by the OACT certifying that the proposal meets the applicable requirements.

Congressional Consideration. This section establishes expedited, or "fast track," parliamentary procedures governing consideration of legislation containing proposals by the Medicare Commission or Secretary. Not later than April 1 of any year in which a proposal is submitted to Congress under Section 3403, the appropriate committees of Congress must report legislation either implementing the proposal or satisfying the fiscal and policy requirements described above. If an appropriate committee has not reported such legislation by April 1, then, (1) the committee will be automatically discharged from further consideration of the legislation, and (2) any Member in either chamber may introduce legislation implementing the proposal, which, when introduced, will be placed directly on that chamber's calendar.

Not less than 15 calendar days after the date on which a committee has been, or could have been, discharged from consideration of such legislation, or after the day on which such legislation is introduced, the Speaker of the House and the Majority Leader of the Senate, or their designees, shall make privileged motions that their respective chamber proceed to consider the legislation. Should they fail to make this motion, at any time after the conclusion of the 15-day period, any Member may move to proceed to consider the legislation in their respective chamber. In either case, the motion to proceed is non-debatable, and may not be amended, postponed, or displaced.

All points of order against the legislation and its consideration, except points of order to strike matter "extraneous to Medicare" from the bill or points of order under the Congressional Budget Act of 1974 (Titles I-IX of P.L. 93-344, 2 U.S.C. 601-688), are waived. If the motion to proceed is adopted, the Senate or House will immediately proceed to consider the legislation under its normal rules and procedures until it is disposed of. In the Senate, consideration of the legislation is governed by a time cap on consideration of not to exceed 30 hours equally divided, with a privileged motion in order to further limit debate.

The parliamentary procedures established by this section include provisions to facilitate the exchange of legislation between the House and Senate. If, before voting upon its own legislation, one chamber receives legislation passed by the other chamber, that engrossed legislation will automatically become the one which the receiving chamber acts upon. The expedited procedures

established by this section further require any conference committee appointed to reconcile differences in the two chambers' version of the legislation to file a conference report not later than 15 days after the appointment of conferees. Debate in each chamber on a conference agreement is limited to 10 hours, after which a final vote on the conference report will occur.

Implementation of Proposals. The Secretary shall, with certain exceptions as described below, implement the recommendations contained in the proposal submitted by the Commission or the Secretary to Congress on August 15 of the year in which the proposal is submitted.

In the case of recommendations that change Medicare payment rates for an item or service in which payment rate changes are on a fiscal year basis (or a cost reporting period basis that relates to a fiscal year), on a calendar year basis (or a cost reporting period basis that relates to a calendar year), or on a rate year basis (or a cost reporting period that relates to a rate year), such recommendation shall apply to items and services furnished on the first day of the first fiscal, calendar or rate year (as the case may be) that begins after such August 15.

In the case of a recommendation relating to payments to plans under parts C and D, such recommendations shall apply to plan years beginning on the first day of the first calendar year that begins after such August 15. In the case of any other recommendation, such recommendation shall be addressed within the regular regulatory process timeframe and shall apply as soon as practicable. The Secretary may use interim final rulemaking to implement such recommendations.

Joint Resolution Required To Discontinue Automatic Implementation of Recommendations After 2019. This section establishes expedited, or "fast track," parliamentary procedures governing consideration of a joint resolution approving the discontinuation of the process for consideration and automatic implementation of the proposals of the Medicare Commission after 2019. These procedures specify the text of such a joint resolution and the time period in which it must be introduced (not later than February 1, 2017) in order to qualify for "fast track" consideration. The expedited procedures used for consideration of such a joint resolution are those which already exist in statute and are used to disapprove regulations under the Congressional Review Act (5 U.S.C. 802). Under these procedures, a joint resolution, when introduced, is referred to the committee of jurisdiction in each chamber.

In the Senate, if the committee to which such a joint resolution is referred has not reported it or an identical joint resolution by the end of 20th day of continuous session occurring after the date the joint resolution is introduced, the committee may be discharged from further consideration of the measure upon a petition supported in writing by 30 Senators. If discharged, the joint resolution is placed on the calendar.

When a Senate committee has reported the joint resolution or been discharged as described above, a motion to proceed to the consideration of the legislation will be in order at any time. This motion to proceed is in order even if a previous motion to the same effect has been defeated. The motion to proceed is non-debatable, and may not be amended, postponed or displaced, and all points of order against the joint resolution and its consideration are waived.

If the motion to proceed is adopted, the Senate will immediately consider the joint resolution under a consideration cap of not more than 10 hours equally divided, with a non-debatable motion to further limit debate in order. The joint resolution may not be amended, postponed or displaced. At the conclusion of debate, after a single quorum call, if requested, the Senate will vote on final passage of the joint resolution. There are no expedited procedures governing House floor consideration of a joint resolution.

The parliamentary procedures established by this section also include provisions to facilitate the exchange of legislation between the House and Senate. If, before voting upon its own joint resolution, one chamber receives a resolution passed by the other chamber, that engrossed legislation will automatically become the one which the receiving chamber acts upon.

Membership and Structure. The Commission would be composed of 15 members, appointed by the President with the advice and consent of the Senate. Members of the Commission would serve six-year, staggered terms and would continue to serve until replaced. The Senate Majority Leader, the Speaker of the House, the Senate Minority Leader, and the House Minority Leader would each present three recommendations for appointees to the President. The President, with the advice and consent of the Senate, would also be required to appoint a Chair for the Commission. The Commission would elect a Vice Chairman. Members could only be removed by the President for neglect of duty or malfeasance in office. In addition to the 15 members of the commission, the Secretary of Health and Human Services (HHS), the Administrator of the Center for Medicare and Medicaid Services (CMS), and the Administrator of the Health Resources and Services Administration (HRSA) would serve as ex-officio, non-voting members of the Commission. Qualifications for membership would be similar to the qualifications required for members of the Medicare Payment Advisory Commission (MedPAC). Individuals involved in the delivery or management of health care services could not constitute a majority of the Commission. In addition to these qualifications, the President would be required to establish a system for publicly disclosing any financial or other conflicts of interests relating to members. Individuals that engage in any other business, vocation, or employment could not serve as appointed members of the Commission. Members would be considered officers in the executive branch for purposes of applying Title I of the Ethics in Government Act of 1978. After serving on the Commission, former members would be barred from lobbying the Commission and other relevant executive branch departments and agencies and relevant congressional committees for one year.

The Chair would be responsible for exercising all of the Commission's executive and administrative functions, including those related to the appointment and supervision of employees and the use of funds. All requests for discretionary appropriations to fund the Commission's activities must be approved by a majority vote.

Funding. The Commission's funding level would be set at $15,000,000 per year, indexed to inflation. Sixty percent of the appropriation would come from the Part A Medicare Trust Fund and 40 percent from the Part B Trust Fund.

Powers. The Commission would have the authority to conduct the following activities under this provision: (1) hold hearings, take testimony, and receive evidence, (2) advise the Secretary on

priorities for health services research, particularly as they pertain to payment reforms under Medicare, (3) secure from any Federal department or agency information necessary to carry out its functions, (4) use the United State mail service, (5) accept, use, and dispose of gifts or donations of services, and (6) maintain a principal office and field offices as it determines necessary.

Personnel. Each member would be compensated at a rate equal to the annual rate of basic pay for Level III of the executive schedule. The Chairman would be compensated at a rate equal to the daily equivalent of the annual rate of pay for Level II of the Executive Schedule. The members would be allowed travel expenses, including per diem in lieu of subsistence at rates authorized for employees of agencies under subchapter I of chapter 57 of title 5 of the USC.

Staff. The Chairperson would have the authority to appoint and terminate an executive director and other personnel as necessary to enable the Commission to perform its duties. The executive director would be subject to confirmation by the Commission. The Chairperson would have the authority to fix the compensation of the Executive Director and other personnel without regard to Chapter 51 and subchapter III of Chapter 53 of Title 5 of the USC, relating to the classification of positions and General Schedule pay rates, except that the rate of pay for the Executive Director and other personnel may not exceed the rate payable for level V of the Executive Schedule

Councils. The provision would establish a consumer advisory council to advise the Commission on the impact of payment policies on consumers. The Council would be composed of 10 consumer representatives appointed by the Comptroller General of the United States, each from among the 10 regions established by the Secretary. The membership would be required to represent the interests of the consumers and particular communities. The Council would be required to meet at least 2 times per year and meetings would be open to the public. FACA would apply to the Council, with the exception of section 14.

GAO Study. The provision would require the GAO to conduct a study on changes in payment policies, methodologies, rates, and coverage policies under Medicare. Specifically, the study would provide an assessment of the effect of the Commission's proposal on Medicare beneficiary's access to providers, affordability of premiums and cost-sharing, the potential impact of changes on other government or private sector purchasers of care, and the quality of care provided. The report would be due by July 1, 2015.

Sec. 3404. Ensuring Medicare Savings are Kept in the Medicare Program.

Present Law

No provision.

Committee Bill

This provision would prevent reductions in Medicare outlays resulting from this Act from being used to offset any outlays under any other program or activity of the Federal government.

Subtitle F – Patient-Centered Outcomes Research

Sec. 3501. Patient-Centered Outcomes Research.

Present Law

The need for credible information about which clinical strategies work best, under what circumstances and for whom has been widely recognized by clinicians, patients, researchers and policy makers. Commonly referred to as comparative effectiveness research (CER), the Institute of Medicine (IOM) defines this type of research as the "the generation and synthesis of evidence that compares the benefits and harms of alternative methods to prevent, diagnose, treat, monitor a clinical condition and improve delivery of care" with the aim of tailoring decisions to the needs of individual patients. CBO has referred to CER as "a comparison of the impact of different options that are available for treating a given medical condition for a particular set of patients." MedPAC has referred to "comparative-effectiveness" as "analysis [that] compares the clinical effectiveness of a service (drugs, devices, diagnostic and surgical procedures, diagnostic tests, and medical services) with its alternatives." The phrase "patient-centered outcomes research" has also been used as an alternate term.

Most recently, comparative effectiveness research has been addressed in present law by the Medicare Modernization Act of 2003 (MMA, P.L. 108-173) and the American Recovery and Reinvestment Act of 2009 (ARRA, P.L. 111-5). Section 1013 of the MMA authorizes the Agency for Healthcare Research and Quality (AHRQ) to conduct and support research on outcomes, comparative clinical effectiveness, and appropriateness of pharmaceuticals, devices, and health care services. The section also prohibits the Center for Medicare and Medicaid Services (CMS) from using the data to withhold coverage of a prescription drug. The ARRA provided $1.1 billion in funds to support the development and dissemination of CER. ARRA also asked the Institute of Medicine to recommend national priorities for the research to be addressed by ARRA funds.

Committee Bill

Patient-Centered Outcomes Research Institute (the "Institute"). The Committee Bill would authorize the establishment of a private, non-profit corporation that would be known as the "Patient-Centered Outcomes Research Institute." The purpose of the 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 research would focus on the manner in which diseases, disorders, and other health conditions can effectively and appropriately be prevented, diagnosed, treated, monitored, and managed, and would consider variations in patient subpopulations. Research conducted would compare the clinical effectiveness, risk and benefits of two or more medical treatments, services or items. The Committee Bill would define treatment, services and items as: health care interventions, protocols for treatment, care management and delivery, procedures, medical devices, diagnostics tools, pharmaceuticals (including drugs and biological), and any strategies or items used in the treatment, management, and diagnosis of, or prevention of illness or injury,

in patients. The Institute would also disseminate their research findings. The Institute would be subject to the provisions specified below and, to the extent consistent with the Committee Bill, to the District of Columbia Non-Profit Corporation Act.

The Committee Bill would establish the duties of the Institute, which would be tax exempt for Federal tax purposes. 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 and resources and build capacity for research, and (12) submit annual reports to the Congress, the President, and the public.

Administration of the Institute. The Committee Bill would establish a Board of Governors for the 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: approving and monitoring disbursements from the Patient-Centered Outcomes Research Trust Fund (PCORTF); identifying research priorities; and adopting priorities, methodological standards, peer review processes, dissemination protocols.

The Institute's Board would have 15 members appointed by the Comptroller General of the United States within six months after enactment and would include three members representing each of the following groups: patients and health care consumers; physicians, including surgeons; private payers (including at least one health insurance plan and one self-insuring employer); pharmaceutical, device, and diagnostic manufacturers; and others (including one member representing each of non-profit health services research organization, quality improvement and decision support organizations, and independent health services researchers.)

The Board would have collective scientific expertise in clinical health sciences research, including epidemiology, decision sciences, health economics, and statistics. The Institute's Board members would be appointed for six years, except for the first appointments, of whom six would be appointed for six years, six for four years, and six for two years. Individuals would be prohibited from serving more than two Board terms. Members whose term expires would serve until a successor takes office or the end of the calendar year, whichever is earlier; vacancies would not affect the functioning of the Board. The Comptroller General would designate a Chairperson and Vice-Chairperson from among the Board members to serve a three-year term.

Board members would be entitled to compensation at the per diem equivalent of the level IV Executive Schedule rate and allowed travel, subsistence, and other necessary expense compensation. The Board would employ and set the compensation for an executive director and other personnel as necessary. It would be allowed to seek assistance from personnel of appropriate departments and agencies of the Federal government, make arrangements and payments necessary for the performance of the Institute's duties, and prescribe such rules and bylaws as it deems necessary.

The Board would hold hearings and meetings at the call of the Chairperson or a majority of the members. Meetings not solely concerning matters of personnel would be advertised at least seven days in advance and open to the public. A majority of the Board members would constitute a quorum, but a lesser number of members could meet and hold hearings.

The Board would adopt certain positions and activities by majority vote; these would include the Institute's priorities, the research project agenda, methodological standards, peer review process(es), and the dissemination protocols and strategies. The Institute would be required to refer any of the above back to staff or to the methodology committee, where appropriate, for further review in the case where adoption is not granted.

Research of the Institute. The Committee Bill would charge the 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: disease incidence and prevalence in the U.S.; evidence gaps, in terms of clinical outcomes; practice variations; the potential for new evidence to improve health and quality of care; expenditures associated with a health care treatment strategy or health condition; patient needs, outcomes, and preferences, including quality of life; and relevance to assisting patients and clinicians in making informed health decisions.

The Institute would be required to use the following methods to provide for the conduct of research and synthesis of evidence: (1) systematic reviews and assessments of existing evidence; (2) primary research, such as randomized clinical trials, molecularly informed trials, and observational studies; and (3) any other methodologies recommended by the methodology committee and adopted by the Board. The research and evidence synthesis would only be conducted in accordance with the methodological standards adopted by the Board.

The Institute would be allowed to request and obtain data from Federal, state, and private entities, including data from clinical databases and registries, if the request is granted by the entity. The use of such data would be in accordance with requirements of the data-granting entity with respect to the release, use, confidentiality and privacy of the data. The Secretary of HHS would make relevant CMS data available to the Institute with appropriate safeguards for privacy and confidentiality.

The Committee Bill would require the Institute to establish a process for peer-review of primary research, under which evidence would be reviewed to assess scientific integrity and adherence to the methodological standards adopted by the Institute. The Institute would make public a list of names of individuals contributing to any peer-review process during the preceding year or years and include the list in the Institute's annual reports.

Any peer-review process would be designed in a manner so as to avoid bias and conflicts of interest on the part of the reviewers; the reviews would be conducted by experts in the scientific field relevant to the research under review. The Institute would be allowed to utilize existing peer-review processes already utilized by entities with which the Institute contracts. This would

include the option to utilize the peer-review process of appropriate medical journals, if these review processes met the Institute's own requirements for a peer-review process.

The Institute would coordinate its own activities and resources with that of other public and private agencies to ensure the most efficient use of the Institute's resources and that research is not unnecessarily duplicated. The Institute would also be permitted to build capacity for comparative clinical effectiveness research and related efforts through activities such as supporting the Cochrane Collaboration and other organizations that develop and maintain a data network to collect, link, and analyze data on outcomes and effectiveness from multiple sources, including electronic health records. Such payments would be allowed up to 20 percent of the Patient-Centered Outcomes Research Trust Fund (PCORTF) amounts for a year.

The Institute would be required to review and update evidence periodically to take into account new research, evolving evidence, advances in medical technology and changes in the standard of care as they become available, as appropriate. In addition, the Institute would assess the feasibility of conducting research in-house and to report to Congress on the results of such assessment within five years of the date of enactment.

Addressing Subpopulations. The 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 comorbidities, genetic and molecular sub-types, or quality of life preferences. Members of such subpopulations would be included in the research as feasible and appropriate.

When appropriate, the Institute would design research that takes into account different characteristics of treatment modalities that could affect research outcomes.

Institute Contracts. The Committee Bill would allow the 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 (AHRQ), 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; (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.

Studies conducted by the Institute would be allowed to cover cost sharing of research participants to the extent necessary to preserve the validity of the study results, such as in the case that a study needs to be blinded.

Advisory Panels. The Committee Bill would require the 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 such research is clinically relevant to decisions made by clinicians and patients at the point of care.

In addition, the Institute would appoint expert advisory panels to assist in carrying out the research project agenda with respect to primary research (such as clinical trials). Such panels would, upon request, advise on the research question, design, or protocol of the study and be available as a resource for technical questions that may arise during the conduct of the research.

In the event of a comparative clinical effectiveness study on a rare disease, the Institute would appoint a separate expert advisory panel for purposes of assisting in the design of research studies for rare diseases and for determining the relative value and feasibility of conducting such research on a particular rare disease.

The Committee Bill would require such panels to include representatives of practicing and research clinicians, patients, and experts in scientific and health services research, health services delivery, and evidence-based medicine who have experience in the relevant topic. The Institute would be permitted to include on the panel a representative of each manufacturer of each medical technology that is included under the relevant topic, project, or category for which the panel is established.

The Committee Bill would also direct the Institute to provide support and resources to help patient and consumer representatives who serve on the Board and expert advisory panels to effectively participate in technical discussions regarding complex research topics. This would include initial and continuing education as well as the potential for regular and ongoing interactions between patients and consumer representatives. The Institute would also provide a per diem and other appropriate compensation to the patient and consumer representatives for their time.

Methodology Committee. The Committee Bill would establish a standing methodology committee to serve the 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.

Within two years of enactment (with periodic updates), the methodology committee would determine a process to establish and maintain detailed methodological standards for comparative clinical effectiveness studies. The standards would provide criteria for study designs that balance generalizability, timeliness and other factors. Within this time period, the committee would also provide a translation table that links comparative effectiveness research methods with specific types of research questions.

The methodology committee would also establish and maintain standards regarding clinical outcomes measures, risk-adjustment, and other aspects of research and assessment; these standards would be scientifically based and include methods by which new information, data, or advances in technology may be considered and incorporated into ongoing research. The process for developing these standards would include input and allow for public comment from all relevant experts, stakeholders, and decision-makers. The standards would also include methods by which patient subpopulations could be accounted for and evaluated.

Where appropriate, the methodology committee would build on existing work on methodological and reporting standards. In developing and updating such standards, the Institute would consult or contract with one or more of the following entities: the Institute of Medicine (IOM), the AHRQ, the National Institutes of Health (NIH), and academic, non-profit, or other private entities with relevant expertise.

The methodology committee would also be required to contract with the IOM within three years after the methodology committee members are appointed to examine the following: (1) methods by which aspects of health care delivery systems, such as benefit design, could be assessed and compared for effectiveness, risks, benefits, advantages, and disadvantages in a scientifically valid and standardized way; and (2) methods by which efficiency and value could be assessed in a scientifically valid and standardized way.

The methodology committee would submit reports to the Board concerning the committee's activities and would include recommendations for the Institute to adopt methodological and reporting standards and for other actions the committee determines necessary to comply with such standards, with the exception of the two three-year studies mentioned above.

Dissemination of Information. The Committee Bill would require the 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 patients and providers in making health care decisions. The dissemination of the research would (1) discuss conclusions and considerations specific to certain subpopulations, comorbidities, or risk factors, as appropriate, and (2) include considerations such as limitations of the research and discussions about what further research might be needed, as appropriate.

The Institute would be prohibited from disseminating research findings from a study or assessment that would include practice guidelines, coverage recommendations, or policy recommendations. Further, in any dissemination, the inclusion of data that would violate the privacy of research participants or violate any confidentiality agreements made with respect to use of the data would be prohibited.

In order to ensure effective communication for the purpose of informing higher quality, more effective and timelier medical decisions, the Institute would develop protocols and strategies for the dissemination of the research findings. The Institute would be required to consult with stakeholders in determining the types of dissemination that would be most useful to the stakeholders and would be allowed to utilize multiple formats for conveying findings to different audiences.

Oversight. The Committee Bill would require the Institute to submit an annual report to Congress, the President, and the public. The report would contain (1) a description of the activities conducted during the previous year, including the use of funds, research projects completed and underway, and a summary of the findings of such projects; (2) the research agenda and budget of the coming year; (3) a description of research priorities, dissemination protocols, and methodological standards adopted by the Institute; (4) a list of names of individuals participating in any peer-review process during a preceding year or years; (5) a description of the Institute's coordination with other private and public entities and capacity-building activities for the year; and (6) any other relevant information such as membership and conflicts of interest of Board members, Institute staff, advisory panels, and methodology committees and any bylaws adopted by the Board during the previous year.

The Committee Bill would establish financial and governmental oversight of the Institute. The Institute would be required to undergo annual financial audits conducted by a private entity. The Comptroller General would also review the results of the audit and submit a report to Congress annually.

The Comptroller General would have several additional oversight responsibilities with respect to the Institute. The Comptroller General would (1) review the processes established by the Institute, including those regarding the identification of research priorities and the conduct of research, in order to determine whether such research is objective and credible, produced in a manner consistent with the requirements of this section and developed in a transparent process; (2) review the overall effectiveness of the Institute and its activities, including the utilization of the research findings by health care decision makers and any effect on innovation; (3) submit a report to Congress at least every five years on the above reviews, along with recommendations for any such legislative and administrative action as the Comptroller determines appropriate; (4) assess the adequacy and use of funding for the Institute under the PCORTF, including a determination of whether, based on utilization of the Institute's findings by public and private payers, funding from private-sector contributions, the Medicare Trust Funds, and general revenues are appropriate and should be continued or adjusted. The Comptroller would submit a report to Congress, together with any recommendations, on the adequacy of funding assessment not later than eight years after the date of enactment.

Institute Transparency and Access. The Committee Bill would direct the 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.

The Institute would provide for public comment periods of not less than 45 and not more than 60 days at the following times: prior to the adoption of national priorities, research project agendas, methodological standards, peer-review processes, and dissemination protocols and strategies; prior to the finalization of individual study designs; and after the release of draft findings from systematic reviews and assessments of existing research and evidence. The Institute would transmit any public comments received in relation to draft study designs to the entity conducting the research. The Institute would support additional forums to increase public awareness and obtain and incorporate public input and feedback on the identification of research priorities, including research topics, and the establishment of the research agenda, research findings, and any other duties, activities, or processes the Institute determines appropriate.

The Institute would make the following information publicly available (disclosed through the official public Internet site and any other forums the Institute deems appropriate): (1) the process and methods for the conduct of research, including the identity of the entity conducting research, any links the entity has to industry (including links that are not directly tied to particular research being conducted under contract with the Institute); draft study designs, including research questions and the finalized study design together with associated public comments and responses to such comments, research protocols, including clinical measures taken; methods of research and analysis used; research results; key decisions made by the Institute, panels or committees of the Institute; the identity of investigators conducting such research and any potential conflicts of interest; and progress reports the Institute deems appropriate; (2) notice of each of the public comments periods established by the Institute along with any deadlines for public comments for such periods; (3) public comments submitted during each of the public comment periods; (4) bylaws, processes, and proceedings of the Institute, as feasible and appropriate; and (5) any report, research findings, and appropriate related information within 90 days after the receipt of such article by the Institute.

Conflicts of Interest. The Committee Bill would direct the Comptroller General to consider and disclose any conflicts of interest of potential Board appointees. Board members would be required to recuse themselves when conflicts of interest arise from participation in Board activities and when such interest is directly related to and could affect or be affected by the member's participation. The Committee Bill would require the Institute to take into consideration any conflicts of interest of potential appointees, participants, and staff in appointing members to advisory panels and the methodology committee, in selecting individuals to contribute to any peer-review process, and in employing executive staff. Any such conflicts of interest would be described in the annual report; in the case of peer-reviewers, such descriptions would not allow peer-reviewers to be associated with a particular study.

The Institute, its Board or staff, would be prohibited from accepting gifts, bequeaths, or donations of services or property. Further, the Institute would be prohibited from establishing a corporation or generating revenues from activities other than as provided for under the Committee Bill.

Use of Institute Findings. The Committee Bill would establish several limitations around the use of the Institute's comparative effectiveness research findings. First, the Institute would not mandate coverage, reimbursement, or other policies for any public or private payer. None of the

reports or research findings would be construed as mandates, guidelines, or policy recommendations. (The Secretary would not be prevented from covering the routine costs of clinical care for Medicare beneficiaries participating in research provided for by the Institute for whom such costs would normally be covered under Medicare.)

Second, the Secretary of HHS would be prohibited from denying coverage based solely on a study conducted by the Institute. The Secretary would be required to use an iterative and transparent process when using research from the Institute in making coverage determinations. The process would allow stakeholders and other individuals to provide informed and relevant information with respect to the determination, to review draft proposals of the determination and to submit public comments with respect to draft proposals. The Secretary would be required to consider other relevant evidence and studies, in addition to research findings from the Institute, as well as any evidence and research that demonstrates or suggests a benefit of coverage with respect to subpopulations, even if the research from the Institute demonstrates or suggests that, on average with respect to the general population, the benefits of coverage do not exceed the harm. The Committee Bill would not supersede or modify the statutory basis of the reasonable and necessary standard that is used to make coverage decisions under Present Law.

Third, 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. The Secretary would also be prohibited from using the Institute's research in determining coverage, or creating reimbursement or incentive programs, for a treatment in a manner that precludes, or with intent to discourage, an individual from choosing a health care treatment based on how the individual values the tradeoff between extending the length of their life and the risk of disability.

These limitations would not be construed to limit the application of differential copayments based on factors such as cost or type of service. Further, the limitations shall not be construed to prevent the Secretary from using comparative effectiveness evidence in determining coverage, reimbursement or incentive programs based upon comparing the difference in the effectiveness of alternative treatments in extending a patient's life due to the patient's age, disability, or terminal illness. Nothing in the Committee Bill would be construed to limit comparative effectiveness research or any other research, evaluation, or dissemination of information concerning the likelihood that a treatment will result in disability.

Finally, the Committee Bill would prohibit the Institute from developing or employing a dollars per quality adjusted life year (or similar measure that discounts the value of a life because of a person's disability) as a threshold to establish what health care is cost-effective or recommended; and the Secretary shall not use such measure (or similar measure) as a threshold to determine coverage, reimbursement, or incentives programs.

Patient-Centered Outcomes Research Trust Fund. The Committee Bill would create a new trust fund, called the Patient-Centered Outcomes Research Trust Fund (the 'PCORTF') in the U.S. Treasury to fund the 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, as described below. The Secretary of Health and Humans Services would be the trustee of the PCORTF.

The following amounts would be transferred to the PCORTF from the general funds in the Treasury: $10 million in FY2010, $50 million in FY2011, $150 million in FY2012, and $150 million for each of FY2013 through FY2019. In addition, the Secretary would transfer amounts from the Medicare Federal Hospital Insurance and the Federal Supplemental Medical Trust Funds to the PCORTF in proportion to total Medicare expenditures that come from each Fund for a given year. In FY2013, the amount would be equivalent to $1 multiplied by the average number of individuals entitled to benefits under Part A or enrolled under Part B of Medicare during the year. In FY2014 through FY2019, the amounts would be equivalent to $2, increased by annual medical inflation after FY2014 multiplied by the average number of such individuals for the given year.

Additionally, The Committee Bill would transfer $10 million from funds appropriated to the Secretary under title VIII of Division A of the American Recovery and Reinvestment Act of 2009 (ARRA) would be transferred to the PCORTF.

In addition to the amounts transferred from the Treasury and from funds made available by ARRA, the PCORTF would also be financed from fees on insured and self-insured health plans. The Committee Bill would create a new Subchapter B of Chapter 34 of the Internal Revenue Code with new sections 4375-4377.

The Committee Bill would impose a fee of $1 in FY2013 and $2 (updated by the rate of medical inflation in FY2014 and in subsequent years) in FY2014 through FY2019, on each health insurance policy in the United States multiplied by the number of lives covered under that policy. Insurance policies that primarily provide non-health benefits would be exempt. This fee would sunset after FY2019.

The Committee Bill would impose a fee of $1 in FY2013 and $2 (updated by the rate of medical inflation in FY2014 and in subsequent years) in FY2014 through FY2019, on each self-insured health plan multiplied by the number of lives covered under that plan. Applicable self-insured health plans in the United States would be defined as plans providing accident or health coverage provided other than through an insurance policy and maintained by a plan sponsor for the benefit of members, employees or former employees, or maintained by a multiple employer welfare arrangement of the Employee Retirement Income Security Act of 1974 (ERISA, P.L. 93-406), or a rural electric or telephone cooperative. Plan sponsors would be defined as employers, employer organizations, or groups or associations maintaining a plan; or the entity maintaining a plan for two or more employers, joint employer-employee groups, or employee organizations, welfare arrangements, or voluntary employee's beneficiary associations (VEBAs) maintaining such plans. This fee would sunset after FY2019.

The amounts in the Patient-Centered Outcomes Research Trust Fund would be available to the Institute to carry out its duties without further appropriation. However, no amounts could be appropriated or transferred to the PCORTF if any amounts expended from the PCORTF were to be used for a purpose that is not permitted.

Sec. 3502. Coordination With Federal Coordinating Council For Comparative Effectiveness Research.

Present Law

Section 804 of Division A of the American Recovery and Reinvestment Act of 2009 (42 U.S.C. 299b–8) established the Federal Coordinating Council (FCC) for Comparative Effectiveness Research, an interagency advisory group that is required to help coordinate and support the comparative effectiveness research and to report to the President and Congress annually. The Federal Coordinating Council for Comparative Effectiveness Research is composed of up to 15 senior officials (including physicians and others with clinical expertise) from Federal agencies with health-related programs. ARRA included language stating that (1) the Council may not mandate coverage, reimbursement, or other policies for public and private payers of health care, and (2) Council reports and recommendations may not be construed as mandates or clinical guidelines for payment, coverage, or treatment. On March 19, 2009, HHS announced the members of the Council.

Committee Bill

The FCC would be given additional responsibilities with respect to the new Patient-Centered Outcomes Research Institute. The FCC would be required to "provide support" to the Institute. The FCC's annual report would be modified to include (a) an inventory of its activities with respect to comparative effectiveness research conducted by relevant Federal departments and agencies; and (b) recommendations concerning better coordination of comparative effectiveness research by such departments and agencies. The FCC would coordinate with the Institute in carrying out its duties under this section.

Sec. 3503. GAO Report on National Coverage Determination Process

Present Law

No provision.

Committee Bill

The Committee Bill would require 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 of HHS 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.

Subtitle G – Administrative Simplification

Sec. 3601. Administrative Simplification.

Present Law

To promote the growth of electronic record keeping and claims processing in the nation's health care system, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Administrative Simplification provisions (SSA Sections 1171-1179) instructed the HHS Secretary to adopt standards for the electronic transmission of routine administrative and financial health care transactions between health care providers and health plans, including data elements and code sets for those transactions. The nine HIPAA-specified transactions are: (1) health claims or equivalent encounter information, (2) health care payment and remittance advice, (3) health claim status inquiry and response, (4) enrollment and disenrollment in a health plan, (5) eligibility inquiry and response, (6) health plan premium payments, (7) referral certification and authorization, (8) first report of injury, and (9) health claims attachments. HIPAA also directed the Secretary to adopt a standard for transferring standard data elements among health plans for the coordination of benefits and the sequential processing of claims for individuals who have more than one health plan. The Secretary was to rely on the recommendations of the National Committee on Vital and Health Statistics (NCVHS) and consult with other Federal and state agencies and private organizations. A final rule, which adopted already widely used standards for seven of the specified transactions and the coordination of benefits, as well as code sets to be used in those transactions, was published in 2000. The transactions standards included: several Accredited Standards Committee X12 (ASC X12) standards for health care transactions, and the National Council for Prescription Drug Programs (NCPDP) standard for pharmacy drug claim transactions.

The health care payment and remittance advice transaction is a communication from a health plan to a provider that includes an explanation of the claim and payment for that claim. The HIPAA standard for this transaction (i.e., ASC X12 835) can accommodate an electronic funds transfer (EFT), in which payment is electronically deposited into a designated bank account. EFT is common in the health care sector—health plan contracts often require it—but there is no EFT mandate in Federal law for Medicare, Medicaid, or private health insurance. However, HHS regulation is gradually requiring providers in Medicare to receive payments via EFT.

HIPAA does not mandate that providers conduct the transactions electronically, though health plans increasingly require it. However, providers that elect to submit one or more of the HIPAA transactions electronically must comply with the standard for those transactions. Generally, HIPAA requires providers and plans to come into compliance within two years of the standards taking effect. In 2001, Congress enacted the Administrative Simplification Compliance Act (P.L. 107-105), which provided for a one-year compliance extension for the standards adopted in 2000. The Act also mandated that Medicare claims be submitted electronically in the HIPAA standard format, with the exception of those from small providers and in other limited circumstances.

HIPAA directed the Secretary to review and, not more frequently than once a year, modify the Administrative Simplification standards. Again, the Secretary was to rely on the recommendations of the NCVHS and consult with other Federal and state agencies and private

organizations. Any modification must be completed in a manner that minimizes disruption and the cost of compliance. On January 16, 2009, CMS published a final rule adopting updated versions of the HIPAA electronic transactions standards to replace the versions currently in use. The compliance deadline for the updated standards is January 1, 2012.

To date, the Secretary has not issued electronic standards for two HIPAA transactions: health claims attachment and first report of injury. In September 2005, the Secretary published a proposed standard for electronic transmission of health claims attachments. A claims attachment transaction is used to request and supply additional data necessary to adjudicate a claim and typically includes specific clinical information that a health plan needs in order to decide whether a service should be covered. The claims attachment standard has yet to be finalized. The Secretary has not proposed an electronic standard for first report of injury.

HIPAA also instructed the Secretary to adopt unique identifiers for health care providers, health plans, employers, and individuals for use in standard transactions. Unique identifiers for providers and employers have been adopted, while the health plan identifier is still under review. Congress has blocked the development of a unique individual identifier through language added to the annual Labor-HHS appropriations bill.

Even though standards have been adopted for seven of the nine HIPAA transactions, there is still significant variability in how these transaction standards are implemented by health plans and clearninghouses. The standards adopted to date do not include sufficient business guidelines about how to operationalize them, which allows health plans and clearinghouses to differ in some of the ways they implement them. The variability in operating rules around the current standards makes it challenging, costly, and inefficient for providers to conduct electronic transactions. This is one of the reasons providers in the United States do not use electronic transactions for some of the most basic transactions related to health care. The Version 5010 and D.0 standards that will be effective in 2012 will address some but not all of the issues surrounding this variability with respect to the implementation of the HIPAA transactions.

The would establish a timeline for accelerating the development, adoption and implementation of a single set of consensus-based operating rules for each HIPAA transaction for which there is an existing standard, with the goal of creating as much uniformity in the implementation and use of the transactions standards as possible. Operating rules are defined as the necessary business rules and guidelines for the electronic exchange of information that are not defined by the electronic standards themselves. Also, the Committee Bill would add EFT for the payment of health claims as a HIPAA transaction. The Committee Bill would require the HHS Secretary to adopt a transaction standard for EFT no later than January 1, 2012, to take effect by January 1, 2014.

In adopting the operating rules, the HHS Secretary would rely on recommendations for such rules developed by a qualified non-profit entity, as selected by the Secretary. The non-profit entity would be one that: (1) focuses on administrative simplification; (2) demonstrates an established multi-stakeholder, consensus-based process for developing operating rules; (3) is guided by a public set of principles; (4) coordinates with the health information technology (HIT) Policy Committee and HIT Standards Committee, and complements the efforts of the

National Healthcare Coordinator; (5) incorporates HIPAA standards; (6) supports nondiscrimination and conflict of interest policies; and (7) allows for public reviews and updates.

The NCVHS would be required to review the operating rules developed by the non-profit entity and determine whether the rules were consistent with the HIPAA standards and with electronic standards adopted for HIT and whether they represented a consensus view from the health care industry. NCVHS would then submit a recommendation to the Secretary on whether to adopt the operating rules. If so recommended, the Secretary would be required to adopt the operating rules through an interim final rule and provide for a 60-day period of public comment on the rule following its publication.

The Committee Bill would require the HHS Secretary to adopt operating rules for eligibility for a health plan and health claim status transactions no later than July 1, 2011, to take effect by January 1, 2013. Such rules may allow for the use of a machine readable identification card. Operating rules for health care payment and remittance advice and EFT would have to be adopted no later than July 1, 2012, and take effect by January 1, 2014. The Secretary would have to adopt operating rules for the remaining completed HIPAA transactions, including health claims or equivalent encounter information, enrollment and disenrollment in a health plan, health plan premium payments, and referral certification and authorization, no later than July 1, 2014, to take effect by January 1, 2016.

The Committee Bill would also require the HHS Secretary, no later than January 1, 2014, to establish a review committee to periodically evaluate the existing HIPAA standards and operating rules and make recommendations for updating and improving such standards and rules. The Secretary could designate the NCVHS as the review committee, or choose any other appropriate committee within HHS. The review committee would: (1) no later than April 1, 2014, and not less than biennially thereafter, conduct hearings to evaluate existing standards and operating rules; and (2) no later than July 1, 2014, and not less than biennially thereafter, provide recommendations to the Secretary for updating and improving such standards and operating rules. The committee would be required to consider Federal HIT standards and only recommend a single set of operating rules per transaction standard. The Secretary would have to adopt the review committee's recommendations by issuing an interim final rule within 90 days of receipt of the committee's report, and provide for a 60-day comment period on the rule following its publication. The updated standards and operating rules would take effect 25 months after the close of the public comment period and the same certification and documentation requirements would apply.

The Committee Bill would require health plans, by December 31, 2013, to file a certification statement with the HHS Secretary that their data and information systems comply with the most current published standards, including the operating rules, for the following transactions: eligibility for a health plan, health claim status, health care payment and remittance advice and EFT. By December 31, 2015, health plans would be required to certify to the Secretary that their data and information systems comply with the most current published standards and operating rules for the remaining completed HIPAA transactions, including health claims or equivalent encounter information, enrollment and disenrollment in a health plan, health plan premium payments, and referral certification and authorization. To be certified, health plans would have to

demonstrate that they conduct these electronic transactions in a manner that fully complies with the regulations and provide documentation showing that they had completed end-to-end testing for these transactions with their partners (e.g., hospitals and physicians). Health plans would also need to comply with these certification and compliance requirements for any entities that provide services through a contract with the health plan. The Secretary would be permitted to designate an outside entity to verify that health plans have met the certification requirements and would have to conduct periodic audits of plans (as well as the contracted entities mentioned above) to ensure that they maintain compliance with the standards and operating rules.

The proposal would require the HHS Secretary, no later than April 1, 2014, and annually thereafter, to assess a penalty fee against health plans that fail to meet the certification requirements. For each day a plan was not in compliance, the Secretary would assess a fee of $1 per person covered by the plan for which its data systems for major medical policies are not in compliance. The fee amount would be increased annually by the projected percentage increase in total national health care expenditures, as determined by the Secretary. A health plan that knowingly misrepresented its compliance status would be subject to a penalty fee that is double the amount otherwise imposed. The fee would not exceed a maximum of $20 per covered life for which the plan's data systems for major medical policies are not in compliance, except for misrepresentation where the maximum penalty could reach $40 per covered life. Data on covered lives would be derived from plans' most recent corporate filings with the Securities and Exchange Commission.

The HHS Secretary would be required to establish a process with a reasonable notice and dispute resolution mechanism before penalties could be assessed by the Secretary of the Treasury (prior to August 1 of that year). Under the Committee Bill, the Secretary of the Treasury, acting through the Financial Management Service (FMS), would be responsible for the collection of penalty fees. Beginning May 1, 2014, and annually thereafter, the HHS Secretary would send to the Treasury Secretary a list of health plans that were assessed a penalty and the amount of the fee. By August 1, 2014, and annually thereafter, the Treasury Secretary would provide each of those health plans with notice of the amount assessed and the payment due date (November 1 of that year). Unpaid penalty fees would be increased by an interest payment determined in a manner similar to underpayment of income taxes and would be considered debts owed to Federal agencies, which may offset and reduce the amount of tax refunds otherwise payable to a health plan. Any fees charged for FMS collection activities would be passed on to the health plans on a pro-rata basis and added to the penalty fees.

In addition to the above provisions, the Committee Bill would require that as of January 1, 2014, no Medicare payment would be made for benefits delivered under Part A or Part B other than by EFT or an electronic remittance in a form specified in the HIPAA payment/remittance advice (i.e., ASC X12 835) standard. It would also require the HHS Secretary, by July 1, 2013, to report to Congress on the extent to which the Medicare and Medicaid programs and the providers that serve beneficiaries under those programs transact electronically in accordance with the HIPAA standards.

Finally, the Committee Bill would require the HHS Secretary to issue a rule to establish a unique health plan identifier, based on NCVHS input. The Secretary would be permitted to issue an interim final rule, which would take effect no later than October 1, 2012.

Subtitle H – Sense of the Senate Regarding Medical Malpractice

Sec. 3701. Sense of the Senate regarding Medical Malpractice.

Present Law

States have the primary authority to define the process for granting and renewing a medical license, and regulating medical practice. By extension, states determine the administrative and legal processes applicable to claims of medical malpractice. There is a lack of uniformity across states regarding licensure, medical practice regulation, and legal remedies for malpractice cases.

Committee Bill

This provision would express the sense of the Senate that (1) health reform presents an opportunity to address issues related to medical malpractice and medical liability insurance, (2) states should be encouraged to develop and test alternatives to the current malpractice tort system, and (3) Congress should consider establishing a state demonstration program to evaluate alternatives to the existing malpractice tort system with respect to resolution of malpractice claims.

Title IV—Transparency and Program Integrity

Subtitle A – Limitation On Medicare Exception To The Prohibition On Certain Physician Referrals For Hospitals

Sec. 4001. Limitation on Medicare Exception to the Prohibition on Certain Physician Referrals for Hospitals.

Present Law

Physicians are generally prohibited from referring Medicare patients for certain services to facilities in which they (or their immediate family members) have financial interests. However, among other exceptions, physicians are not prohibited from referring patients to whole hospitals in which they have ownership or investment interests. Providers that furnish substantially all of their designated health services to individuals residing in rural areas are exempt as well.

Committee Bill

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. These requirements include a limitation on the expansion of the facilities' service capacity and would address conflict of interest, bona fide investments, and patient safety issues. In addition, the hospital could not have converted from an ambulatory surgical center to a hospital after the date of enactment.

Specifically, to address conflicts of interest, an exempt hospital would (1) submit an annual report containing the identity of each physician owner and any other owners or investors as well as information on the nature and extent of all ownership interests in the hospital; (2) have procedures in place to require that any referring physician owner or investor disclose to each patient (by a time that permits the patient to make a meaningful decision regarding the receipt of care) their ownership interest in the hospital and, if applicable, any such ownership interest of the referring or treating physician; (3) not condition ownership, either directly or indirectly, on the physician owners or investors making or influencing referrals to the hospital; and (4) disclose the fact that the hospital is owned in whole or in part by physicians on any public website for the hospital and in public advertising for the hospital. Information from the annual report would be published and updated annually on the Internet website of the Centers for Medicare & Medicaid Services (CMS).

Exempt hospitals would ensure bona fide investments and proportional returns by meeting the following requirements: (1) physician owners or investors could not own more than the percentage of the value of physician ownership determined on the date of enactment, or the investment interest in an entity whose assets include the hospital; (2) any ownership or investment interest offered to a physician could not be offered on more favorable terms than those offered to an individual who is not a physician owner or investor; (3) the hospital (or any owner or investor in the hospital) could not directly or indirectly provide loans or financing for physician investments in the hospital; (4) the hospital (or any owner or investor in the hospital) could not directly or indirectly guarantee a loan, make a payment toward a loan, or otherwise subsidize a loan to any individual physician owner or group of physician owners that is related to acquiring ownership interest in the hospital; (5) investment returns must be distributed to investors in the hospital in an amount that is directly proportional to the ownership or investment interest in the hospital investor; (6) physician owners and investors could not receive, directly or indirectly, any guaranteed receipt of or exclusive right to purchase other business interests related to the hospital, including the purchase or lease of any property under the control of other investors in the hospital or located near the premises of the hospital; and (7) the hospital does not offer a physician owner the opportunity to purchase or lease any property under hospital control or under the control of other owners or investors in the hospital on more favorable terms than individuals who are not physician owners or investors.

To ensure patient safety, exempt hospitals would be required to disclose to all patients prior to admission in the instance it does not have any physician available on the premises to provide services during all hours in which the hospital is providing services. Following such a disclosure, the hospital would receive a signed acknowledgement from the patient that no physician will be present. Also the hospital would be required to have the capacity to provide assessment and initial treatment for patients and procedures for the referral and transfer of patients to hospitals with the capability to treat the needs of the patient involved.

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 without going through a process established by the Secretary. A procedure room includes a room in which catheterizations, angiographies, angiograms, and endoscopies are performed, but would not include emergency rooms or departments.

A process would be established to allow certain exempt hospitals to expand. To implement such a process, the Secretary would collect physician ownership and investment information for each hospital. Hospitals eligible for expansion would include: (1) a hospital that is located in a county where the population increased during the most recent five year period at a rate that is at least 150 percent of the State's population increase, as estimated by the Bureau of Census; (2) a hospital whose Medicaid inpatient admission percentage is equal to or greater than average percentage for all hospitals located in the county; (3) a hospital that does not discriminate against beneficiaries of Federal health care programs and does not permit physicians practicing at the hospital to discriminate against such beneficiaries; (4) a hospital that is located in a state with a state average bed capacity less than the national average; and (5) a hospital that has an average bed occupancy rate that is greater than the state average bed occupancy rate. This capacity increase would be limited to facilities on the main campus of the hospital and could not exceed 200 percent of the number of operating rooms, procedure rooms and beds for which the hospital is licensed at the time of enactment. The process for expansion would allow the opportunity for community input and should permit an applicable hospital to apply for the expansion exception up to once every two years. The Secretary would publish final decisions on an expansion in the *Federal Register* no later than 60 days after receiving a complete application. The Secretary would implement this process on May 1, 2011, and would promulgate regulations to carry out this process no later than April 1, 2011. There would be no administrative or judicial review of this process.

The Secretary would be required to establish policies and procedures to ensure compliance with these requirements, beginning on their effective date. The enforcement efforts would be able to include unannounced site reviews of hospitals. These audits would begin no later than August 1, 2011. Nothing in this section would prevent the Secretary from revoking the hospital's provider agreement if not otherwise in compliance with Medicare hospital regulations.

Subtitle B – Physician Ownership And Other Transparency

Sec. 4101. Transparency Reports and Reporting of Physician Ownership or Investment Interests.

Present Law

No provision.

Committee Bill

The Committee Bill would amend title XI of the Social Security Act to provide for transparency in the relationship between physicians of certain hospitals and applicable manufacturers with respect to payments and other transfers of value and physician ownership or investment interests in manufacturers. It calls for annual transparency reports, penalties for noncompliance, procedures for the submission of information and public availability of this information.

The Committee Bill would require any manufacturer of a covered drug, device, biological, or medical supply that makes a payment or another transfer of value to a physician, a physician medical practice, a physician group practice, or a hospital with an approved medical residency training program to report annually, in electronic form, specified information on such transactions to the Secretary of HHS. The report would include the transfer recipient's name, business address, amount of the payment, date of the payment, a description of the form of the payment, a description of the nature of the payment, if the payment is related to marketing, education, or research specific to a covered drug, device, biological or medical supply the name of that product, and any other category of information that the Secretary determines appropriate. If the recipient requests a transfer of payment to another entity or individual at the request of the recipient the manufacturer should disclose that information. Delayed reporting requirements would apply for payments made pursuant to a product development agreement or clinical trial. Some information would be excluded from these reporting requirements, including payments or transfers of $10 or less, unless the aggregate annual payments or transfers to a recipient exceeds $100, in which case all payments or transfers must be reported; samples intended for patient use; patient educational materials; loan of a covered device for a short-term time period, discounts and rebates, payments made to a physician for the provision of health care to employees; payments to a physician who is also a licensed, non-medical professional if the payment is solely related to non-medical services; payments to a physician solely for services related to a civil or criminal action or an administrative proceeding; and in-kind items used for charity care. This reporting requirement would begin on March 31, 2012 and continue on the 90th day of each subsequent calendar year.

The Committee Bill also requires any such manufacturer, or related group purchasing organization to report annually to the Secretary, in electronic form, certain information regarding any ownership or investment interest (other than in a publicly traded security and mutual fund) held by a physician (or an immediate family member) in the manufacturer or group purchasing organization during the preceding year.

Manufacturers or group purchasing organizations would be subject to a civil monetary penalty (CMP) of not less than $1,000 but not more than $10,000 for each payment or transfer not reported. The total amount of the penalties for any annual submission shall not exceed $150,000. Any manufacturer or group purchasing organization that knowingly fails to submit information would be subject to a CMP of not less than $10,000 but not more than $100,000 for each payment or transfer not reported. The total amount of the penalties for this failure to report category of submissions shall not exceed $1,000,000 annually.

The Committee Bill would require the Secretary to establish procedures no later than October 1, 2010 to ensure public availability of this information. Beginning September 30, 2012 and on June 30 of subsequent years, submitted information should be available on an Internet website

that meets formatting, search, and usability requirements. In addition to the transfer information, the website should include information on enforcement actions during the preceding year, background information on industry-physician relationships, a separate listing for payments related to clinical research, and other information that the Secretary deems appropriate. The Secretary should also allow recipients an opportunity to submit corrections to their information. This reporting procedure should be established after consulting the HHS OIG, affected industry, consumers and other parties in order to ensure that the information is presented in an appropriate context. The Secretary would be required to submit an annual report to Congress and the states beginning April 1, 2012.

Effective January 1, 2011, the Committee Bill would preempt any state (or political subdivision of a state) law or regulation that requires manufacturers to disclose the type of information required under this provision regarding payments or transfers to covered recipients. The proposal would not preempt any state (or political subdivision of a state) law or regulation that requires the disclosure or reporting of (1) any information not required under this provision; (2) the types of information excluded from reporting requirements under this provision, with the exception of the $10 de minimis/$100 aggregate reporting requirement; (3) information by any person or entity other than an applicable manufacturer or covered recipient described above; and (4) information reported to a Federal, state, or local government for public health purposes.

The Secretary would be required to consult with the HHS OIG on the implementation of this section.

Sec. 4102. Disclosure Requirements for In-office Ancillary Services Exception to the Prohibition on Physician Self-referral for Certain Imaging Services.

Present Law

Section 1877(b)(2) of the Social Security Act 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 (DHS) for which payment may be made under Medicare or Medicaid, and the entity may not present (or cause to be presented) a claim to the Federal health care program or bill to any individual or entity for DHS furnished pursuant to a prohibited referral. One of the many exceptions to this prohibition is for in-office ancillary services. This exception permits the furnishing of certain designated health services that are ancillary to the referring physician's medical services and where certain supervision, location, and billing requirements are met.

Committee Bill

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 in writing 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 these services in the area in which the individual resides. This new requirement would apply to services furnished after January 1, 2010.

Sec. 4103. Prescription Drug Sample Transparency.

Present Law

Section 503 of the Prescription Drug Marketing Act of 1987 (PDMA, P.L. 100-293), regulates the distribution of drug samples by a drug manufacturer or distributor. Under the Committee Bill, drug manufacturers or distributors may distribute drug samples by mail or common carrier to practitioners licensed to prescribe such drugs or, at the request of a licensed practitioner, to pharmacies of hospitals or other health care entities, only in response to a written request for drug samples, and under a system which requires the recipient of the drug sample to execute a written receipt for the drug sample upon delivery and the return of the receipt to the manufacturer or distributor of record. A written request for a sample must contain: (1) the name, address, professional designation, and signature of the practitioner making the request; (2) the identity of the drug sample requested and the quantity requested; (3) the name of the manufacturer of the drug sample requested; and (4) the date of the request. A drug manufacturer or distributor may distribute drug samples by means other than mail or a common carrier meets these requirements and carries out specified additional activities. Drug manufacturers and distributors must also comply with certain recordkeeping requirements, including, for a period of three years, a record of distributions of drug samples which identifies the drugs distributed and the recipients of the distributions.

Committee Bill

The Committee Bill would require drug manufacturers and authorized distributors of an applicable drug to annually submit to the Secretary of HHS the identity and quantity of drug samples requested and the identity and quantity of drug samples distributed under section 503, aggregated by the name, address, professional designation, and signature or the practitioner making the request for the sample (or an individual acting on the practitioner's behalf), as well as any other category of information that the Secretary determines is appropriate. An applicable drug is defined to include drugs that are available by prescription and for which payment is available under Medicare or Medicaid state plan (or a waiver of such plan).

Sec. 4104. Pharmacy Benefit Managers Transparency Requirements.

Present Law

No provision.

Committee Bill

The Committee Bill would require Pharmacy Benefit Managers (PBMs) that manage prescription drug coverage under a contract with a Part D drug plan or a qualified health benefits

plan offered through an exchange established by a state under title XXII of the Social Security Act to share information with the Secretary, the plans the PBMs contract with through Medicare Part D, or the exchanges in a manner, form and timeframe specified by the Secretary. Plans would only be given access to information on their own PBM contracts. This information would be considered confidential except as the Secretary determines necessary to carry out this provision or the Part D program, to permit the Government Accountability Office (GAO) or the Congressional Budget Office (CBO) to review the information, or for states to carry out title XXII.

The PBM would 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 for each type of pharmacy (which includes independent pharmacies, chain pharmacies, supermarket pharmacies, or mass merchandiser pharmacies that are licensed as a pharmacy by the state and that dispense medication to the general public) that is paid by the PBM under contract; (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 the total number of prescriptions; and (3) the aggregate amount of the difference between the amount the plan pays the PBM and the amount that the PBM pays retail and mail order pharmacies and the total number of prescriptions. There are not mandates that these rebates are passed through, only that they be reported to plans.

Subtitle C – Nursing Home Transparency And Improvement

PART I – Improving Transparency of Information

Sec. 4201. Required Disclosure of Ownership and Additional Disclosable Parties Information.

Present Law

In general, Medicare and Medicaid require that skilled nursing facilities (SNF) and nursing facilities (NF) be administered in a manner that maintains residents' well being. To ensure residents' safety, SNF and NF are required to report the following changes: ownership or controlling interest; the individuals who are officers, directors, agents or managing employees; the corporation, association or other company responsible for facility management; or when changes in the SNF or NF administrator are provided to state licensing agencies. Administrators must meet standards established by the Secretary. SNF and NF also are required to disclose ownership and other information as a condition of participation, certification, or re-certification.

A person is considered to have an ownership or controlling interest, directly or indirectly, when they (1) own five percent or more of an entity, or they hold a whole or part of any mortgage, deed of trust, note, or other obligation secured by the entity (nursing facility) or any property or assets that equal five percent of the total property; (2) are an officer or director of the entity, if the entity is organized as a corporation; or (3) are a partner in the entity if it is organized as a partnership. To the extent feasible under regulations, nursing facility entities also are required to

report other ownership and control interests for any people named as owners or having a control interest in the entity.

Committee Bill

Upon enactment of the Committee Bill and until final regulations are promulgated by the Secretary covering public disclosure, SNFs and NF would be required to make available upon request by the Secretary, the HHS OIG, the state where facilities are located, and the State LTC 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. SNF and NF would be required to make disclosure information available to the public as soon as final regulations were issued, which the Secretary would be required to promulgate within two years of enactment of the Committee Bill.

Information to be disclosed would include the identity of and information on each member of the governing body of the facility (name, title, period of service); each person or entity who is an officer, director, member, partner, trustee, or managing employee of the facility (name, title, period of service); and each person or entity who is an additional disclosable party of the facility. The reporting of each additional disclosable party's organizational structure also would be required as well as a description of the relationship of those additional disclosable parties to the facility and each other.

SNF and NF would be required to the extent that the required disclosable party information is submitted to the IRS as part of Form 990, to the Securities and Exchange Commission, or to the Secretary, to use that information for reporting.

Ownership and control interests would include direct or indirect interests, including interests in intermediate entities. Intermediate interests would include the owner of a whole or part interest in any mortgage, deed of trust, note or other obligation secured, in while or in part, by the entity or any property or assets of the entity if those interests exceed five percent of the total property or assets of the entity.

Within two years after enactment, the Secretary would be required to promulgate final regulations that required SNF and NF to report the ownership, governing board, and organizational structure information in a standardized format. These final regulations would ensure that SNF and NF certify as a condition of participation and payment under Medicare and Medicaid that ownership and affiliated party information is accurate and current. The Secretary would be required to make the regulations final 90 days after publication in the *Federal Register*. The Secretary would also be required to provide guidance and technical assistance to states on how to adopt the standardized format.

Additional disclosable parties would be defined as any person or entity which (1) exercises operational, managerial or financial control over the facility or part thereof, or provides policies or procedures for any of the operations of the facility, or provides financial or cash management services to the facility; (2) leases or sublease real property to the facility, or owns a whole or part interest equal to or exceeding five percent of the total value of such real property; (3) provides

management or administrative services, management or clinical consulting services, or accounting or financial services to the facility.

Organizational structure would be defined as officers, directors and shareholders who have an ownership interest equal to or greater than five percent in the case of corporations. For a limited liability company, organizational structure would be defined as members and managers; for a general partnership, the partners; for a limited partnership, general partners and any limited partners who have an ownership interest equal to ten percent or greater in the limited partnership; for a trust, the trustees; for an individual, contact information; and for any other person or entity, such information as the Secretary determines appropriate.

The Secretary, within one year of promulgating final regulations requiring reporting by facilities, would be required to make information about ownership and additional disclosable parties available to the public.

Sec. 4202. Accountability Requirements for Skilled Nursing Facilities and Nursing Facilities.

Present Law

No provision.

Committee Bill

The Committee Bill would require organizations operating SNFs and NF (operating organizations) to develop and implement compliance and ethics programs within three years of enactment of the Committee Bill. The compliance and ethics programs would need to be effective in preventing and detecting criminal, civil, and administrative violations and in promoting quality of care.

Within two years of enactment of the Committee Bill, the Secretary, working with the HHS OIG, would be required to issue regulations, for effective ethics and compliance programs, which may include model compliance programs. 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, with larger organizations having more formal programs and written policies that define standards and procedures.

The Secretary would evaluate the compliance and ethics program regulations and submit a report to Congress within three years after these regulations are final. The Secretary's evaluation would determine if the compliance and ethics program evaluation led to changes in deficiency citations, quality performance, or changes in other patient care quality metrics. The Secretary's report to Congress would include recommendations to improve the compliance and ethics program.

Requirements for operating organizations' compliance and ethics programs would need to be reasonably designed, implemented, and enforced to be effective in preventing and detecting civil,

criminal, and administrative violations as well as promoting quality of care. Operating organizations' compliance and ethics programs would need to include at least the following required components:

- standards and procedures to guide employees and other agents that would reduce criminal, civil, and administrative violations as defined under this Committee Bill;
- identification of individuals with sufficient authority to be responsible for compliance with the standards and procedures established by the organization;
- demonstration of diligence in ensuring that individuals who are at risk for engaging in criminal, civil, or administrative violations are not delegated responsibility for implementing or monitoring an organization's compliance and ethics program;
- effective communication of standards and procedures to employees (and other agents), such as through training programs or explanatory publications that practically illustrate what is required;
- procedures to detect criminal, civil, and administrative violations; the use of monitoring and auditing procedures; and reporting systems that enable employees and agents to report violations without fear of retribution;
- appropriate disciplinary mechanisms that are consistently followed to enforce the compliance and ethics program standards and evidence that, where appropriate, disciplinary measures were used on individuals for failing to detect offenses;
- appropriate responses to violations and offenses and mechanisms to prevent future similar offenses, including modification of operating organization's compliance and ethics programs; and
- processes to periodically reassess compliance and ethics programs to identify changes necessary to ensure the program remains effective as the organization and facilities change.

Before December 31, 2011, the Secretary would be required to promulgate regulations establishing a quality assurance and performance improvement (QAPI) plan for SNF and NF. In addition, the Secretary would be required to provide technical assistance to facilities on development of "best practices" in order to meet QAPI standards. Within one year of the Secretary issuing final QAPI regulations, facilities would be required to submit a plan to the Secretary for how facilities will meet the QAPI standards and implement best practices. These plans would include how the facility will coordinate the implementation of the plan with other Medicare and Medicaid quality assessment and assurance activities.

Sec. 4203. Nursing Home Compare Medicare Website.

Present Law

No provision.

Committee Bill

The Committee Bill would require the Secretary to include additional information on the Medicare Nursing Home Compare website that is prominent, easily accessible, searchable, and readily understandable to long-term services and supports (LTSS) consumers. This additional information would include: (1) information required to be reported to the Secretary; (2) information on the "Special Focus Facility program" including the names and locations of those facilities that were newly enrolled in the program, are enrolled in the program and have failed to significantly improve, enrolled in the program and have significantly improved, have gradated from the program and have closed voluntarily or no longer participate in Medicare or Medicaid; (3) staffing data for each facility (including resident census data and data on the hours of care provided per resident per day, which would include staff turnover and tenure) in formats that are easily understood by LTSS consumers (including an explanation of the data); (4) links to state internet websites regarding state survey and certification programs, and links to Form 2567 (or successor forms) 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; (5) a standardized complaint form (see section 4205 below) 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 LTSS Ombudsman program; (6) a summary of information on the number, type, severity and outcome of substantiated complaints; and (7) the number of adjudicated instances of criminal violations by a facility or the employees of a facility that were committed inside the facility.

The Secretary would be required to add the additional information to the Nursing Home Compare website within one year of enactment of this Committee Bill, except where the data would not yet be available.

Also within one year of enactment of this law, the Secretary would be required to develop and include on the Nursing Home Compare website a consumer rights information page that contains links to information along with descriptions on the following:

- documentation that is available to the public on nursing homes;
- general information and tips on choosing a nursing home that meets the needs of the individual;
- general information on consumer rights with respect to NF;
- information on the nursing facility survey process (on a national and state-specific basis); and
- on a state-specific basis, information on the services available through the State LTSS Ombudsman.

The Secretary would be required to review the accuracy, clarity of the presentation, timeliness, and comprehensiveness of information currently reported on the Nursing Home Compare website as of the day before enactment of the Committee Bill. Within one year after implementation of the Committee Bill, the Secretary would be required to modify or revamp the site in accordance with comments received from the review. In conducting the review, the Secretary would be required to consult with State LTSS Ombudsman programs, consumer advocacy groups, provider stakeholder groups, and other representatives of programs or groups as the Secretary determines appropriate.

Within one year after enactment of the Committee Bill, states would be required to submit survey information to the Secretary no later than they send such information to the facility, and the Secretary would be required to update the Nursing Home Compare website as expeditiously as practicable.

Within one year after enactment of this law, facilities would be required to have available on request by any individual reports on surveys, certifications, and complaint investigations made on the facility for the preceding three years. Facilities also would be required to post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. The Secretary would be required to issue guidance to states on establishing electronic links to Form 2567 reports, to facility plan of correction reports or other responses to 2567 reports, and posting of complaint investigation reports.

Sec. 4204. Reporting of Expenditures.

Present Law

No provision.

Committee Bill

Within two years of enactment of the Committee Bill, SNFs would be required to separately report wage and benefit expenditures 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. Within in one year of enactment of the Committee Bill, the Secretary would be required to consult with private sector accountants experienced with Medicare cost reports to assist in redesigning cost reports to meet the requirements for reporting expenditures for direct care workers wages and benefits.

Within 30 months of enactment of the Committee Bill, the Secretary, in consultation with Medicare Payment Advisory Commission , the Medicaid and CHIP Payment and Access Commission, HHS OIG, and other experts identified by the Secretary, would be required to categorize SNFs' newly collected annual expenditure data for each facility, regardless of payment source, into these functional accounts on an annual basis: (1) spending on direct care services, including nursing, therapy, and medical services;(2) spending on indirect care, including housekeeping and dietary services; (3) capital assets, including building and land costs; and (4) administrative services costs.

The Secretary would be required to establish procedures to make the direct care staff wage and benefit expenditure data readily available to interested parties upon request, subject to requirements established by the Secretary.

Sec. 4205. Standardized Complaint Form.

Present Law

No provision.

Committee Bill

Under the Committee Bill, within one year of enactment of the Committee Bill, the Secretary would be required to develop a standardized form for SNF and NF residents and their representatives to use in filing complaints to state survey and certification agencies and State LTSS Ombudsman Programs. States would need to make the new standardized complaint form available on request to SNF or NF residents; and people acting on behalf of SNF or nursing facility residents.

States also would be required to establish a complaint resolution process that ensures that legal representatives of SNF residents and NF (or other parties responsible for SNF or NF residents) would not be denied access to residents or otherwise retaliated against by SNFs or NF for filing quality of care or other complaints against the facility. States' complaint resolution procedures would need to include (1) accurate tracking of complaints including notification to the complainant that a claim was filed; (2) procedures to determine complaint severity and to investigate complaints; and (3) deadlines in which to respond to complaints and for notifying complainants of investigation outcomes.

Sec. 4206. Ensuring Staffing Accountability.

Present Law

No provision.

Committee Bill

Within two years after enactment of the Committee Bill, SNF and NF would be required to electronically submit direct care staffing information, including agency and contract staff, to the Secretary. In developing specifications and direct care staffing data requirements, the Secretary would consult with State LTSS Ombudsman programs, consumer advocacy groups, provider stakeholder groups, employees and their representatives, and other parties deemed appropriate by the Secretary. The direct care staffing specifications would be based on payroll and other verifiable data provided by SNFs and NF to the Secretary in a uniform format.

The reporting requirements would include (1) the category of work an employee performs such as whether the employee is an registered nurse, licensed practical nurse, licensed vocational nurse, certified nurse assistant, therapist, or other medical personnel; (2) resident census data and information on resident case mix; (3) a regular reporting schedule; and (4) information on employee turnover and tenure, and the hours of care provided per resident per day. The Secretary may first require staffing data be submitted on selected categories of certified employees, such as nursing staff, before reporting on other categories. Reporting on contract staff would be separate from information on employees.

Sec. 4207. GAO Study and Report on Five-Star Quality Rating System.

Present Law

No provision.

Committee Bill

Under the Committee Bill, the Government Accountability Office (GAO) would be required to conduct a study on CMS' Five-Star Quality Rating System for nursing homes which would include analysis of (1) how the Five-Star System is being implemented, (2) problems associated with implementation, and (3) how the Five-Star system could be improved. Within two years of enactment of the Committee Bill, GAO would be required to submit a report to Congress on the results of its analysis of CMS' Five-Star Rating System. The report would include GAO's recommendations for legislative and administrative action.

PART II – Targeting Enforcement

Sec. 4211. Civil Monetary Penalties.

Present Law

Under Medicaid, states have authority to impose monetary penalties, deny payments, appoint temporary management to bring facilities into compliance, and close facilities if NF fail to meet state plan requirements or have deficiencies that jeopardize residents' health or safety. State expenses for enforcement may be funded under the proper and efficient state plan administration provision of Medicaid. States also have authority to establish reward programs for NF that deliver the highest quality care to medical assistance patients and fund these incentive rewards programs under Medicaid's proper and efficient administration provisions.

Committee Bill

Within one year of enactment of the Committee Bill and subject to limitations where reductions are prohibited, if SNFs or NF self-report and promptly correct deficiencies within ten calendar days after imposition of a penalty, the Secretary would be authorized to reduce the imposed civil monetary penalties (CMPs) by up to 50 percent. Facilities cited for a repeat deficiency that had been self-reported during the preceding year where the Secretary had reduced the CMP would not eligible for a reduction under this provision. In addition, the Secretary would be prohibited from reducing CMPs where a deficiency was found to result in a pattern of harm or widespread harm that immediately jeopardizes the health or safety of facility residents; or where a deficiency resulted in the death of a resident.

This provision also would require the Secretary to issue regulations that provide facilities with the opportunity to participate in an independent informal dispute resolution process.

Sec. 4212. National Independent Monitor Pilot Program.

Present Law

No provision.

Committee Bill

The Committee Bill would require 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 SNF and NF chains.

The Secretary would select SNF and NF chains to participate in the independent monitor program from among those chains that apply and submit information as determined by the Secretary. The Secretary would be required implement the pilot program under this section within one year after enactment.

The Secretary would evaluate chains to participate in the independent monitor pilot program based on criteria identified by the Secretary including where evidence exists that one or more facilities within the chain experienced serious safety and quality of care problems. Other criteria the Secretary may use to select chains to participate in the independent monitor program would include evaluation of chains with one or more facilities participating in the "Special Focus Facility" program (or a successor), or chains with one or more facilities with a record of repeated serious safety and quality of care deficiencies.

Independent monitors that enter into contracts with the Secretary to participate in this program would (1) conduct periodic reviews and prepare root-cause quality and deficiency analyses of chains to assess if chains are in compliance with state and Federal laws and regulations; (2) undertake sustained oversight of chains, (public or private) efforts to involve the owners of, and any additional disclosable parties, the chain in complying with state and Federal laws and regulations; (3) analyze the management structure, expenditure distribution, and nurse staffing levels of chains' individual facilities compared to resident census, staff turnover rates, and tenure; (4) report findings and recommendations based on reviews, analyzes, and oversight the chains, individual facilities of the chain, the Secretary and states; and (5) publish the results of these reviews, analyses, and oversight.

Chains that receive a report containing findings and recommendations from the independent monitor would be required to submit a report to the independent monitor within ten days of receipt of the independent monitors report. The report submitted by the chain would (1) outline corrective actions that will be taken to implement the recommendations of the independent monitor or (2) indicate that the chain would not implement the independent monitor's recommendations. The independent monitor would have ten days after receiving the corrective action report from the chain to issue its final recommendations and submit a report to the chain and facilities of the chain, the Secretary, and the state or states, as appropriate. Chains would be responsible for a portion of the costs associated with appointment of independent monitors.

Within 180 days after completion of the independent monitor pilot program, the HHS OIG would be required to complete and submit an evaluation of the independent monitor program. The HHS OIG's evaluation would contain recommendations as to (1) the feasibility of making the independent monitor program permanent; (2) the identification of appropriate procedures and mechanisms to implement the independent monitor program permanently; and (3) required legislation and administrative actions as determined appropriate by the HHS OIG.

Sec. 4213. Notification of Facility Closure.

Present Law

Medicare and Medicaid law identifies patients' rights and SNF and NF requirements in ensuring residents are aware of their rights. Residents have specific discharge and transfer rights, which include advance notification in cases where facilities close.

Committee Bill

Within one year after the enactment of the Committee Bill, administrators of SNF and NF would be required to provide written notification to the Secretary, the state, the State LTC Ombudsman, as well as residents and their representatives (or other responsible parties) of an impending nursing facility closure. Facilities would be required in the notice to issue a plan for the transfer and relocation of residents. This notification would be required to be made at least 60 days before the SNF or NF closure. In cases where the Secretary terminates a facility's participation in Medicare or Medicaid, the notification would be required before the date the Secretary establishes for the facility termination. The administrator also would be required to not admit any new residents after the date the facility closure notice is issued. Any administrator of a facility that fails to comply with these requirements would be subject to a civil monetary penalty of up to $1,000,000 and any other applicable penalties prescribed by law, and may be subject to exclusion from participation in Federal health programs.

The resident transfer plan must include assurances that residents will be transferred to the most appropriate facility or other settings in terms of quality, services, and location, taking into consideration the needs and best interests of each resident. States would be required to ensure that before a facility closes that all residents have been successfully relocated to another facility or an alternative home- and community-based setting. The Secretary would be authorized to continue making payments during the period beginning with the notification of intent to close and ending on the date when a resident is successfully transferred.

Sec. 4214. National Demonstration Projects on Culture Change and Use of Information Technology in Nursing Homes.

Present Law

No provision.

Committee Bill

This Committee Bill would require the Secretary to conduct the following two demonstration projects for SNF and NF: (1) projects for the development of best practices for facilities involved in culture change; and (2) projects 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.

Each demonstration project would be required to consider the special needs of NF and SNF residents with cognitive impairments, including dementia.

PART III – Improving Staff Training

Sec. 4221. Dementia and Abuse Prevention Training.

Present Law

Medicare and Medicaid law have provisions that govern training for nurse aides for both SNF and NF. These laws require the Secretary to establish requirements for nurse aide training and competency evaluation programs as well as parameters for states to use in monitoring these programs.

Committee Bill

Within one year of enactment of the Committee Bill, the Secretary would be required to 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.

Subtitle D – Nationwide Program for National and State Background Checks on Direct Patient Access Employees of Long-Term Care Facilities and Providers.

Sec. 4301. Nationwide Program for National and State Background Checks on Direct Patient Access Employees of Long-Term Care Facilities and Providers.

Present Law

Section 307 of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 (P.L. 108-173) established the framework for a program to evaluate national and state background checks on prospective employees who have direct access to patients of long-term services and supports (LTSS) facilities or providers. A pilot program was administered by CMS, in consultation with the Department of Justice (DoJ). The pilot program operated from January

2005 through September 2007 in seven States (Alaska, Idaho, Illinois, Michigan, Nevada, New Mexico, and Wisconsin) selected by CMS.

Committee Bill

The Committee Bill would require the Secretary to establish a nationwide program for national and state background checks on direct patient access employees of certain (LTSS) facilities or providers and provide Federal matching funds to states to conduct these activities. Except for certain modifications described below, the Secretary would be required to carry out the nationwide program under similar terms and conditions as the Background Check Pilot program ("pilot program") under Section 307 of the MMA, as specified. Under the nationwide program, the Secretary would be required to enter into agreements with newly participating states, as specified, and certain previously participating states, as specified.

According to the procedures established under the pilot program, certain LTSS providers would be required to obtain State and national criminal history background checks on their prospective employees through such means as the Secretary determines appropriate, efficient, and effective. To conduct these checks, states would utilize a search of state-based abuse and neglect registries and specified state and Federal databases and records. States would be required to describe and test methods that reduce duplicative fingerprinting, including the development of a "rap back" capability, such that if an employee is convicted of a crime following the initial background check and the employee's fingerprints match the prints on file, the state will immediately inform the employer of such conviction. States would also require that background checks conducted under the program remain valid for a period of time specified by the Secretary.

States that enter into an agreement with the Secretary would be responsible for monitoring compliance with the requirements of the nationwide program and have specified procedures in place, including procedures to: (1) conduct screening and criminal history background checks; (2) monitor compliance by LTSS facilities and providers; (3) provide for a provisional period of employment of a direct patient access employee, as specified; (4) provide procedures for an independent process by which a provisional employee or an employee may appeal or dispute the accuracy of the information obtained in a background check, as specified; (5) provide for the designation of a single state agency with specified responsibilities; (6) determine which individuals are direct patient access employees; (7) as appropriate, specify offenses, including convictions for violent crimes; and (8) describe and test methods that reduce duplicative fingerprinting, as specified.

States would be required to guarantee (directly or through donations from public or private entities) a designated amount of non-Federal contributions to the program. The Federal government would provide a match equal to three times the amount a State guarantees; except that Federal funds would not exceed $3 million for newly participating States and $1.5 million for previously participating States.

The HHS OIG would be required to conduct an evaluation of the nationwide program, as specified, and submit a report to Congress no later than 180 days after completion of the national program. The Secretary of the Treasury would be required to transfer to HHS an amount

specified by the HHS Secretary as necessary (not to exceed $160 million) to carry out the nationwide program for fiscal years 2010 through 2012. Such amounts would be required to remain available until expended. To provide for conducting the evaluation, the HHS Secretary would be authorized to reserve no more than $3 million of the amount transferred.

TITLE V—FRAUD, WASTE, AND ABUSE

Subtitle A – Medicare, Medicaid, and CHIP Provisions

Sec. 5001. Provider Screening and Other Enrollment Requirements under Medicare and Medicaid.

Present Law

Medicare statute requires the Secretary to establish a process for enrolling providers and suppliers in the Medicare program. As part of the enrollment process, the Centers for Medicare & Medicaid Services (CMS) collects information necessary to uniquely identify the provider (*i.e.*, proof of business name, social security number, or tax ID number), including documentation necessary to verify licensure or eligibility to furnish Medicare covered items or services. CMS reserves the right to perform on-site inspections of a provider or supplier to verify compliance with enrollment requirements. If these requirements are not met, CMS may revoke Medicare billing privileges. Although it is not a statutory requirement, it is CMS policy that providers and suppliers resubmit and recertify the accuracy of their enrollment information every five years.

Medicaid statute delegates the administration of the Medicaid program to the states. There is considerable variation in how states administer their provider enrollment processes. State Medicaid agencies determine whether a provider or supplier is eligible to participate in the Medicaid program through written agreements with providers and suppliers. The agreements require that providers and suppliers maintain specific records, disclose certain ownership information, and grant access to Federal and state auditors to books and records. States establish policies for provider and supplier re-enrollment, although Federal rules must be met for certain providers, such as nursing facilities and intermediate care facilities for the mentally retarded (ICF/MRs), which must have passed survey and certification inspection (at least every 15 months) before they can be re-enrolled as Medicaid providers or suppliers.

States are required to create a state plan for their Medicaid and CHIP programs that are subject to approval by CMS. These documents describe all aspects of each state's Medicaid and CHIP programs, including administrative activities, eligibility, enrollment, covered benefits, provider credentialing, provider reimbursement, quality assurance, beneficiary cost sharing, and many more program elements. In creating their Medicaid and CHIP plans, states must conform to Federal rules and guidance. Whenever states make changes to their Medicaid or CHIP programs, they must update their state plans by submitting a state plan amendment (SPA). SPAs also are subject to review and approval by CMS. As part of the Medicaid or CHIP plan, states establish participation requirements and reimbursement rules for different providers and suppliers that deliver services to Medicaid and CHIP beneficiaries.

Since 1998, the Health and Human Services Office of Inspector General (HHS OIG) has been issuing a series of compliance guidance documents for providers participating in Federal health care programs to assist in preventing fraud, waste, and abuse. These documents encourage health care providers to adopt compliance programs and internal control measures to monitor their adherence to applicable rules, regulations, and requirements. The adoption of these programs is not mandatory. There is no Present Law explicitly directing health care providers to adopt compliance programs.

Committee Bill

The Committee Bill would require that the Secretary, in consultation with the HHS OIG, establish procedures for screening providers and suppliers participating in the Medicare, Medicaid, and CHIP programs. Such procedures must be established within six months from enactment. Screening requirements for new providers and suppliers would be effective within one year and within two years for current providers and suppliers. The Committee Bill requires that all providers be screened within three years from the date of enactment.

The Secretary would be required to determine the level of screening according to the risk of fraud, waste, and abuse with respect to each category of providers or suppliers. At a minimum, all providers and suppliers would be subject to licensure checks. The Secretary would have the authority to impose additional screening measures based on risk, including fingerprinting, criminal background checks, multi-state data base inquiries, and random or unannounced site visits. The Secretary would also be required to establish procedures for a provisional period of between 30 days and one year during which new providers and suppliers would be subject to enhanced oversight, such as prepayment review and payment caps. The Secretary would have the authority to impose a moratorium on enrolling providers within a category of providers and suppliers if the Secretary determines that a moratorium is necessary to combat fraud, waste, and abuse. Moratoria would not be subject to judicial review. In Medicaid, states could receive exceptions to some of these requirements if they determined that compliance might reduce beneficiaries' access to Medicaid services.

An application fee would be imposed on providers and suppliers to cover the costs of screening. The amount of the fee would be $350 in 2010, and for 2011 and beyond, the amount would be the fee for the preceding year adjusted by the percentage change in the Consumer Price Index (CPI). Current providers would be offered a discounted screening fee of $250 if they pay it within 12 months of enactment. A hardship exception to the fee would be permitted. The Secretary would be required to use all of the fees collected to cover the costs of screening.

In addition, within 90 days of enactment of this law, CMS would be required to establish a process for making available to each state Medicaid and CHIP agency the name, national provider identifier, and other identifying information for providers or suppliers who were terminated from the Medicare program. CMS would be required to make the information on terminated providers available within 30 days of the providers' or suppliers' termination.

The Committee Bill would also impose new disclosure requirements on providers and suppliers enrolling or re-enrolling in Medicare, Medicaid, or CHIP. Applicants would be required to disclose current or previous affiliations with any provider or supplier that has uncollected debt, has had their payments suspended, has been excluded from participating in a Federal health care program, or has had their billing privileges revoked. The Secretary would be authorized to deny enrollment in these programs if these affiliations pose an undue risk to a program. Providers would be allowed to appeal the denial. To satisfy any past-due obligations, the Secretary would have the authority to adjust future payments to these providers.

By a date determined by the Secretary, certain providers and suppliers would be required to establish a compliance program. The requirements for the compliance program would be developed by the Secretary and the HHS OIG. In Medicaid, states would require providers and suppliers to establish a compliance program for services provided under a Medicaid plan or waiver. The Secretary would be required to consider the extent to which compliance programs have been adopted by providers when creating a timeline for implementation.

States would also be required to comply with the national system for reporting to the Secretary criminal and civil convictions, sanctions, negative licensure actions, and other adverse provider actions. These enhanced state compliance programs also would require that enrolling or ordering physician and referring providers submit NPIs on claims under a Medicaid state plan or waiver. States could impose other compliance requirements on providers and suppliers.

Sec. 5002. Enhanced Medicare and Medicaid Program Integrity Provisions.

Present Law

Integrated Data Repository. Currently, claims and payment data for Medicare and Medicaid are housed in multiple databases. CMS is in the process of consolidating information stored in these databases into an Integrated Data Repository (IDR).

Access to Data. The Inspector General Act of 1978 (P.L. 95-452) and its amendments of 1988 (P.L. 100-504) granted inspectors general (IGs) substantial independence and powers to carry out their mandate to combat fraud, waste, and abuse. In carrying out their functions, IGs have broad authority, including subpoena power, to access all records and information of an agency.

Overpayments. In accordance with CMS instructions, overpayments must be repaid to CMS within 30 days of receiving a demand letter. If the debt is not paid in full after 30 days, interest would be assessed and CMS reserves the right to collect the overpayment by adjusting future payments. Providers have the option to request an extended repayment plan to pay off the debt.

National Provider Identifier. Health care providers often have many different provider numbers, one for billing each private insurance plan or public health care program. The administrative simplification provisions of Health Insurance Portability and Accountability Act (HIPAA, P.L. 104-191) required the adoption and use of a standard unique identifier for health care providers or National Provider Identifier (NPI). CMS issued its final rule implementing the NPI in January 2004. All health care providers who are considered covered entities under

HIPAA were required to obtain and submit claims using an NPI as of May 2007. To receive an NPI, providers must submit an application to CMS. CMS requires an NPI as a condition of enrollment.

Medicaid Management Information System. States are required to operate automated claims processing systems, or the Medicaid Management Information System (MMIS), to administer their state plans. The Secretary must approve states' MMISs and require them to meet a number of requirements including compatibility with Medicare claims processing and information systems, and consistency with uniform coding systems for claims processing and data interchange. Among other requirements, MMISs also must be capable of providing timely and accurate data, meet other specifications as required by the Secretary, and provide for electronic transmission of claims data as well as be consistent with Medicaid Statistical Information Systems data formats.

Permissive Exclusions. HHS OIG has the authority to exclude health care providers from participation in Federal health care programs. Exclusions from Federal health programs are mandatory under certain circumstances and permissive in others (*i.e.*, HHS OIG has discretion in whether to exclude an entity or individual). HHS OIG has permissive authority to exclude an entity or an individual from a Federal health program under numerous circumstances, including: conviction of certain misdemeanors relating to fraud, theft, embezzlement, breach of fiduciary duty or other financial misconduct, and revocation or suspension of a health care practitioner's license for reasons bearing on the individual's or entity's professional competence, professional performance, or financial integrity.

Civil Monetary Penalties. Section 1128A(a) of the Social Security Act authorizes the imposition of civil monetary penalties (CMPs) and assessments on a person, including an organization, agency, or other entity, who engages in various types of improper conduct with respect to Federal health care programs, including the imposition of penalties against a person who knowingly presents or causes to be presented false or fraudulent claims. This section generally provides for CMPs of up to $10,000 for each item or service claimed, $15,000 or $50,000 under other circumstances, and an assessment of up to three times the amount claimed.

Testimonial Subpoena Authority. The testimonial subpoena authority grants the authority to issue subpoenas and require the attendance and testimony of witnesses and the production of any other evidence that relates to matters under investigation or in question.

Surety Bonds. To be eligible to receive a provider number from CMS and bill Medicare, durable medical equipment (DME) suppliers are required to provide the Secretary with a surety bond in the amount of $50,000 or greater. A surety bond issued by a state would satisfy this requirement. The Secretary has the authority to impose these requirements on other Medicare Part A and B providers and suppliers, except physicians. Home health agencies are required to provide the Secretary with a surety bond equal to ten percent of the aggregate Medicare and Medicaid payments made to the agency for that year or $50,000, whichever is smaller. A surety bond for a home health agency is effective for four years, with limited exceptions.

Payment Suspensions. CMS and its contractors have the authority to withhold payment in whole or in part if there is reliable evidence of an overpayment or fraud. CMS regulations stipulate the procedures CMS and its contractors must follow when deciding to suspend payment.

Health Care Fraud and Abuse Control Account. Medicare program integrity and anti-fraud activities are funded through the Health Care Fraud and Abuse Control (HCFAC) program. HCFAC was established by HIPAA, which sought to increase and stabilize Federal funding for health care anti-fraud activities. HIPAA appropriated funds to HHS, the HHS OIG, the Department of Justice (DOJ), and the Federal Bureau of Investigation (FBI) for activities undertaken for fiscal years 1997 through 2003. For each fiscal year after 2003, the amount was capped at the 2003 level. In December 2006, Congress passed the Tax Relief and Health Care Act of 2006 (P.L. 109-432) which extended the mandatory annual appropriation for HCFAC to 2010. For fiscal years 2007 through 2010, the mandatory annual appropriation is the limit for the preceding year plus the percentage increase in the Consumer Price Index for urban consumers (CPI-U). For each fiscal year beyond 2010, the mandatory annual appropriation was capped at the FY2010 level.

Every year, HHS and the DOJ are required to release a joint annual report to Congress on HCFAC results and accomplishments. These reports include numbers and examples of enforcement actions, program accomplishments, and amounts deposited into the Health Insurance Trust Fund resulting from health care fraud enforcement activities. Congress did not require that HHS and DOJ include expenditures or results for the Medicare Integrity Program in these reports.

Medicare and Medicaid Integrity Programs. Under the Medicare Integrity Program (Medicare MIP), CMS contracts with private entities to conduct a variety of activities designed to protect Medicare from fraud, waste, and abuse. Activities include auditing providers, identifying and recovering improper payments, educating providers about fraudulent activities, and instituting a Medicare-Medicaid data matching program. Established by the Deficit Reduction Act of 2005 (DRA, P.L. 109-171), the Medicaid Integrity Program (Medicaid MIP) is modeled after Medicare's MIP program. Medicaid MIP provides HHS with dedicated resources to promote Medicaid integrity; to contract with entities to reduce fraud, waste, and abuse; and to add 100 full-time equivalent Medicaid MIP staff. Annual Medicaid MIP reports to Congress on program accomplishments and use of funds are required. In addition, the Secretary is required to develop comprehensive five-year plans for Medicaid MIP.

Committee Bill

Integrated Data Repository. The Committee Bill would require CMS to include in the IDR claims and payment data from the following programs: Medicare (Parts A, B, C, and D), Medicaid, CHIP, health-related programs administered by the Departments of Veterans Affairs (VA) and Defense (DOD), the Social Security Administration, and the Indian Health Service (IHS). Integrating Medicare and Medicaid data would be a top priority. Data from the remaining Federal health programs would be integrated as appropriate.

Access to Data. The Secretary would be required to enter into data-sharing agreements with the Commissioner of Social Security, the Secretaries of the VA and DOD, and the Director of the IHS to help identity fraud, waste, and abuse. The Committee Bill would grant the HHS OIG and DOJ access to the IDR for the purposes of conducting law enforcement and oversight activities consistent with applicable privacy, security, and disclosure laws, including HIPAA and title V of the United States Code (USC). For the purpose of protecting program integrity, the provision would also grant the HHS OIG authority to obtain information from certain individuals or entities, such as providers or suppliers that either directly or indirectly provide medical items and services under a Federal health care program. This includes access to any documentation necessary to support a claim under Medicare, Medicaid, or CHIP (*i.e.*, medical records). The provision would require the Social Security Commissioner, upon request by the Secretary or the HHS IG, to enter into an agreement for the purpose of matching data between SSA and HHS. Agreements would be required to include safeguards to assure confidentiality.

Individuals who knowingly participate in fraud would be subject to administrative penalties imposed by the Secretary.

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

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

Medicaid Management Information System. The Secretary would have authority to withhold the Federal matching payment to states for medical assistance expenditures when the state does not report enrollee encounter data (as defined by the Secretary) in a timely manner (as determined by the Secretary) to the state's MMIS.

Permissive Exclusions. The Committee Bill would subject providers and suppliers to exclusion for providing false information on any application to enroll or participate in a Federal health care program. In addition to providers and suppliers, the provision would apply to Medicaid managed care organizations, Medicare Advantage (MA) organizations and MA plans, Prescription Drug Plan (PDP) sponsors and plans, and providers and suppliers that participate in these Medicare or Medicaid plans.

Civil Monetary Penalties. The Committee Bill would add specific actions that would be subject to CMPs. Specifically, excluded individuals who order or prescribe an item or service, make false statements on applications or contracts to participate in a Federal health care program, or who know of an overpayment and do not return the overpayment would be subject to CMPs of $50,000 for each violation. In addition to providers and suppliers, the provision would apply to Medicaid managed care organizations, Medicare Advantage (MA) organizations and plans, Prescription Drug Plan (PDP) sponsors and plans, and providers and suppliers that participate in these Medicare or Medicaid plans. In addition, such a person may be subject to an assessment of

not more than three times the amount claimed as the result of the false statement, omission, or misrepresentation.

Testimonial Subpoena Authority. Sections 205(d) and (e) of the Social Security Act would apply with respect to the Secretary's program exclusion authority. The Secretary would be able to issue subpoenas and require the attendance and testimony of witnesses and the production of any other evidence that relates to matters under investigation or in question by the Secretary. The Secretary would also have the ability to delegate this authority to the HHS OIG and the Administrator of CMS for the purposes of a program exclusion investigation. Certain requirements regarding the serving of subpoenas and compensation for subpoenaed witnesses may apply. This section would also provide for judicial enforcement of subpoenas, including in cases where a person refuses to obey a properly served subpoena. The Committee Bill would apply to investigations beginning on or after January 1, 2010.

Surety Bonds. The Committee Bill would require that the Secretary take into account the volume of billing for a DME supplier and home health agency when determining the size of the surety bond. The Secretary would have the authority to impose this requirement on other providers and suppliers considered to be at risk by the Secretary. The Committee Bill would retain the Secretary's authority to waive the requirement for providers that receive a comparable surety bond under state law.

Payment Suspensions. The Secretary would have the authority to suspend payments to a provider or supplier pending a fraud investigation, except when there is not good cause.

Health Care Fraud and Abuse Control Account. HCFAC funding would be increased by $10 million each year for fiscal years 2011 through 2020. The provision would also permanently apply the CPI-U adjustment to HCFAC and MIP funding. Funds would be allocated in the same manner as in Present Law and would be available until expended.

Medicare and Medicaid Integrity Programs. The Committee Bill would require Medicare and Medicaid Integrity Program contractors to provide the Secretary and the HHS OIG with performance statistics, including the number and amount of overpayments recovered, the number of fraud referrals, and the return on investment for such activities. The Secretary would also be required to conduct evaluations of eligible entities not less than every three years. No later than six months after the end of the fiscal year, the Secretary would be required to submit a report to Congress describing the use and effectiveness of MIP funds.

Sec. 5003. Elimination of Duplication between the Healthcare Integrity and Protection Data Bank and the National Practitioner Data Bank.

Present Law

The Social Security Act requires the Secretary to develop and maintain a national health care fraud and abuse data collection program for the reporting of adverse actions taken against health care providers or suppliers. The statute requires the following types of health care related adverse actions be reported to the Healthcare Integrity and Protection Data Bank (HIPDB): civil

judgments, Federal or state criminal convictions, actions taken by Federal or state licensing agencies, and provider exclusions from Medicare and Medicaid. Only final adverse actions are reportable to the HIPDB. Administrative fines, citations, corrective action plans, and other personnel actions are not reportable except under certain circumstances. Settlements, in which a finding of liability has not been established, are also not reportable. Federal and state government agencies as well as health plans are required to report to the HIPDB. Health plans that fail to report are subject to a civil monetary penalty of $25,000. The Secretary is required to publish a report identifying government agencies that fail to report to the HIPDB. HIPDB cannot duplicate the reporting requirements established for the National Practitioner Data Bank (NPDB).

Title IV of the Health Care Quality Improvement Act of 1986 (HCQIA, P.L. 99-660), as amended, established the NPDB. The NPDB collects and releases data related to the professional competence of physicians, dentists, and certain health care practitioners. The types of information included in the NPDB are medical malpractice payments, certain adverse licensure actions, adverse privilege actions, adverse professional society actions, and exclusions from Medicare and Medicaid. The statute defines the entities eligible to report and query the databank. Malpractice payers that fail to report are subject to a civil monetary penalty.

Section 1921 of the Social Security Act expanded the scope of reporting requirements for the NPDB to encompass additional adverse licensure actions and actions taken by state licensing and certification agencies, peer review organizations, and private accreditation organizations. Section 1921 also required that actions taken against all health care practitioners be included in the databank. States are required to have a system for reporting adverse actions to the NPDB. A final rule implementing section 1921 has not yet been promulgated.

Committee Bill

The Committee Bill would require the Secretary to maintain a national health care fraud and abuse data collection program for reporting certain adverse actions taken against health care providers, suppliers, and practitioners, and submit information on the actions to the NPDB. Certain agencies and officials as well as health care providers that were subject to such adverse actions would have access to this information, at a reasonable fee established by the Secretary. During implementation, the Secretary would be required to take into account the adverse event reporting requirements established under Part B of the Health Care Quality Improvement Act of 1986 and those mandated for states under section 1921 of the Social Security Act.

The Committee Bill would modify the information reporting requirements for states under Section 1921 and add a requirement that states have a system for reporting information with respect to any final adverse action taken against a health care provider, supplier, or practitioner. States would also be required to provide the Secretary with access to documents held by a state licensing or certification agency or state law or fraud enforcement agency. Individuals and entities would be protected from any liability with respect the reporting of this type of information.

Upon enactment, this provision would require the Secretary to establish a process to terminate the HIPDB and ensure that the information that was formerly collected in the HIPDB is

transferred to the NPDB. The transition would be funded from the fees collected to access the database and from additional amounts as necessary from the annual HCFAC appropriation available to the Secretary and the HHS OIG. The Department of Veterans Affairs (VA) would be exempted from these charges for one year.

Sec. 5004. Maximum Period of Submission of Medicare Claims Reduced To Not More Than 12 Months.

Present Law

Medicare statute requires that payments only be made if a written request for payment is filed within three calendar years after the year in which the services were provided. The Secretary is authorized to reduce this period to no less than one year if it deems it necessary for the efficient administration of the program. As established by CMS regulations, the time limit on submitting a claim for payment is the close of the calendar year after the year in which the services were furnished.

Committee Bill

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

Sec. 5005. Physicians who Order Items and Services Required to be Medicare Enrolled Physicians or Eligible Professionals.

Present Law

Medicare statute defines "eligible professionals" as physicians, certain types of practitioners (*i.e.*, physician assistants, nurse practitioners, clinical social workers, and others), physical or occupational therapists, qualified speech language pathologists, or qualified audiologists.

Committee Bill

Beginning January 1, 2010, the Committee Bill would require durable medical equipment or home health services to be ordered by a Medicare eligible professional or physician enrolled in the Medicare program. The Secretary would have the authority to extend these requirements to other Medicare items and services, including covered Part D drugs, to reduce fraud, waste, and abuse.

Sec. 5006. Requirement for Physicians to Provide Documentation on Referrals to Programs at High Risk of Waste and Abuse.

Present Law

HHS OIG has permissive authority to exclude an entity or an individual from a Federal health care program under numerous circumstances, including failing to supply documentation related to payment for items and services.

Committee Bill

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

Sec. 5007. Face-to-Face Encounter with Patient Required Before Physicians May Certify Eligibility for Home Health Services or Durable Medical Equipment Under Medicare.

Present Law

Home health services are covered under Medicare Parts A and B. In order to receive payment from Medicare, physicians are required to certify and re-certify that specified services (*i.e.*, inpatient psychiatric services, post-hospital extended care services, and home health services) meet certain conditions. In the case of home health services, physicians are required to certify that such services were required because the individual was confined to his home and needed skilled nursing care or physical, speech, or occupational therapy; a plan for furnishing services to the individual has been established; and such services were provided under the care of a physician.

In the case of DME, the Secretary is authorized to require that payment be made for specified covered items and services only if a physician has submitted to the supplier a written order for the item.

Committee Bill

The Committee Bill would require that, after January 1, 2010, physicians have a face-to-face encounter (including through telehealth) with the individual prior to issuing a certification for home health services or DME as a condition for payment under Medicare Parts A and B. The Committee Bill would also apply to physicians making home health and DME certifications in Medicaid and CHIP. Physicians must document that they had the face-to-face encounter with the individual during the six-month period preceding the certification, or other reasonable timeframe as determined by the Secretary. The Secretary would be authorized to apply the face-to-face encounter requirement to other Medicare items and services based upon a finding that doing so would reduce the risk of fraud, waste, and abuse.

Sec. 5008. Enhanced Penalties.

Present Law

Section 1128A(a) of the Social Security Act authorizes the imposition of civil monetary penalties (CMPs) and assessments on a person, including an organization, agency, or other entity, who engages in various types of improper conduct with respect to Federal health care programs. This includes the imposition of penalties against a person who knowingly presents or causes to be presented false or fraudulent claims. This section generally provides for CMPs of up to $10,000 for each item or service claimed, $15,000 or $50,000 under other circumstances, and an assessment of up to three times the amount claimed.

Medicare Advantage (MA) plans enter into contracts with the Secretary to participate in the Medicare program. The Secretary has the authority to impose sanctions and CMPs on MA plans that violate the terms of the contract. Among the violations for which CMPs are authorized are failing to provide medically necessary care, imposing excess beneficiary premiums, expelling or refusing to re-enroll beneficiaries, discouraging or denying enrollment among eligible individuals expected to require future medical services, misrepresenting or falsifying information, failing to comply with balance billing requirements, interfering with a provider's advice to beneficiaries, and contracting with providers excluded from the Medicare program. For violations related to discouraging or denying enrollment or misrepresenting information provided to the Secretary, the Secretary can impose a maximum penalty of $100,000. For all other violations, the maximum penalty is $25,000. The Secretary has the authority to impose additional penalties for imposing excess beneficiary premiums and engaging in activities that discourage enrollment.

Committee Bill

The Committee Bill would add a new clause to the CMP statute: persons who fail to grant timely access, upon reasonable request to the HHS OIG, for the purpose of audits, investigations, evaluations, or other statutory functions of the HHS OIG, would be subject to CMPs of $15,000 for each day of failure. The provision would also modify the contractual requirements for MA plans to allow the Secretary to conduct timely audits and inspections of MA plans.

The Committee Bill would provide that persons who knowingly make, use, or cause to be made or used any false statement or record material to a false or fraudulent claim submitted for payment to a Federal health care program would be subject to a civil monetary penalty of $50,000 for each violation. This amendment would apply to violations committed on or after January 1, 2010.

The Committee Bill would increase the number of violations that could be subject to the imposition of sanctions and CMPs by the Secretary. Beginning on the date this bill is enacted, plans that: (1) enroll individuals in a MA or Part D plan without their consent (except Part D dual eligibles), (2) transfer an individual from one plan to another for the purpose of earning a commission, (3) fail to comply with marketing requirements and CMS guidance, or (4) employ or contract with an individual or entity that commits a violation, would be subject to sanctions imposed by the Secretary. Sanctions would apply to any employee or agent of a MA or Part D plan, or any provider or supplier who contracts with a MA or Part D plan.

The Committee Bill would enhance penalties for MA and Part D plans that misrepresent or falsify information to include an assessment of up to three times the amount claimed by a plan or plan sponsor based on the misrepresentation or falsified information. The provision would apply to violations committed on or after January 1, 2010.

Sec. 5009. Medicare Self-Referral Disclosure Protocol.

Present Law

The Federal prohibition on physician self-referrals (section 1877 of the Social Security Act) generally provides 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 (DHS) for which payment may be made under Medicare or Medicaid. Also, the entity may not present (or cause to be presented) a claim to the Federal health care program or bill to any individual, third-party payer, or other entity for DHS furnished pursuant to a prohibited referral.

Under section 1128B of the Social Security Act, commonly referred to as the anti-kickback statute, it is a felony for a person to knowingly and willfully offer, pay, solicit, or receive anything of value (*i.e.*, remuneration), directly or indirectly, overtly or covertly, in cash or in kind, in return for a referral or to induce generation of business reimbursable under a Federal health care program.

Violations of these statutes may be subject to various penalties. Persons found guilty of violating the anti-kickback statute may be subject to a fine of up to $25,000, imprisonment of up to five years, and exclusion from participation in Federal health care programs for up to one year. Violators of the physician self-referral law may be subject to sanctions including a denial of payment for relevant services, CMPs, and exclusion from participation in the Medicare and Medicaid programs. In addition, the physician self-referral law requires a person who collects any amount that was billed in violation of the Social Security Act to refund the amount to the individual billed in a timely manner.

In 1998, the HHS OIG issued a self-disclosure protocol (SDP), which included a process by which a health care provider could voluntarily self-disclose evidence of potential fraud, in an effort to avoid the costs or disruptions that may be associated with an investigation or litigation. On March 24, 2009, HHS OIG issued an "Open Letter to Health Care Providers" that makes refinements to the SDP. In the Open Letter, HHS OIG announced that it would no longer accept disclosure of a matter that involves only liability under the physician self-referral law in "the absence of a colorable anti-kickback statute violation." Further, for anti-kickback-related submissions accepted into the SDP following the date of the letter, HHS OIG requires a minimum $50,000 settlement amount to resolve the matter.

Committee Bill

Within six months of enactment, the Secretary, in cooperation with the HHS OIG, would be required to establish a self-referral disclosure protocol (SRDP) to enable health care providers

and suppliers to disclose actual or potential violations of the physician self-referral law. The SRDP would be required to include direction to health care providers and suppliers on: (1) a specific person, official, or office to which such disclosures would be made and (2) instruction on the implication of the SRDP on corporate integrity agreements and corporate compliance agreements.

In addition, the Secretary would be required to post information on CMS' website to inform stakeholders of how to disclose actual or potential SRDP violations. The Secretary would be authorized to reduce the amount for self-referral violations to an amount less than the amount specified in the self-referral statute and regulations. In establishing violation amounts, the Secretary could consider: (1) the nature and extent of the improper illegal practice, (2) the timeliness of the self-disclosure, (3) the cooperation in providing additional information on the disclosure, and (4) other factors the Secretary considers appropriate.

Within 18 months of establishment of the SRDP, the Secretary would be required to submit to Congress a report on the implementation of the self-referral disclosure protocol under this provision. The Secretary's report would be required to include: (1) the number of health care providers and suppliers making disclosures, (2) the amounts collected, (3) the types of violations reported, and (4) other information that may be necessary to evaluate the impact of this section.

Sec. 5010. Adjustments to the Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies Competitive Acquisition Program.

Present Law

Medicare Part B covers a wide variety of durable medical equipment, prosthetics, orthotics, and other medical supplies (DMEPOS) if they are medically necessary and are prescribed by a physician.

Medicare pays for most durable medical equipment (DME) on the basis of a fee schedule. The Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA, P.L. 108-173) required the Secretary to establish a competitive acquisition program for specified durable medical equipment; the single payment amount derived from the competitive acquisition program would replace the Medicare fee schedule payments. The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA, P.L. 110-271) delayed the phase-in and made changes to the program. The program is to be phased-in, starting in nine of the largest metropolitan statistical areas (MSAs) in 2009 (round one), expanding to an additional 70 of the largest MSAs in 2011 (round two), and remaining areas after 2011.

Starting in 2011, the Secretary has the authority to use information on payments determined in competitive acquisition areas to adjust payments for items and services in non-competitive acquisition areas. Before 2015, the following three types of areas are exempt from the competitive acquisition program: (a) rural areas; (b) metropolitan statistical areas (MSA) not selected under round one or round two with a population of less than 250,000; and (c) areas with a low population density within an MSA that is otherwise selected to be part of the competitive acquisition program.

Committee Bill

The Committee Bill would require the Secretary to expand the number of areas to be included in Round Two of the program from 79 of the largest MSAs to 100 of the largest MSAs by including the next 21 largest MSAs 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 Present Law would remain in place, such as the Secretary's discretion to exempt rural areas and areas with low population density within an MSA.

Sec. 5011. Expansion of the Recovery Audit Contractor (RAC) Program.

Present Law

Recovery Audit Contractors (RACs) are private organizations that contract with the CMS to identify and collect improper payments made in Medicare's fee-for-service (FFS) program. In the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA, P.L. 108-173), Congress required the Secretary to conduct a three-year demonstration of RACs. However, the Tax Relief and Health Care Act of 2006 (TRHCA, P.L. 109-432) made the RAC program permanent and mandated its expansion nationwide by January 1, 2010. The RAC program expansion still applied only to Medicare Parts A and B. CMS began the national rollout of the permanent RAC program in 19 states in March 2009.

Committee Bill

By December 31, 2010, states would be required to establish contracts, consistent with state law, and similar to the contracts the Secretary has established for the Medicare RAC program, with one or more RACs. These state RAC contracts would be established to identify underpayments and overpayments and to recoup overpayments made for services provided under state Medicaid plans as well as state plan waivers.

The state Medicaid RAC program would be subject to exceptions and requirements the Secretary may establish for the state RAC program or for individual states. States would be required to provide the Secretary with the following assurances for their RAC programs:

(1) RACs would be paid only from recovered amounts;
(2) the contracts would be contingent on collecting overpayments;
(3) payments may be made in such amounts as the state may specify for identifying underpayments;
(4) the state has a process for appealing adverse RAC determinations;
(5) the state's RAC program follows requirements established by the Secretary;
(6) amounts expended by the state would be considered administrative expenditures (as necessary for the proper and efficient administration of the state plan or waiver);

(7) recovered amounts would be subject to a state's quarterly expenditure estimates and the funding of the state's share; and

(8) the state will coordinate the efforts of RACs with other program integrity contractors performing audits of entities receiving payments for any Medicaid services, including coordination with Federal and state law enforcement (the Department of Justice, the Federal Bureau of Investigation, the HHS OIG, and the state Medicaid fraud control unit.

The Secretary, acting through CMS, would be required to coordinate with states on the RAC program expansion to Medicaid, particularly to ensure that each state enters into a contract with a RAC prior to December 31, 2010. The Secretary would be required to promulgate regulations to implement the RAC program expansion to Medicaid, including conditions for Federal financial participation.

In addition, the Secretary would be required to submit an annual report to Congress. The Secretary's report would assess the effectiveness of the RAC program expansion to Medicaid and Medicare Parts C and D and also would include recommendations for expanding or improving the program.

Subtitle B – Additional Medicaid Provisions

Sec. 5101. Termination of Provider Participation under Medicaid if Terminated under Medicare or Other State Plan.

Present Law

Subject to certain exceptions, the Secretary is required to exclude from Medicare or Medicaid program participation providers that: (1) have been convicted of a criminal offense related to the delivery of an item or service under Medicare or under any state health care program; (2) have been convicted, under Federal or state law, of a criminal offense relating to neglect or abuse of patients in connection with the delivery of a health care item or service; (3) have been convicted of a felony conviction related to health care fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct; or (4) have been convicted of a felony relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.

The Secretary also may exclude from Medicare or Medicaid participation providers or individuals involved in acts specifically prohibited, such as program-related convictions, license revocation, failure to supply information, and default on loan or scholarship obligations. CMS must promptly notify HHS OIG of the receipt of any application for participation that identifies any principal of a provider that has engaged in prohibited activities.

Committee Bill

Under the Committee Bill, states would be required to terminate individuals or entities from their Medicaid programs if the individuals or entities were terminated from Medicare or another

state's Medicaid program (subject to exclusion exceptions allowed under the Social Security Act).

Sec. 5102. Medicaid Exclusion from Participation Relating to Certain Ownership, Control, and Management Affiliations.

Present Law

Subject to Federal rules and guidance, states are required to create a state plan for their Medicaid programs that is subject to approval by CMS. State plans describe all aspects of the state's Medicaid program, including participation requirements and reimbursement rules for different providers and suppliers that deliver services to Medicaid beneficiaries. Medicaid law requires states to exclude individuals or entities from Medicaid participation when a state is directed to do so by the Secretary and to deny payment for any item or service furnished by the individual or entity. States are required to exclude these individuals and deny payment for a period specified by the Secretary.

Committee Bill

Under the Committee Bill, Medicaid agencies would be required to exclude individuals or entities from participating in Medicaid for a specified period of time if the entity or individual owns, controls, or manages an entity that: (1) has failed to repay overpayments during the period as determined by the Secretary; (2) is suspended, excluded, or terminated from participation in any Medicaid program; or (3) is affiliated with an individual or entity that has been suspended, excluded, or terminated from Medicaid participation.

Sec. 5103. Billing Agents, Clearinghouses, or Other Alternate Payees Required to Register under Medicaid.

Present Law

As a condition of participation, certification, or recertification in Medicaid, the Secretary requires disclosing entities to supply upon request, either to the Secretary or the state Medicaid agency, information on the identity of each person with ownership or control interests in the entity or subcontractor that is equal to five percent or more of such entity. Disclosing entities include providers of service, independent clinical laboratories, renal disease facilities, managed care organizations or health maintenance organizations, entities (other than individual practitioners or groups of practitioners) that furnish or arrange for services, carriers or other agencies, or organizations that act as fiscal intermediaries or agents for service providers. Federal rules applicable to Medicaid state plans also require states to exclude individuals or entities from Medicaid participation when a state is directed to do so by the Secretary and to deny payment for any item or service furnished by the individual or entity. States are required to exclude these individuals and deny payment for a period as specified by the Secretary.

Committee Bill

Under the Committee Bill, any agents, clearinghouses, or other alternate payees that submit claims on behalf of health care providers would be required to register with the state and the Secretary in a form and manner specified by the Secretary.

Sec. 5104. Requirement to Report Expanded Set of Data Elements under MMIS to Detect Fraud and Abuse.

Present Law

States are required to operate automated claims processing systems, or the Medicaid Management Information System (MMIS), to administer their state plans. The Secretary must approve states' MMISs to ensure that they meet a number of requirements including compatibility with Medicare claims processing and information systems and consistency with uniform coding systems for claims processing and data interchange. Among other requirements, MMISs also must be capable of providing timely and accurate data, provide for electronic transmission of claims data and be consistent with Medicaid Statistical Information Systems data formats, and meet other specifications as required by the Secretary.

Committee Bill

Beginning January 1, 2010, states would be required to submit from the automated data system data elements as determined necessary by the Secretary for program integrity, program oversight, and administration. The Secretary also would determine how frequently these data would need to be submitted. In addition, Medicaid managed care entities would be required to submit data elements as determined necessary by the Secretary for program integrity, program oversight, and administration. Medicaid managed care organizations would need to submit these data for contract years beginning January 1, 2010 at a frequency to be determined by the Secretary.

Sec. 5105. Prohibition on Payments to Institutions or Entities Located Outside of the United States.

Present Law

No provision.

Committee Bill

Under the Committee Bill, states would be prohibited from making any payments for items or services provided under a Medicaid state plan or waiver to any financial institution or entity located outside of the United States.

Sec. 5106. Overpayments.

Present Law

Under Present Law, when states discover that overpayments have been made to individuals or other entities, they have 60 days to recover or attempt to recover the overpayment before an

adjustment is made to their Federal matching payment. Adjustments in Federal payments are made at the end of the 60 days, whether or not recovery is made. When states are unable to recover overpayments because the debts were discharged in bankruptcy or were otherwise uncollectable, Federal matching payments would not be adjusted or would be readjusted in cases where the 60 day recovery deadline had passed.

Committee Bill

The Committee Bill would extend the period for states to repay overpayments to one year when a final determination of the amount of the overpayment has not been determined due to an ongoing judicial or administrative process. When overpayments due to fraud are pending, state repayments of the Federal portion would not be due until 30 days after the date of the final judgment. This amendment would take effect on the date of enactment and apply to overpayments discovered after that date.

Sec. 5107. Mandatory State Use of National Correct Coding Initiative.

Present Law

In 1996, to help ensure correct payment for reimbursement claims, Centers for Medicare & Medicaid Services implemented a national correct coding initiative (NCCI). Under NCCI, CMS' contractors use automated pre-payment edits to review Medicare claims submitted by Part B providers. Medicare contractors use software to scan claims and apply NCCI edits designed to detect anomalies that indicate a claim has incorrect information. For example, NCCI edits can detect claims with duplicate services delivered to the same beneficiary on the same date of service. In addition, by comparing medical billing codes, NCCI software can identify when medical procedures were billed erroneously as service bundles (when individual services are grouped together, but cheaper comprehensive codes are available to describe the same services) or in other cases when services should have been billed individually, but were grouped as bundled services. Medicaid does not require the use of NCCI prepayment edits.

Committee Bill

Beginning October 1, 2010 states would be required to incorporate into their Medicaid Management Information Systems methodologies compatible with Medicare's NCCI that promoted correct coding and controlled improper coding. By September 1, 2010, the Secretary would be required to: (1) identify NCCI methodologies (or methodologies of any successor initiative) that are compatible with claims filed for Medicaid payment; and (2) identify methodologies that would be applicable to Medicaid, but for which no Medicare NCCI methodologies have been established. The Secretary also would be required to notify states of the NCCI methodologies that were identified and how states should incorporate those methodologies into their Medicaid claims processing systems. The Secretary would be required to submit a report to Congress that includes the notice to states about the NCCI methodologies and analysis that supports the identification of NCCI methodologies to be applied to Medicaid claims by March 1, 2011.

Sec. 5108. General Effective Date.

Present Law

No provision.

Committee Bill

States would be required to have implemented fraud, waste, and abuse programs required under the America's Healthy Future Act of 2009 before January 1, 2011, regardless of whether final regulations to implement these provisions were promulgated.

TITLE VI—REVENUE PROVISIONS

Sec. 6001. Taxation of Insurance Companies.

Present Law

Present Law provides special rules for determining the taxable income of insurance companies (subchapter L of the Code). Separate sets of rules apply to life insurance companies and to property and casualty insurance companies. Insurance companies generally are subject to Federal income tax at regular corporate income tax rates.

An insurance company that provides health insurance is subject to Federal income tax as either a life insurance company or as a property insurance company, depending on its mix of lines of business and on the resulting portion of its reserves that are treated as life insurance reserves. For Federal income tax purposes, an insurance company is treated as a life insurance company if the sum of its (1) life insurance reserves and (2) unearned premiums and unpaid losses on noncancellable life, accident or health contracts not included in life insurance reserves, comprise more than 50 percent of its total reserves.[22]

Some insurance providers may be exempt from Federal income tax under section 501(a) if specific requirements are satisfied. Section 501(c)(8), for example, describes certain fraternal beneficiary societies, orders, or associations operating under the lodge system or for the exclusive benefit of their members that provide for the payment of life, sick, accident, or other benefits to the members or their dependents. Section 501(c)(9) describes certain voluntary employees' beneficiary associations that provide for the payment of life, sick, accident, or other benefits to the members of the association or their dependents or designated beneficiaries. Section 501(c)(12)(A) describes certain benevolent life insurance associations of a purely local character. Section 501(c)(15) describes certain small non-life insurance companies with annual gross receipts of no more than $600,000 ($150,000 in the case of a mutual insurance company). Section 501(c)(26) describes certain membership organizations established to provide health insurance to certain high-risk individuals. Section 501(c)(27) describes certain organizations established to provide workmen's compensation insurance. A health maintenance organization

[22] Sec. 816(a).

that is tax-exempt under section 501(c)(3) or (4) is not treated as providing prohibited[23] commercial-type insurance, in the case of incidental health insurance provided by the health maintenance organization that is of a kind customarily provided by such organizations.

Treatment of employer-sponsored health coverage. As with other compensation, the cost of employer-provided health coverage is a deductible business expense under section 162.[24] Employer-provided health insurance coverage is generally not included in an employee's gross income.

In addition, employees participating in a cafeteria plan may be able to pay the portion of premiums for health insurance coverage not otherwise paid for by their employers on a pre-tax basis through salary reduction.[25] Such salary reduction contributions are treated as employer contributions for Federal income purposes, and are thus excluded from gross income.

Employers may agree to reimburse medical expenses of their employees (and their spouses and dependents), not covered by a health insurance plan, through flexible spending arrangements which allow reimbursement not in excess of a specified dollar amount (either elected by an employee under a cafeteria plan or otherwise specified by the employer). Reimbursements under these arrangements are also excludible from gross income as employer-provided health coverage.

A flexible spending arrangement for medical expenses under a cafeteria plan ("Health FSA") is an unfunded arrangement under which employees are given the option to reduce their current cash compensation and instead have the amount made available for use in reimbursing the employee for his or her medical expenses.[26] Health FSAs that are funded on a salary reduction basis are subject to the requirements for cafeteria plans, including a requirement that amounts remaining under a Health FSA at the end of a plan year must be forfeited by the employee (referred to as the "use-it-or-lose-it rule").[27]

Alternatively, the employer may specify a dollar amount that is available for medical expense reimbursement. These arrangements are commonly called Health Reimbursement Arrangements ("HRAs"). Some of the rules applicable to HRAs and Health FSAs are similar (e.g., the amounts in the arrangements can only be used to reimburse medical expenses and not for other purposes), but the rules are not identical. In particular, HRAs cannot be funded on a salary reduction basis and the use-it-or-lose-it rule does not apply. Thus, amounts remaining at the end of the year may be carried forward to be used to reimburse medical expenses in following years.[28]

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[23] Sec. 501(m).

[24] Sec. 162. However see special rules in section 419 and 419A for the deductibility of contributions to welfare benefit plans with respect to medical benefits for employees and their dependents.

[25] Sec. 125.

[26] Sec. 125. Prop. Treas. Reg. sec. 1.125-5 provides rules for Health FSAs. There is a similar type of flexible spending arrangement for dependent care expenses.

[27] Sec. 125(d)(2). A cafeteria plan is permitted to allow a grace period not to exceed two and one-half months immediately following the end of the plan year during which unused amounts may be used. Notice 2005-42, 2005-1 C.B. 1204.

[28] Guidance with respect to HRAs, including the interaction of FSAs and HRAs in the case of an individual covered under both, is provided in Notice 2002-45, 2002-2 C.B. 93.

Present Law provides that individuals with a high deductible health plan (and generally no other health plan) may establish and make tax-deductible contributions to a health savings account ("HSA"). An HSA is subject to a condition that the individual is covered under a high deductible health plan (purchased either through the individual market or through an employer). Subject to certain limitations,[29] contributions made to an HSA by an employer, including contributions made through a cafeteria plan through salary reduction, are excluded from income (and from wages for payroll tax purposes). Contributions made by individuals are deductible for income tax purposes, regardless of whether the individuals itemize.

The Employee Retirement Income Security Act of 1974 ("ERISA")[30] preempts State law relating to certain employee benefit plans, including employer-sponsored health plans. While ERISA specifically provides that its preemption rule does not exempt or relieve any person from any State law which regulates insurance, ERISA also provides that an employee benefit plan is not deemed to be engaged in the business of insurance for purposes of any State law regulating insurance companies or insurance contracts. As a result of this ERISA preemption, self-insured employer-sponsored health plans need not provide benefits that are mandated under State insurance law.

While ERISA does not require an employer to offer health benefits, it does require compliance if an employer chooses to offer health benefits, such as compliance with plan fiduciary standards, reporting and disclosure requirements, and procedures for appealing denied benefit claims. ERISA was amended (as well as the Public Health Service Act and the Internal Revenue Code) in the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA")[31] and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"),[32] adding other Federal requirements for health plans, including rules for health care continuation coverage, limitations on exclusions from coverage based on preexisting conditions, and a few benefit requirements such as minimum hospital stay requirements for mothers following the birth of a child.

COBRA requires that a group health plan offer continuation coverage to qualified beneficiaries in the case of a qualifying event (such as a loss of employment).[33] A plan may require payment of a premium for any period of continuation coverage. The amount of such premium generally may not exceed 102 percent of the "applicable premium" for such period and the premium must be payable, at the election of the payor, in monthly installments. The applicable premium for any period of continuation coverage means the cost to the plan for such period of coverage for

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[29] For 2009, the maximum aggregate annual contribution that can be made to an HSA is $3,000 in the case of self-only coverage and $5,950 in the case of family coverage ($3,050 and $6,150 for 2010). The annual contribution limits are increased for individuals who have attained age 55 by the end of the taxable year (referred to as "catch-up contributions"). In the case of policyholders and covered spouses who are age 55 or older, the HSA annual contribution limit is greater than the otherwise applicable limit by $1,000 in 2009 and thereafter. Contributions, including catch-up contributions, cannot be made once an individual is enrolled in Medicare.

[30] Pub. L. No. 93-406.

[31] Pub. L. No. 99-272.

[32] Pub. L. No. 104-191.

[33] A group health plan is defined as a plan (including a self-insured plan) of, or contributed to by, an employer (including a self-employed person) or employee organization to provide health care (directly or otherwise) to the employees, former employees, the employer, others associated or formerly associated with the employer in a business relationship, or their families. The COBRA requirements are enforced through the Code, ERISA, and the Public Health Service Act ("PHSA").

similarly situated non-COBRA beneficiaries with respect to whom a qualifying event has not occurred, and is determined without regard to whether the cost is paid by the employer or employee. There are special rules for determining the applicable premium in the case of self-insured plans. Under the special rules for self-insured plans, the applicable premium generally is equal to a reasonable estimate of the cost of providing coverage for similarly situated beneficiaries which is determined on an actuarial basis and takes into account such other factors as the Secretary of Treasury may prescribe in regulations.

Present Law imposes an excise tax on group health plans that fail to meet HIPAA and COBRA requirements.[34] The excise tax generally is equal to $100 per day per failure during the period of noncompliance and is imposed on the employer sponsoring the plan.

Deduction for health insurance costs of self-employed individuals. Under Present Law, self-employed individuals may deduct the cost of health insurance for themselves and their spouses and dependents.[35] The deduction is not available for any month in which the self-employed individual is eligible to participate in an employer-subsidized health plan. Moreover, the deduction may not exceed the individual's earned income from self-employment. The deduction applies only to the cost of insurance (i.e., it does not apply to out-of-pocket expenses that are not reimbursed by insurance). The deduction does not apply for self-employment tax purposes. For purposes of the deduction, a more than two percent shareholder-employee of an S corporation is treated the same as a self-employed individual. Thus, the exclusion for employer provided health care coverage does not apply to such individuals, but they are entitled to the deduction for health insurance costs as if they were self-employed.

Deductibility of excise taxes. In general, excise taxes may be deductible under section 162 of the Code if such taxes are paid or incurred in carrying on a trade or business, and are not within the scope of the disallowance of deductions for certain taxes enumerated in section 275 of the Code.

Committee Bill

The Committee Bill imposes an excise tax on insurers if the aggregate value of employer-sponsored health insurance coverage for an employee exceeds a threshold amount. The tax is equal to 40 percent of the aggregate value that exceeds a threshold amount. For 2013, the threshold amount is $8,000 for individual coverage and $21,000 for family coverage. The threshold amounts are indexed to the Consumer Price Index for Urban Consumers ("CPI-U") as determined by the Department of Labor beginning in 2014, plus one percentage point. 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 FSA or an HRA, the excise tax is paid by the entity that administers benefits under the plan or arrangement ("plan administrator"). Where the employer acts as plan administrator to a self-insured group health plan, a Health FSA or an HRA, the excise tax is paid by the employer. Where an employer contributes to an HSA, the employer is responsible for payment of the excise tax, as the insurer.

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[34] Secs. 4980B and 4980D.
[35] Sec. 162(l).

Employer-sponsored health insurance coverage is health coverage offered by an employer to an employee without regard to whether the employer provides the coverage (and thus the coverage is excludable from the employee's gross income) or the employee pays for the coverage with after-tax dollars. Employer-sponsored health insurance coverage includes both fully-insured and self-insured health coverage excludable from the employee's gross income, including, in the self-insured context, on-site medical clinics that offer more than a de minimus amount of medical care to employees and executive physical programs. 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).

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 FSA or an HRA, contributions to an HSA, and coverage for dental, vision, and other supplementary health insurance coverage. The value of employer-sponsored coverage for disability benefits or long term care under an accident or health plan is not taken into account in the determination of whether the value of health coverage exceeds the threshold amount. The value of employer-sponsored health insurance coverage does not include the value of fixed indemnity health coverage that is purchased exclusively by the employee with after-tax dollars; however, it includes the value of such coverage if any portion of the coverage is employer-provided. Fixed indemnity health coverage pays fixed dollar amounts based on the occurrence of qualifying events, including but not limited to the diagnosis of a specific disease, an accidental injury or a hospitalization, provided that the coverage is not coordinated with other health coverage.

Calculation and proration of excise tax and reporting requirements.

Amount of Applicable Premium. Under the provision, the aggregate value of all employer-sponsored health insurance coverage, including dental, vision, and other supplementary health insurance coverage is generally calculated in the same manner as the applicable premiums for the taxable year for the employee determined under the rules for COBRA continuation coverage, but without regard to the excise tax. If the plan provides for the same COBRA continuation coverage premium for both individual coverage and family coverage, the plan is required to calculate separate individual and family premiums for this purpose. In determining the coverage value for retirees, employers may elect to treat pre-65 retirees together with post-65 retirees.

Value of Coverage in the Form of Health FSA Reimbursements. In the case of a Health FSA from which reimbursements are limited to the amount of the salary reduction, the value of employer-sponsored health insurance coverage is equal to the dollar amount of the aggregate salary reduction contributions for the year. To the extent that the Health FSA provides for reimbursement in excess of the amount of the employee's salary reduction, the value of the coverage generally is determined in the same manner as the applicable premium for COBRA continuation coverage. If the plan provides for the same COBRA continuation coverage premium for both individual coverage and family coverage, the plan is required to calculate separate individual and family premiums for this purpose.

Amount Subject to the Excise Tax and Reporting Requirement. The amount subject to the excise tax on high cost employer-sponsored health insurance coverage for each employee is the sum of the aggregate premiums for health insurance coverage, the amount of any salary reduction contributions to a Health FSA for the taxable year, and the dollar amount of employer contributions to an HSA, minus the dollar amount of the threshold. The aggregate premiums for health insurance coverage include all employer-sponsored health insurance coverage including coverage for major medical, dental, vision and other supplementary health insurance coverage. The applicable premium for health coverage provided through an HRA is also included in this aggregate amount.

Under a separate rule (described below), an employer is required to disclose the aggregate premiums for health insurance coverage for each employee on his or her annual Form W-2.

Under the Committee Bill, the excise tax is allocated pro rata among the insurers, with each insurer responsible for payment of the excise tax on an amount equal to the amount subject to the total excise tax multiplied by a fraction, the numerator of which is the amount of employer-sponsored health insurance coverage provided by that insurer to the employee and the denominator of which is the aggregate value of all employer-sponsored health insurance coverage provided to the employee. In the case of a self-insured group health plan, a Health FSA or an HRA, the excise tax is allocated to the plan administrator. If an employer contributes to an HSA, the employer is responsible for payment of the excise tax, as the insurer. The employer is responsible for calculating the amount subject to the excise tax allocable to each insurer and plan administrator and for reporting these amounts to each insurer, plan administrator and the Secretary, in such form and at such time as the Secretary may prescribe. Each insurer and plan administrator is then responsible for calculating, reporting and paying the excise tax to the IRS on such forms and at such time as the Secretary may prescribe.

For example, if in 2013 an employee elects family coverage under a fully-insured health care policy covering major medical and dental with a value of $28,000, the amount subject to the excise tax is $7,000 ($28,000 less the threshold of $21,000). The employer reports $7,000 as taxable to the insurer, which calculates and remits the excise tax to the IRS.

Alternatively, if in 2013 an employee elects family coverage under a fully-insured major medical policy with a value of $23,000 and a separate fully-insured dental policy with a value of $2,000 and contributes $3,000 to a Health FSA, the employee has an aggregate health insurance coverage value of $28,000. The amount subject to the excise tax is $7,000 ($28,000 less the threshold of $21,000). The employer reports $5,750 ($7,000 x $23,000/$28,000) as taxable to the major medical insurer and $500 ($7,000 x $2,000/$28,000) as taxable to the dental insurer, each of which then calculates and remits the excise tax to the IRS. If the employer uses a third-party administrator for the Health FSA, the employer reports $750 ($7,000 x $3,000/$28,000) to the administrator and the administrator calculates and remits the excise tax to the IRS. If the employer is acting as the plan administrator of the Health FSA, the employer is responsible for calculating and remitting the excise tax on the $750 to the IRS.

Penalty for underreporting liability for tax to insurers. If the employer reports to insurers, plan administrators and the IRS a lower amount of insurance cost subject to the excise tax than

required, the employer is subject to a penalty equal to the sum of any additional excise tax that each such insurer and administrator would have owed if the employer had reported correctly and interest attributable to that additional excise tax as determined under Code section 6621 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.

Transition relief and other rules. Under a transition rule for health insurance plans maintained in the 17 States with the highest average cost for employer-sponsored coverage under health plans based on aggregate premiums **for the year ended December 31, 2012,** as determined by the Secretary, the threshold amount is initially increased by 20 percent. The Secretary is required to determine the 17 highest cost States based on the most recent available data as of August 31, 2012. The initial 20 percent increase is reduced by half each year thereafter (i.e., to 10 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 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. In addition, this rule applies prior to any additional transition relief to which an individual is entitled on account of his or her status as a retiree over age 55 or as a participant in a plan that covers employees in a high risk profession.

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 also indexed to the CPI-U plus one percentage point.

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 CPI-U plus one percentage point. 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. Individuals engaged in the construction industry include individuals employed by electrical and telecommunications companies to repair and install electrical and telecommunications lines.

Under this provision, an individual's threshold cannot be increased by more than $1,850 for individual coverage or $5,000 for family coverage (indexed as described above), 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.

Under the provision, the amount of the excise tax imposed is not deductible for Federal income tax purposes.

Effective Date

The provision is effective for taxable years beginning after December 31, 2012.

Sec. 6002. Employer Health Insurance Reporting.

Present Law

In many cases, an employer pays for all or a portion of its employees' health insurance coverage as an employee benefit. This benefit often includes premiums for major medical, dental, and other supplementary health insurance coverage. Under present law, the value of employer-provided health coverage is not required to be reported to the IRS or any other Federal agency. The value of the employer contribution to health coverage is excludible from an employee's income.[36]

Under Present Law, every employer is required to furnish each employee and the Federal government with a statement of compensation information, including wages, paid by the employer to the employee, and the taxes withheld from such wages during the calendar year. The statement, made on the Form W-2, must be provided to each employee by January 31 of the succeeding year. There is no requirement that the employer report the total value of employer-sponsored health insurance coverage on the Form W-2,[37] although some employers voluntarily report the amount of salary reduction under a cafeteria plan resulting in tax-free employee benefits in box 14.

Committee Bill

Under the Committee Bill, an employer is required to disclose on each employee's annual Form W-2 the value of the employee's health insurance coverage sponsored by the employer. If an employee enrolls in employer-sponsored health insurance coverage under multiple plans, the employer must disclose the aggregate value of all such health coverage (excluding the value of a health flexible spending arrangement). For example, if an employee enrolls in employer-sponsored health insurance coverage under a major medical plan, a dental plan, and a vision plan, the employer is required to report the total value of the combination of all of these health related insurance policies. For this purpose, employers generally use the same value for all similarly situated employees receiving the same category of coverage (such as single or family health insurance coverage).

To determine the value of employer-sponsored health insurance coverage, the employer calculates the applicable premiums for the taxable year for the employee under the rules for COBRA continuation coverage under section 4980B(f)(4) (and accompanying Treasury regulations), including the special rule for self-insured plans. The value that the employer is required to report is the portion of the aggregate premium. If the plan provides for the same

[36] Sec. 106.

[37] Any portion of employer sponsored coverage that is paid for by the employee with after- tax contributions is included as wages on the W-2 Form.

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.

Effective Date

The provision is effective for taxable years beginning after December 31, 2009.

Sec. 6003. Modify the Definition of Qualified Medical Expenses.

Present Law

Individual deduction for medical expenses. Expenses for medical care, not compensated for by insurance or otherwise, are deductible by an individual under the rules relating to itemized deductions to the extent the expenses exceed 7.5 percent of AGI.[38] Medical care generally is defined broadly as amounts paid for diagnoses, cure, mitigation, treatment or prevention of disease, or for the purpose of affecting any structure of the body.[39] However, any amount paid during a taxable year for medicine or drugs is explicitly deductible as a medical expense only if the medicine or drug is a prescribed drug or is insulin.[40] Thus, any amount paid for medicine available without a prescription ("over-the-counter medicine") is not deductible as a medical expense, including any medicine recommended by a physician.[41]

Exclusion for employer-provided health care. The Code generally provides that the value of employer-provided health coverage under an accident or health plan is excluded from gross income.[42] In addition, any reimbursements under an accident or health plan for medical care expenses for employees, their spouses, and their dependents generally are excluded from gross income.[43] An employer may agree to reimburse expenses for medical care of its employees (and their spouses and dependents), not covered by a health insurance plan, through a flexible spending arrangement ("FSA") which allows reimbursement not in excess of a specified dollar amount. Such dollar amount is either elected by an employee under a cafeteria plan ("Health FSA") or otherwise specified by the employer under an arrangement called a health reimbursement arrangement ("HRA"). Reimbursements under these arrangements are also excludible from gross income as employer-provided health coverage. The general definition of medical care without the explicit limitation on medicine applies for purposes of the exclusion for employer-provided health coverage and medical care.[44] Thus, under an HRA or under a Health FSA, amounts paid for over-the-counter medicine are treated as medical expenses, and reimbursements for such amounts are excludible from gross income.

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[38] Sec. 213(a).
[39] Sec. 213(d). There are certain limitations on the general definition including a rule that cosmetic surgery or similar procedures are generally not medical care.
[40] Sec. 213(b).
[41] Rev. Rul. 2003-58, 2003-1 CB 959.
[42] Sec. 106.
[43] Sec. 105(b).
[44] Sec. 105(b) provides that reimbursements for medical care within the meaning of section 213(d) pursuant to employer-provided health coverage are excludible from gross income. The definition of medical care in section 213(d) does not include the prescription drug limitation in section 213(b).

Medical savings arrangements. Present law provides that individuals with a high deductible health plan (and generally no other health plan) purchased either through the individual market or through an employer may establish and make tax-deductible contributions to a health savings account ("HSA").[45] Subject to certain limitations,[46] contributions made to an HSA by an employer, including contributions made through a cafeteria plan through salary reduction, are excluded from income (and from wages for payroll tax purposes). Contributions made by individuals are deductible for income tax purposes, regardless of whether the individuals itemize. Distributions from an HSA that are used for qualified medical expenses are excludible from gross income.[47] The general definition of medical care without the explicit limitation on medicine also applies for purposes of this exclusion.[48] Similar rules apply for another type of medical savings arrangement called an Archer MSA.[49] Thus, a distribution from a HSA or an Archer MSA used to purchase over-the-counter medicine also is excludible as an amount used for qualified medical expenses.

Committee Bill

Under the Committee Bill, with respect to medicines, the definition of medical expense for purposes of employer-provided health coverage (including HRAs and Health FSAs), HSAs, and Archer MSAs, generally is conformed to the definition for purposes of the itemized deduction for medical expenses. However, this change does not apply to over-the-counter medicine that is prescribed for a patient by a physician. Thus, under the provision, the cost of over-the-counter medicines (other than physician prescribed) may not be reimbursed through a Health FSA or HRA. In addition, the cost of over-the-counter medicines (other than doctor prescribed) may not be reimbursed on a tax-free basis through a HSA or Archer MSA.

Effective Date

The Committee Bill is effective for taxable years beginning after December 31, 2009.

Sec. 6004. Increase in Additional Tax on Distributions from HSAs Not Used for Medical Expenses.

Present Law

Present law provides that individuals with a high deductible health plan (and generally no other health plan) may establish and make tax-deductible contributions to a health savings account

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[45] Sec. 223.

[46] For 2009, the maximum aggregate annual contribution that can be made to an HSA is $3,000 in the case of self-only coverage and $5,950 in the case of family coverage ($3,050 and $6,150 for 2010). The annual contribution limits are increased for individuals who have attained age 55 by the end of the taxable year (referred to as "catch-up contributions"). In the case of policyholders and covered spouses who are age 55 or older, the HSA annual contribution limit is greater than the otherwise applicable limit by $1,000 in 2009 and thereafter. Contributions, including catch-up contributions, cannot be made once an individual is enrolled in Medicare.

[47] Sec. 223(f).

[48] Sec. 223(d)(2).

[49] Sec. 220.

("HSA").[50] An HSA is a tax-exempt account held by a trustee or custodian for the benefit of the individual. An HSA is subject to a condition that the individual is covered under a high deductible health plan (purchased either through the individual market or through an employer). The decision to create and fund an HSA is made on an individual-by-individual basis and does not require any action on the part of the employer.

Subject to certain limitations, contributions made to an HSA by an employer, including contributions made through a cafeteria plan through salary reduction, are excluded from income (and from wages for payroll tax purposes). Contributions made by individuals are deductible for income tax purposes, regardless of whether the individuals itemize. Income from investments made in HSAs is not taxable and the overall income is not taxable upon disbursement for medical expenses.

For 2009, the maximum aggregate annual contribution that can be made to an HSA is $3,000 in the case of self-only coverage and $5,950 in the case of family coverage ($3,050 and $6,150 for 2010). The annual contribution limits are increased for individuals who have attained age 55 by the end of the taxable year (referred to as "catch-up contributions"). In the case of policyholders and covered spouses who are age 55 or older, the HSA annual contribution limit is greater than the otherwise applicable limit by $1,000 in 2009 and thereafter. Contributions, including catch-up contributions, cannot be made once an individual is enrolled in Medicare.

A high deductible health plan is a health plan that has an annual deductible that is at least $1,150 for self-only coverage or $2,300 for family coverage for 2009 (increasing to $1,200 and $2,400 for 2010) and that limits the sum of the annual deductible and other payments that the individual must make in respect of covered benefits to no more than $5,800 in the case of self-only coverage and $11,600 in the case of family coverage for 2009 (increasing to $5,950 and $11,900 for 2010).

Distributions from an HSA that are used for qualified medical expenses are excludible from gross income. Distributions from an HSA that are not used for qualified medical expenses are includible in gross income. An additional 10 percent tax is added for all HSA disbursements not made for qualified medical expenses. The additional 10-percent tax does not apply, however, if the distribution is made after death, disability, or attainment of age of Medicare eligibility (currently, age 65). Unlike reimbursements from a flexible spending arrangement or health reimbursement arrangement, distributions from an HSA are not required to be substantiated by the employer or a third party for the distributions to be excludible from income.

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[50] An individual with other coverage in addition to a high deductible health plan is still eligible for an HSA if such other coverage is "permitted insurance" or "permitted coverage." Permitted insurance is: (1) insurance if substantially all of the coverage provided under such insurance relates to (a) liabilities incurred under worker's compensation law, (b) tort liabilities, (c) liabilities relating to ownership or use of property (e.g., auto insurance), or (d) such other similar liabilities as the Secretary may prescribe by regulations; (2) insurance for a specified disease or illness; and (3) insurance that provides a fixed payment for hospitalization. Permitted coverage is coverage (whether provided through insurance or otherwise) for accidents, disability, dental care, vision care, or long-term care. With respect to coverage for years beginning after December 31, 2006, certain coverage under a Health Flexible Spending Account is disregarded in determining eligibility for an HSA.

Like IRAs, the individual owns his or her HSA, and thus the individual is required to maintain books and records with respect to the expense and claim the exclusion for a distribution from the HSA on their tax return. The determination of whether the distribution is for a qualified medical expense is subject to individual self-reporting and IRS enforcement.

Committee Bill

The additional tax on distributions from an HSA that are not used for qualified medical expenses is increased to 20 percent of the disbursed amount.

Effective Date

The change is effective for disbursements made during tax years starting after December 31, 2010.

Sec. 6005. Limitation on Health Flexible Spending Arrangements Under Cafeteria Plans.

Present Law

Exclusion from income for employer-provided health coverage. The Code generally provides that the value of employer-provided health coverage under an accident or health plan is excludible from gross income.[51] In addition, any reimbursements under an accident or health plan for medical care expenses for employees, their spouses, and their dependents generally are excluded from gross income.[52] The exclusion applies both to health coverage in the case in which an employer absorbs the cost of employees' medical expenses not covered by insurance (i.e., a self-insured plan) as well as in the case in which the employer purchases health insurance coverage for its employees. There is no limit on the amount of employer-provided health coverage that is excludable. A similar rule excludes employer-provided health insurance coverage from the employees' wages for payroll tax purposes.[53]

Employers may also provide health coverage in the form of an agreement to reimburse medical expenses of their employees (and their spouses and dependents), not reimbursed by a health insurance plan, through flexible spending arrangements which allow reimbursement for medical care not in excess of a specified dollar amount (either elected by an employee under a cafeteria plan or otherwise specified by the employer). Health coverage provided in the form of one of these arrangements is also excludible from gross income as employer-provided health coverage under an accident or health plan.[54]

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[51] Sec. 106. Health coverage provided to active members of the uniformed services, military retirees, and their dependents are excludable under section 134. That section provides an exclusion for "qualified military benefits," defined as benefits received by reason of status or service as a member of the uniformed services and which were excludable from gross income on September 9, 1986, under any provision of law, regulation, or administrative practice then in effect.

[52] Sec. 105(b).

[53] Secs. 3121(a)(2), and 3306(a)(2). See also section 3231(e)(1) for a similar rule with respect to compensation for purposes of Railroad Retirement Tax.

[54] Sec. 106.

Flexible spending arrangement under a cafeteria plan. A flexible spending arrangement for medical expenses under a cafeteria plan ("Health FSA") is an unfunded arrangement under which employees are given the option to reduce their 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.[55] Health FSAs are subject to the general requirements for cafeteria plans, including a requirement that amounts remaining under a Health FSA at the end of a plan year must be forfeited by the employee (referred to as the "use-it-or-lose-it rule").[56] A Health FSA is permitted to allow a grace period not to exceed two and one-half months immediately following the end of the plan year during which unused amounts may be used.[57] A Health FSA can also include employer flex-credits which are non-elective employer contributions that the employer makes for every employee eligible to participate in the employer's cafeteria plan, to be used only for one or more tax excludible qualified benefits (but not as cash or a taxable benefit).[58]

A flexible spending arrangement including a Health FSA (under a cafeteria plan) is generally distinguishable from other employer-provided health coverage by the relationship between the value of the coverage for a year and the maximum amount of reimbursement reasonably available during the same period. A flexible spending arrangement for health coverage generally is defined as a benefit program which provides employees with coverage under which specific incurred medical care expenses may be reimbursed (subject to reimbursement maximums and other conditions) and the maximum amount of reimbursement reasonably available is less than 500 percent of the value of such coverage.[59]

Health reimbursement arrangement. Rather than offering a Health FSA through a cafeteria plan, an employer may specify a dollar amount that is available for medical expense reimbursement. These arrangements are commonly called Health Reimbursement Arrangements ("HRAs"). Some of the rules applicable to HRAs and Health FSAs are similar (e.g., the amounts in the arrangements can only be used to reimburse medical expenses and not for other purposes), but the rules are not identical. In particular, HRAs cannot be funded on a salary reduction basis and the use-it-or-lose-it rule does not apply. Thus, amounts remaining at the end of the year may be carried forward to be used to reimburse medical expenses in following years.[60]

Committee Bill

Under the Committee Bill, salary reductions by an employee for a taxable year for purposes of coverage under a Health FSA under a cafeteria plan are limited to $2,500.[61] 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 be made available for use in reimbursing the employee for his or

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[55] Sec. 125 and proposed Treas. Reg. sec. 1.125-5.
[56] Sec. 125(d)(2) and proposed Treas. Reg. sec. 1.125-5(c).
[57] Notice 2005-42, 2005-1 C.B. 1204 and proposed Treas. Reg. sec. 1.125-1(e).
[58] Proposed Treas. Reg. sec. 1-125-5(b).
[59] Sec. 106(c)(2) and proposed Treas. Reg. sec. 1.125-5(a).
[60] Guidance with respect to HRAs, including the interaction of FSAs and HRAs in the case of an individual covered under both, is provided in Notice 2002-45, 2002-2 C.B. 93.
[61] The provision does not change the present law treatment as described in proposed Treas. Reg. sec. 1.125-5 for dependent care flexible spending arrangements or adoption assistance flexible spending arrangements.

her medical expenses, the amount of the reduction in cash compensation is limited to $2,500 for a taxable year. The provision does not limit the exclusion for health coverage offered through an HRA.

Effective Date

The Committee Bill is effective for taxable year beginning after December 31, 2010.

Sec. 6006. Require Information Reporting on Payments to Corporations.

Present Law

Present law imposes a variety of information reporting requirements on participants in certain transactions.[62] These requirements are intended to assist taxpayers in preparing their income tax returns and to help the IRS determine whether such returns are correct and complete.

The primary provision governing information reporting by payors requires an information return by every person engaged in a trade or business who makes payments aggregating $600 or more in any taxable year to a single payee in the course of that payor's trade or business.[63] Payments subject to reporting include fixed or determinable income or compensation, but do not include payments for goods or certain enumerated types of payments that are subject to other specific reporting requirements.[64] The payor is required to provide the recipient of the payment with an annual statement showing the aggregate payments made and contact information for the payor.[65] The regulations generally except from reporting, payments to corporations, exempt organizations, governmental entities, international organizations, or retirement plans.[66] However, the following types of payments to corporations must be reported: Medical and healthcare payments;[67] fish purchases for cash;[68] attorney's fees;[69] gross proceeds paid to an attorney;[70] substitute payments in lieu of dividends or tax-exempt interest;[71] and payments by a Federal executive agency for services.[72]

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[62] Secs. 6031 through 6060.

[63] Sec. 6041(a). The information return is generally submitted electronically as a Form-1099 or Form-1096, although certain payments to beneficiaries or employees may require use of Forms W-3 or W-2, respectively. Treas. Reg. sec. 1.6041-1(a)(2).

[64] Sec. 6041(a) requires reporting as to "other fixed or determinable gains, profits, and income (other than payments to which section 6042(a)(1), 6044(a)(1), 6047(c), 6049(a) or 6050N(a) applies and other than payments with respect to which a statement is required under authority of section 6042(a), 6044(a)(2) or 6045)[.]" These excepted payments include most interest, royalties, and dividends.

[65] Sec. 6041(d).

[66] Treas. Reg. sec. 1.6041-3(p). Certain for-profit health provider corporations are not covered by this general exception, including those organizations providing billing services for such companies.

[67] Sec. 6050T.

[68] Sec. 6050R.

[69] Sec. 6045(f)(1) and (2); Treas. Reg. secs. 1.6041-1(d)(2) and 1.6045-5(d)(5).

[70] *Ibid*.

[71] Sec. 6045(d).

[72] Sec. 6041(d)(3).

Failure to comply with the information reporting requirements results in penalties, which may include a penalty for failure to file the information return,[73] and a penalty for failure to furnish payee statements[74] or failure to comply with other various reporting requirements.[75]

Detailed rules are provided for the reporting of various types of investment income, including interest, dividends, and gross proceeds from brokered transactions (such as a sale of stock).[76] In general, the requirement to file Form 1099 applies with respect to amounts paid to U.S. persons and is linked to the backup withholding rules of section 3406. Thus, a payor of interest, dividends or gross proceeds generally must request that a U.S. payee (other than certain exempt recipients) furnish a Form W-9 providing that person's name and taxpayer identification number.[77] That information is then used to complete the Form 1099.

Committee Bill

Under the Committee Bill, a business is required to file an information return for all payments aggregating $600 or more in a calendar year to a single payee (other than a payee that is a tax-exempt corporation), notwithstanding any regulation promulgated prior to the date of enactment. The payments to be reported include gross proceeds paid in consideration for property or services.

Effective Date

The Committee Bill is effective for payments made after December 31, 2011.

Sec. 6007. Requirements for Section 501(c)(3) Hospitals.

Present Law

Tax exemption. Charitable organizations, i.e., organizations described in section 501(c)(3), generally are exempt from Federal income tax, are eligible to receive tax deductible contributions,[78] have access to tax-exempt financing through State and local governments (described in more detail below),[79] and generally are exempt from State and local taxes. A charitable organization must operate primarily in pursuit of one or more tax-exempt purposes

[73] Sec. 6721. The penalty for the failure to file an information return generally is $50 for each return for which such failure occurs. The total penalty imposed on a person for all failures during a calendar year cannot exceed $250,000. Additionally, special rules apply to reduce the per-failure and maximum penalty where the failure is corrected within a specified period.

[74] Sec. 6722. The penalty for failure to provide a correct payee statement is $50 for each statement with respect to which such failure occurs, with the total penalty for a calendar year not to exceed $100,000. Special rules apply that increase the per-statement and total penalties where there is intentional disregard of the requirement to furnish a payee statement.

[75] Sec. 6723. The penalty for failure to timely comply with a specified information reporting requirement is $50 per failure, not to exceed $100,000 for a calendar year.

[76] Secs. 6042 (dividends), 6045 (broker reporting) and 6049 (interest) and the Treasury regulations thereunder.

[77] See Treas. Reg. sec. 31.3406(h)-3.

[78] Sec. 170.

[79] Sec. 145.

constituting the basis of its tax exemption.[80] The Code specifies such purposes as religious, charitable, scientific, educational, literary, testing for public safety, to foster international amateur sports competition, or for the prevention of cruelty to children or animals. In general, an organization is organized and operated for charitable purposes if it provides relief for the poor and distressed or the underprivileged.[81]

The Code does not provide a per se exemption for hospitals. Rather, a hospital qualifies for exemption if it is organized and operated for a charitable purpose and otherwise meets the requirements of section 501(c)(3).[82] The promotion of health has been recognized by the IRS as a charitable purpose that is beneficial to the community as a whole.[83] It includes not only the establishment or maintenance of charitable hospitals, but clinics, homes for the aged, and other providers of health care.

Since 1969, the IRS has applied a "community benefit" standard for determining whether a hospital is charitable.[84] According to Revenue Ruling 69-545, community benefit can include, for example: maintaining an emergency room open to all persons regardless of ability to pay; having an independent board of trustees composed of representatives of the community; operating with an open medical staff policy, with privileges available to all qualifying physicians; providing charity care; and utilizing surplus funds to improve the quality of patient care, expand facilities, and advance medical training, education and research. Beginning in 2009, hospitals generally are required to submit information on community benefit on their annual information returns filed with the IRS.[85] Present law does not include sanctions short of revocation of tax-exempt status for hospitals that fail to satisfy the community benefit standard.

Although section 501(c)(3) hospitals generally are exempt from Federal tax on their net income, such organizations are subject to the unrelated business income tax on income derived from a trade or business regularly carried on by the organization that is not substantially related to the performance of the organization's tax-exempt functions.[86] In general, interest, rents, royalties, and annuities are excluded from the unrelated business income of tax-exempt organizations.[87]

Charitable contributions. In general, a deduction is permitted for charitable contributions, including charitable contributions to tax-exempt hospitals, subject to certain limitations that depend on the type of taxpayer, the property contributed, and the donee organization. The

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[80] Treas. Reg. sec. 1.501(c)(3)-1(c)(1).

[81] Treas. Reg. sec. 1.501(c)(3)-1(d)(2).

[82] Although nonprofit hospitals generally are recognized as tax-exempt by virtue of being "charitable" organizations, some might qualify for exemption as educational or scientific organizations because they are organized and operated primarily for medical education and research purposes.

[83] Rev. Rul. 69-545, 1969-2 C.B. 117; see also Restatement (Second) of Trusts secs. 368, 372 (1959); see Bruce R. Hopkins, *The Law of Tax-Exempt Organizations*, sec. 6.3 (8th ed. 2003) (discussing various forms of health-care providers that may qualify for exemption under section 501(c)(3)).

[84] Rev. Rul. 69-545, 1969-2 C.B. 117. From 1956 until 1969, the IRS applied a "financial ability" standard, requiring that a charitable hospital be "operated to the extent of its financial ability for those not able to pay for the services rendered and not exclusively for those who are able and expected to pay." Rev. Rul. 56-185, 1956-1 C.B. 202.

[85] IRS Form 990, Schedule H.

[86] Secs. 511-514.

[87] Sec. 512(b).

amount of deduction generally equals the fair market value of the contributed property on the date of the contribution. Charitable deductions are provided for income, estate, and gift tax purposes.[88]

Tax-exempt financing. In addition to issuing tax-exempt bonds for government operations and services, State and local governments may issue tax-exempt bonds to finance the activities of charitable organizations described in section 501(c)(3). Because interest income on tax-exempt bonds is excluded from gross income, investors generally are willing to accept a lower pre-tax rate of return on such bonds than they might otherwise accept on a taxable investment. This, in turn, lowers the cost of capital for the users of such financing. Both capital expenditures and limited working capital expenditures of charitable organizations described in section 501(c)(3) of the Code generally may be financed with tax-exempt bonds. Private, nonprofit hospitals frequently are the beneficiaries of this type of financing.

Bonds issued by State and local governments may be classified as either governmental bonds or private activity bonds. Governmental bonds are bonds the proceeds of which are primarily used to finance governmental functions or which are repaid with governmental funds. Private activity bonds are bonds in which the State or local government serves as a conduit providing financing to nongovernmental persons (e.g., private businesses or individuals). For these purposes, the term "nongovernmental person" generally includes the Federal government and all other individuals and entities other than States or local governments, including section 501(c)(3) organizations. The exclusion from income for interest on State and local bonds does not apply to private activity bonds, unless the bonds are issued for certain permitted purposes ("qualified private activity bonds") and other Code requirements are met.

Reporting and disclosure requirements. Exempt organizations are required to file an annual information return, stating specifically the items of gross income, receipts, disbursements, and such other information as the Secretary may prescribe.[89] Section 501(c)(3) organizations that are classified as public charities must file Form 990 (Return of Organization Exempt From Income Tax),[90] including Schedule A, which requests information specific to section 501(c)(3) organizations. Additionally, an organization that operates at least one facility that is, or is required to be, licensed, registered, or similarly recognized by a state s a hospital must complete Schedule H (Form 990), which requests information regarding charity care, community benefits, bad debt expense, and certain management company and joint venture arrangements of a hospital.

An organization described in section 501(c) or (d) generally is also required to make available for public inspection for a period of three years a copy of its annual information return (Form 990) and exemption application materials.[91] This requirement is satisfied if the organization has

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[88] Secs. 170, 2055, and 2522, respectively.

[89] Sec. 6033(a). An organization that has not received a determination of its tax-exempt status, but that claims tax-exempt status under section 501(a), is subject to the same annual reporting requirements and exceptions as organizations that have received a tax-exemption determination.

[90] Social welfare organizations, labor organizations, agricultural organizations, horticultural organizations, and business leagues are subject to the generally applicable Form 990, Form 990-EZ, and Form 990-T annual filing requirements.

[91] Sec. 6104(d).

made the annual return and exemption application widely available (e.g., by posting such information on its website).[92]

Committee Bill

Additional requirements for section 501(c)(3) hospitals[93]

In general. The Committee Bill establishes new requirements applicable to section 501(c)(3) hospitals. The new requirements are in addition to, and not in lieu of, the requirements otherwise applicable to an organization described in section 501(c)(3). The requirements generally apply to any section 501(c)(3) organization that operates at least one hospital facility. For purposes of the provision, a hospital facility generally includes: (1) any facility that is, or is required to be, licensed, registered, or similarly recognized by a State as a hospital; and (2) any other facility or organization the Secretary of the Treasury (the "Secretary"), in consultation with the Secretary of Health and Human Services and after public comment, determines has the provision of hospital care as its principal purpose. An organization subject to the provision is required to comply with the following requirements with respect to each hospital facility operated by such organization.

Community health needs assessment. Each hospital facility is required to conduct a community health needs assessment at least once every three taxable years and adopt an implementation strategy to meet the community needs identified through such assessment. The assessment may be based on current information collected by a public health agency or non-profit organizations and may be conducted together with one or more other organizations, including related organizations. The assessment process must take into account input from persons who represent the broad interests of the community served by the hospital, including those with special knowledge or expertise of public health issues. The hospital must disclose in its annual information report to the IRS (i.e., Form 990 and related schedules) how it is addressing the needs identified in the assessment and, if all identified needs are not addressed, the reasons why (e.g., lack of financial or human resources). Each hospital facility is required to make the assessment widely available. Failure to complete a community health needs assessment in any applicable three-year period results in a penalty on the organization of up to $50,000. For example, if a facility does not complete a community health needs assessment in taxable years one, two or three, it is subject to the penalty in year three. If it then fails to complete a community health needs assessment in year four, it is subject to another penalty in year four (for failing to satisfy the requirement during the three-year period beginning with taxable year two and ending with taxable year four). An organization that fails to disclose how it is meeting needs identified in the assessment is subject to existing incomplete return penalties.[94]

Financial assistance policy. Each hospital facility is required to adopt, implement, and widely publicize a written financial assistance policy. Each hospital facility is required to adopt and implement a policy to provide emergency medical treatment to individuals. The policy must prevent discrimination in the provision of emergency medical treatment, including denial of

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[92] Sec. 6104(d)(4); Treas. Reg. sec. 301.6104(d)-2(b).
[93] No inference is intended regarding whether an organization satisfies the present law community benefit standard.
[94] Sec. 6652.

service, against those eligible for financial assistance under the facility's financial assistance policy or those eligible for government assistance. The financial assistance policy must indicate the eligibility criteria for financial assistance and whether such assistance includes free or discounted care. For those eligible for discounted care, the policy must indicate the basis for calculating the amounts that will be billed to such patients. The policy must also indicate how to apply for such assistance. If a hospital does not have a separate billing and collections policy, the financial assistance policy must also indicate what actions the hospital may take in the event of non-response or non-payment, including collections action and reporting to credit rating agencies.

Limitation on charges. Each hospital facility is permitted to bill patients who qualify for financial assistance no more than the amount generally billed to insured patients. A hospital facility may not use gross charges (i.e., "chargemaster" rates), when billing individuals who qualify for financial assistance. It is intended that amounts billed to those who qualify for financial assistance may be based on either the best, or an average of the three best, negotiated commercial rates, or Medicare rates.

Collection processes. Under the provision, a hospital facility (or its affiliates) generally is 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 efforts to inform the patient about the hospital's financial assistance policy and to determine whether the patient is eligible for assistance under such policy. Such extraordinary collection actions include lawsuits, liens on residences, arrests, body attachments, or other similar collection processes. The Secretary is directed to issue guidance concerning what attempts to determine eligibility for financial assistance constitute reasonable attempts. It is intended that for this purpose, "reasonable attempts" includes notification by the hospital of its financial assistance policy upon admission and in written and oral communications with the patient regarding the patient's bill, including invoices and telephone calls, before collection action or reporting to credit rating agencies is initiated.

Reporting and Disclosure Requirements. The Committee Bill includes new reporting and disclosure requirements. Under the provision, the IRS is 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.[95] The provision also requires each organization to which the provision applies to file with its annual information return (i.e., Form 990) a copy of its audited financial statements (or, in the case of an organization the financial statements of which are included in a consolidated financial statement with other organizations, such consolidated financial statements).

The Committee Bill requires the Secretary, in consultation with the Secretary of Health and Human Services, to report annually 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

[95] See http://www.sec.gov/divisions/corpfin/cffilingreview.htm for SEC procedures.

hospitals. In addition, the Secretary, in consultation with the Secretary of Health and Human Services, 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.

Effective Date

The Committee Bill generally is effective for taxable years beginning after the date of enactment. The community health needs assessment requirement is effective for taxable years beginning after the date which is two years after the date of enactment.[96]

Sec. 6008. Imposition of Annual Fee on Branded Prescription Pharmaceutical Manufacturers and Importers

Present Law

There are two Medicare trust funds under present law, the Hospital Insurance ("HI") fund and the Supplementary Medical Insurance ("SMI") fund.[97] The HI trust fund is primarily funded through payroll tax on covered earnings. Employers and employees each pay 1.45 percent of wages, while self-employed workers pay 2.9 percent of a portion of their net earnings from self-employment. Other HI trust fund revenue sources include a portion of the Federal income taxes paid on Social Security benefits, and interest paid on the U. S. Treasury securities held in the HI trust fund. For the SMI trust fund, transfers from the general fund of the Treasury represent the largest source of revenue, but additional revenues include monthly premiums paid by beneficiaries, and interest paid on the U.S. Treasury securities held in the SMI trust fund.

IRS authority to assess and collect taxes is generally provided in subtitle F of the Code (secs. 6001-7874), relating to procedure and administration. That subtitle establishes the rules governing both how taxpayers are required to report information to the IRS and to pay their taxes, as well as their rights. It also establishes the duties and authority of the IRS to enforce the Federal tax law, and sets forth rules relating to judicial proceedings involving Federal tax.

Present law does not impose a fee creditable to the Medicare trust funds on companies that manufacture or import prescription drugs for sale in the United States.

Committee Bill

The Committee Bill imposes a fee each calendar year on each covered entity engaged in the business of manufacturing or importing branded prescription drugs for sale in the United States. The fee is due each calendar year on a date to be determined by the Secretary, but in no event later than September 30th. Fees collected are credited to the Medicare SMI trust fund. The

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[96] For example, assume the date of enactment is December 1, 2009. A calendar year taxpayer would test whether it meets the community health needs assessment requirement in the taxable year ending December 31, 2012. To avoid the penalty, the taxpayer must have satisfied the community health needs assessment requirements in 2010, 2011, or 2012.

[97] See 2009 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, available at http://www.cms.hhs.gov/ReportsTrustFunds/downloads/tr2009.pdf.

aggregate fee under the provision is $2.3 billion payable annually beginning in 2010. Under the provision, the aggregate fee is apportioned among the covered entities each year based on each entity's relative market share of branded prescription drug sales taken into account during the preceding calendar year.

A covered entity is defined under the provision as any manufacturer or importer with gross receipts from branded prescription drug sales. For purposes of the provision, covered entity includes all persons treated as a single employer under subsection (a) or (b) of section 52 or subsection (m) or (o) of section 414. The otherwise applicable exclusion of foreign corporations under those rules is disregarded for these purposes.

Under the Committee Bill, branded prescription drug sales means sales of branded prescription drugs to any specified government program or pursuant to coverage under any such program, but does not include sales of orphan drugs.[98] A branded prescription drug is any prescription drug for which an application was submitted under section 505(b) of the Federal Food, Drug, and Cosmetic Act, or any biological product the license for which was submitted under section 351(a) of the Public Health Service Act. A prescription drug is any drug subject to section 503(b) of the Federal Food, Drug, and Cosmetic Act.

Under the Committee Bill, specified government program means the Medicare Part D program, the Medicare Part B program, the Medicaid program, any program under which branded prescription drugs are procured by the Department of Veteran Affairs, any program under which branded prescription drugs are procured by the Department of Defense, or the TRICARE retail pharmacy program. The provision requires the Secretary of Health and Human Services, the Secretary of Veterans Affairs, and the Secretary of Defense to report to the Secretary of the Treasury the total branded prescription drug sales for each covered entity with respect to each specified government program under such Secretary's jurisdiction.

The Committee Bill authorizes the Secretary of the Treasury to prescribe the timing and the manner for reporting such sales. Additionally the provision prescribes a methodology to be used by the Secretary of Health and Human Services to compute such amounts for the Medicare Part D, Medicare Part B programs, and Medicaid programs, by the Secretary of Veterans Affairs for its programs, and by the Secretary of Defense for TRICARE and other programs.

Under the Committee Bill, a covered entity's individual assessment for each calendar year is the total fee multiplied by the ratio of (1) the covered entity's branded prescription drug sales taken into account during the preceding calendar year to (2) the aggregate branded prescription drug sales of all covered entities taken into account during such preceding calendar year.

Sales taken into account for this purpose includes zero percent of a covered entity's branded prescription drug sales for the preceding calendar year up to $5 million; ten percent of a covered

[98] Orphan drugs include any drug or biological product with respect to which a credit was allowed for any taxable year under section 45C. Sales of any drug or biological product which qualified under section 45C will not be excluded after the date on which such drug or biological product is approved by the Food and Drug Administration for marketing for any indication other than the treatment of the rare disease or conditions with respect to which the section 45C credit was allowed.

entity's branded prescription drug sales for the preceding calendar year over $5 million and up to $125 million; 40 percent of a covered entity's branded prescription drug sales for the preceding calendar year over $125 million and up to $225 million; 75 percent of a covered entity's branded prescription drug sales for the preceding calendar year over $225 million and up to $400 million; and 100 percent of a covered entity's branded prescription drug sales for the preceding calendar year over $400 million.

The following is an example of how the relative market share would be determined if the market included only three entities with branded prescription drug sales, Company A with branded prescription drug sales of $1 million, Company B with branded prescription drug sales of $100 million, and Company C with branded prescription drug sales of $899 million, for a combined market of $1 billion.

	Applicable Branded Prescription Drug Sales (Millions)	Percentage	Covered Entity's Sales Taken into Account (Millions)
Company A: Total Branded Prescription Drug Sales $1m			
up to $5m	1	0 percent	0
Total Sales	1		0
Company B: Total Branded Prescription Drug Sales $100m			
up to $5m	5	0 percent	0
>$5m up to $125m	95	10 percent	10
Total Sales	100		10
Company C: Total Branded Prescription Drug Sales $899m			
up to $5m	5	0 percent	0
>$5m up to $125m	120	10 percent	12
>$125m up to $225m	100	40 percent	40
>$225m up to $400m	175	75 percent	131
>$400m	499	100 percent	499
Total Sales	899		682
Total Market	1,000		692

Covered Entity	**Relative Market Share of Sales Taken Into Account**
Company A	0.0 percent
Company B	1.4 percent
Company C	98.6 percent

For purposes of procedure and administration under the rules of subtitle F of the Code, any fee assessed under this provision is treated as an excise tax with respect to which only civil actions for refund under subtitle F apply. The Secretary of the Treasury may readjust covered entities' shares of the fee for any calendar year for which the statute of limitations remains open.

The fees are treated as nondeductible taxes under section 275 of the Code for U.S. income tax purposes.

Effective Date

The Committee Bill is effective for calendar years beginning after 2009. The fee is allocated based on the market share of branded prescription drug sales for calendar years beginning after December 31, 2008.

Sec. 6009. Imposition of Annual Fee on Medical Device Manufacturers and Importers.

Present Law

IRS authority to assess and collect taxes is generally provided in subtitle F of the Code (secs. 6001 -7874), relating to procedure and administration. That subtitle establishes the rules governing both how taxpayers are required to report information to the IRS and to pay their taxes, as well as their rights. It also establishes the duties and authority of the IRS to enforce the Federal tax law, and sets forth rules relating to judicial proceedings involving Federal tax.

Present law does not impose an annual sector fee on companies that manufacture or import medical devices for sale in the United States.

Committee Bill

The Committee Bill imposes a fee each calendar year on each covered entity engaged in the business of manufacturing or importing medical devices offered for sale in the United States. The aggregate fee under the provision is $4 billion payable annually beginning in 2010. The fee is due each calendar year on a date to be determined by the Secretary, but in no event later than September 30th. Under the provision, the aggregate fee would be apportioned among the covered entities each year based on each entity's relative share of gross receipts from medical device sales taken into account for the prior year.

A covered entity is defined under the provision as any manufacturer or importer with gross receipts from medical device sales. For purposes of the provision, covered entity includes all persons treated as a single employer under subsection (a) or (b) of section 52 or subsection (m) or (o) of section 414. The otherwise applicable exclusion of foreign corporations under those rules is disregarded for these purposes.

Under the Committee Bill, medical device sales means sales for use in the United States of any medical device, other than the sales of a medical device that has been classified in class II under section 513 of the Federal Food, Drug, and Cosmetic Act and is primarily sold to consumers at retail for not more than $100 per unit, or has been classified in class I under such section. A medical device is any device as defined in section 201(h) of the Federal Food, Drug, and Cosmetic Act intended for humans.[99] The Secretary has authority under this provision to publish guidance necessary to carry out the purposes of this provision. It is expected that the Secretary

[99] A product labeled, promoted or used in a manner that meets the definition in section 201(h) of the Federal Food, Drug, and Cosmetic Act. For these purposes, a device is "an instrument, apparatus, implement, machine, contrivance, implant, in vitro reagent, or other similar or related article, including any component, part, or accessory, which is (1) recognized in the official National Formulary, or the United States Pharmacopeia, or any supplement to them, (2) intended for use in the diagnosis of disease or other conditions, or in the cure, mitigation, treatment, or prevention of disease, in man or other animals, or (3) intended to affect the structure or any function of the body of man or other animals, and which does not achieve its primary intended purposes through chemical action within or on the body of man or other animals and which is not dependent upon being metabolized for the achievement of its primary intended purposes."

will provide guidance as to class II items primarily sold to consumers at retail for not more than $100 per unit, such as a list of class II items excluded under this provision. The provision is intended to exclude low cost items (such as pregnancy tests, contact lenses, and blood pressure monitors) that are normally sold directly to consumers through retail outlets. The Committee intends that a unit is an entire item as typically sold (for example a box of 30 disposable contact lenses), and does not refer to an item's component parts. Additionally the Secretary may publish guidance for the treatment of gross receipts from the sale of medical devices by a covered entity directly to another covered entity for use as a material in the manufacture or production of, or as a component part of a medical device for subsequent sale in order to eliminate double inclusion of the gross receipts from such sales.

Under the Committee Bill, each covered entity is required to file an annual report of its gross receipts from medical device sales for the preceding calendar year. Under the provision, a covered entity's individual assessment for each calendar year is the total fee multiplied by the ratio of (1) the covered entity's gross receipts from medical device sales taken into account during the preceding calendar year to (2) the aggregate gross receipts from medical device sales of all covered entities taken into account during such preceding calendar year.

Sales taken into account for this purpose includes zero percent of a covered entity's gross receipts from medical device sales for the preceding calendar year up to $5 million; 50 percent of a covered entity's gross receipts from medical device sales for the preceding calendar year over $5 million and up to $25 million; and 100 percent of a covered entity's gross receipts from medical device sales for the preceding calendar year over $25 million.

The following is an example of how the relative market share would be determined if the medical device market included three covered entities, Company A with gross receipts from covered medical device sales of $1 million, Company B with gross receipts from covered medical device sales of $20 million and Company C with gross receipts from covered medical device sales of $979 million for a combined market of $1 billion.

	Applicable Gross Receipts (Millions)	Percentage	Covered Entity's Sales Taken into Account (Millions)
Company A: Total Gross Receipts $1m			
up to $5m	1	0 percent	0
Total Sales	1		0
Company B: Total Gross Receipts $20m			
up to $5m	5	0 percent	0
>$5m up to $25m	15	50 percent	8
Total Sales	20		8
Company C: Total Gross Receipts $979m			
up to $5m	5	0 percent	0
>$5m up to $25m	20	50 percent	10
>$25m	954	100 percent	954
Total Sales	979		964
Total Market	1,000		972

Covered Entity	**Relative Market Share of Sales Taken Into Account**
Company A	0.0 percent
Company B	0.8 percent
Company C	99.2 percent

For purposes of procedure and administration under the rules of subtitle F of the Code, any fee assessed under this provision is treated as an excise tax with respect to which only civil actions for refund under subtitle F apply. The Secretary may readjust covered entities' shares of the fee for any calendar year for which the statute of limitations remains open.

The fees are treated as nondeductible taxes under section 275 of the Code for U.S. income tax purposes.

Effective Date

The Committee Bill is effective for calendar years beginning after 2009. The fee is allocated based on the market share of gross receipts from medical device sales for calendar years beginning after December 31, 2008.

Sec. 6010. Imposition of Annual Fee on Health Insurance Providers.

Present Law

Present law provides special rules for determining the taxable income of insurance companies (subchapter L of the Code). Separate sets of rules apply to life insurance companies and to property and casualty insurance companies. Insurance companies are subject to Federal income tax at regular corporate income tax rates.

An insurance company that provides health insurance is subject to Federal income tax as either a life insurance company or as a property insurance company, depending on its mix of lines of business and on the resulting portion of its reserves that are treated as life insurance reserves. For Federal income tax purposes, an insurance company is treated as a life insurance company if the sum of its (1) life insurance reserves and (2) unearned premiums and unpaid losses on noncancellable life, accident or health contracts not included in life insurance reserves, comprise more than 50 percent of its total reserves.[100]

Some insurance providers may be exempt from Federal income tax under section 501(a) if specific requirements are satisfied. Section 501(c)(8), for example, describes certain fraternal beneficiary societies, orders, or associations operating under the lodge system or for the exclusive benefit of their members that provide for the payment of life, sick, accident, or other benefits to the members or their dependents. Section 501(c)(9) describes certain voluntary employees' beneficiary associations that provide for the payment of life, sick, accident, or other benefits to the members of the association or their dependents or designated beneficiaries. Section 501(c)(12)(A) describes certain benevolent life insurance associations of a purely local character. Section 501(c)(15) describes certain small non-life insurance companies with annual gross receipts of no more than $600,000 ($150,000 in the case of a mutual insurance company). Section 501(c)(26) describes certain membership organizations established to provide health insurance to certain high-risk individuals. Section 501(c)(27) describes certain organizations established to provide workmen's compensation insurance.

An excise tax applies to premiums paid to foreign insurers and reinsurers covering U.S. risks.[101] The excise tax is imposed on a gross basis at the rate of one percent on reinsurance and life insurance premiums, and at the rate of four percent on property and casualty insurance premiums. The excise tax does not apply to premiums that are effectively connected with the conduct of a U.S. trade or business or that are exempted from the excise tax under an applicable income tax treaty. The excise tax paid by one party cannot be credited if, for example, the risk is reinsured with a second party in a transaction that is also subject to the excise tax.

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[100] Sec. 816(a).
[101] Secs. 4371-4374.

IRS authority to assess and collect taxes is generally provided in subtitle F of the Code (secs. 6001-7874), relating to procedure and administration. That subtitle establishes the rules governing both how taxpayers are required to report information to the IRS and to pay their taxes, as well as their rights. It also establishes the duties and authority of the IRS to enforce the Federal tax law, and sets forth rules relating to judicial proceedings involving Federal tax.

Committee Bill

Under the Committee Bill, an annual fee applies to any covered entity engaged in the business of providing health insurance with respect to United States health risks. The fee applies for calendar years beginning after 2009. The aggregate annual fee for all covered entities is $6.7 billion. Under the Committee Bill, the aggregate fee is apportioned among the providers based on a ratio designed to reflect relative market share of U.S. health business.

The annual payment date for a calendar year is determined by the Secretary of the Treasury, but in no event may be later than September 30 of that year.

For each covered entity, the fee for a calendar year is an amount that bears the same ratio to $6.7 billion as (1) the covered entity's net premiums written during the preceding calendar year with respect to health insurance for any United States health risk, bears to (2) the aggregate net written premiums of all covered entities during such preceding calendar year with respect to such health insurance.

The Committee requires the Secretary of the Treasury to calculate the amount of each covered entity's fee for the calendar year, determining the covered entity's net written premiums with respect to health insurance for any United States health risk on the basis of reports submitted by the covered entity and through the use of any other source of information available to the Treasury Department. It is intended that the Treasury Department be able to rely on published aggregate annual statement data to the extent necessary, and may use annual statement data and filed annual statements that are publicly available to verify or supplement the reports submitted by covered entities. Net written premiums is intended to mean premiums written, including reinsurance premiums written, reduced by reinsurance ceded, and reduced by ceding commissions. Net written premiums do not include amounts arising under arrangements that are not treated as insurance (i.e., in the absence of sufficient risk shifting and risk distribution for the arrangement to constitute insurance).[102]

For this purpose, a covered entity is an entity that provides health insurance with respect to United States health risks. Thus for example, an insurance company subject to tax under part I or II of subchapter L, an organization exempt from tax under section 501(a), or a foreign insurer, that provides health insurance with respect to United States health risks, is a covered entity under the provision. Similarly, an insurer that provides health insurance with respect to United States health risks under Medicare Advantage, Medicare Part D, or Medicaid is a covered entity. A covered entity does not, however, include an employer to the extent that the employer self-insures the health risks of its employees, nor does it include any governmental entity. For

[102] See *Helvering v. Le Gierse*, 312 U.S. 531 (1941).

example, a manufacturer that enters into a self-insurance arrangement with respect to the health risks of its employees is not treated as a covered entity. As a further example, an insurer that sells health insurance and that also enters into a self-insurance arrangement with respect to the health risks of its own employees is treated as a covered entity with respect to its health insurance business, but is not treated as a covered entity to the extent of the self-insurance of its own employees' health risks.

For purposes of the provision, all persons treated as a single employer under section 52(a) or (b) or section 414(m) or (o) are treated as a single covered entity (or as a single employer, for purposes of the rule relating to employers that self-insure the health risks of employees), and otherwise applicable exclusion of foreign corporations under those rules is disregarded.

A United States heath risk means the health risk of an individual who is a U.S. citizen, is a U.S. resident within the meaning of section 7701(b)(1)(A) (whether or not located in the United States), or is located in the United States, with respect to the period that the individual is located there. In general, it is intended that risks in the following lines of business reported on the annual statement as prescribed by the National Association of Insurance Commissioners and as filed with the insurance commissioners of the States in which insurers are licensed to do business constitute health risks for this purpose: comprehensive (hospital and medical), Medicare supplemental, dental, vision, Federal Employees Health Benefit plan, title XVIII Medicare, title XIX Medicaid, and other health. However, it is intended that the risk of coverage of long term care does not constitute a health risk for purposes of the provision.

For purposes of procedure and administration under the rules of Subtitle F of the Code, the fee under this provision is treated as an excise tax with respect to which only civil actions for refund under Subtitle F apply. The Secretary of the Treasury may redetermine covered entities' shares of the fee for any calendar year for which the statute of limitations remains open.

For purposes of section 275 of the Code, relating to the nondeductibility of specified taxes, the fee is considered to be a nondeductible tax described in section 275(a)(6).

A reporting rule applies under the Committee Bill. A covered entity is required to report to the Secretary of the Treasury the amount of its net premiums written during any calendar year with respect to health insurance for any United States health risk.

The Committee Bill provides authority for the Secretary of the Treasury to publish guidance necessary to carry out the purposes of the Committee Bill.

Effective Date

The annual fee is required to be paid in each calendar year beginning after 2009. The provision applies to net premiums written after December 31, 2008, with respect to health insurance for any United States health risk.

Sec. 6011. Study and Report of Effect on Veterans Health Care.

Present Law

No provision.

Committee Bill

The Committee Bill requires the Secretary of Veterans Affairs to conduct a study on the effect (if any) of the fees assessed on manufacturers and importers of branded prescription drugs, manufacturers and importers of medical devices, and health insurance providers on (1) the cost of medical care provided to veterans and (2) veterans' access to branded prescription drugs and medical devices.

The Secretary of Veterans Affairs will report the results of the study to the Committee on Ways and Means of the House of Representatives and to the Committee on Finance of the Senate no later than December 31, 2012.

Effective Date

The Committee Bill is effective on the date of enactment.

Sec. 6012. Elimination of Deduction for Expenses Allocable to Medicare Part D Subsidy.

Present Law

In general. Sponsors[103] of qualified retiree prescription drug plans are eligible for subsidy payments from the Secretary of Health and Human Services ("HHS") with respect to a portion of each qualified covered retiree's gross covered prescription drug costs ("qualified retiree prescription drug plan subsidy").[104] A qualified retiree prescription drug plan is employment-based retiree health coverage[105] that has an actuarial value at least as great as the Medicare Part D standard plan for the risk pool and that meets certain other disclosure and recordkeeping requirements.[106] These qualified retiree prescription drug plan subsidies are excludable from the

103 The identity of the plan sponsor is determined in accordance with section 16(B) of ERISA, except that for cases where a plan is maintained jointly by one employer and an employee organization, and the employer is the primary source of financing, the employer is the plan sponsor.
104 Sec. 1860D-22 of the Social Security Act ("SSA"), 42 USC Sec. 1395w-132.
105 Employment-based retiree health coverage is health insurance coverage or other coverage of health care costs (whether provided by voluntary insurance coverage or pursuant to statutory or contractual obligation) for Medicare Part D eligible individuals (their spouses and dependents) under group health plans based on their status as retired participants in such plans. For purposes of the subsidy, group health plans generally include employee welfare benefit plans (as defined in section 607(1) of ERISA) that provide medical care (as defined in section 213(d)), Federal and State governmental plans, collectively bargained plans, and church plans.
106 In addition to meeting the actuarial value standard, the plan sponsor must also maintain and provide the Secretary of HHS access to records that meet the Secretary of HHS's requirements for purposes of audits and other oversight activities necessary to ensure the adequacy of prescription drug coverage and the accuracy of payments made to eligible individuals under the plan. In addition, the plan sponsor must disclose to the Secretary of HHS whether the plan meets the actuarial equivalence requirement and if it does not, must disclose to retirees the limitations of their ability to enroll in Medicare Part D and that non-creditable coverage enrollment is subject to penalties such as fees for late enrollment. 42 USC 1395w-132(a)(2).

plan sponsor's gross income for the purposes of regular income tax and alternative minimum tax (including the adjustment for adjusted current earnings).[107]

Subsidy amounts. For each qualifying covered retiree enrolled for a coverage year in a qualified retiree prescription drug plan, the qualified retiree prescription drug plan subsidy is equal to 28 percent of the portion of the allowable retiree costs paid by the plan sponsor on behalf of the retiree that exceed the cost threshold but do not exceed the cost limit. A "qualifying covered retiree" is an individual who is eligible for Medicare but not enrolled in either a Medicare Part D prescription drug plan ("PDP") or a Medicare Advantage-Prescription Drug ("MA-PD") plan, but who is covered under a qualified retiree prescription drug plan. Generally allowable retiree costs are with respect to prescription drug costs under a qualified retiree prescription drug plan, the part of the actual costs paid by the plan sponsor on behalf of a qualifying covered retiree under the plan.[108] Both the threshold and limit are indexed to the percentage increase in Medicare per capita prescription drug costs; the cost threshold was $250 in 2006 ($295 in 2009) and the cost limit was $5,000 in 2006 ($6,000 in 2009).[109]

Expenses relating to tax exempt income. In general, no deduction is allowed under any provision of the Code for any expense or amount which would otherwise be allowable as a deduction if such expense or amount is allocable to a class or classes of exempt income.[110] Thus, expenses or amount paid or incurred with respect to the subsidies excluded from income under section 139A would generally not be deductible. However, a provision under section 139A specifies that the exclusion of the qualified retiree prescription drug plan subsidy from income is not taken into account in determining whether any deduction is allowable with respect to covered retiree prescription drug expenses that are taken into account in determining the subsidy payment. Therefore, under present law, a taxpayer may claim a business deduction for covered retiree prescription drug expenses incurred notwithstanding that the taxpayer excludes from income qualified retiree prescription drug plan subsidies allocable to such expenses.

Committee Bill

The Committee Bill 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, under the provision, the amount otherwise allowable as a deduction for retiree prescription drug expenses is reduced by the amount of the excludable subsidy payments received.

Effective Date

The Committee Bill is effective for taxable years beginning after December 31, 2010.

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[107] Sec. 139A.

[108] For purposes of calculating allowable retiree costs, actual costs paid are net of discounts, chargebacks, and average percentage rebates, and exclude administrative costs.

[109] Patricia M. Davis, "Medicare Part D Prescription Drug Benefit," Congressional Research Service. June 1, 2009. The cost threshold is indexed in the same manner as the Medicare Part D annual deductible, while the cost limit is indexed in the same manner as the Medicare Part D annual out-of-pocket threshold.

[110] Sec. 265(a) and Treas. Reg. sec. 1.265-1(a).

Sec. 6013. Modify the Itemized Deduction for Medical Expenses.

Present Law

Regular income tax. For regular income tax purposes, individuals are allowed an itemized deduction for unreimbursed medical expenses, but only to the extent that such expenses exceed 7.5 percent of adjusted gross income ("AGI").[111]

This deduction is available both to insured and uninsured individuals; thus, for example, an individual with employer-provided health insurance (or certain other forms of tax-subsidized health benefits) may also claim the itemized deduction for the individual's medical expenses not covered by that insurance if the 7.5 percent AGI threshold is met. The medical deduction encompasses health insurance premiums to the extent they have not been excluded from taxable income through the employer exclusion or self-insured deduction or have otherwise not been reimbursed.

Alternative minimum tax. For purposes of the alternative minimum tax ("AMT"), medical expenses are deductible only to the extent that they exceed 10 percent of AGI.

Committee Bill

The Committee Bill increases the threshold for the deduction from 7.5 percent of AGI to ten percent of AGI for regular income tax purposes. However if either the taxpayer or the taxpayer's spouse is age 65 or older, the increased threshold does not apply and the threshold remains at 7.5 percent of AGI. The provision does not change the AMT treatment of the itemized deduction for medical expenses.

Effective Date

The Committee Bill is effective for taxable years beginning after December 31, 2012. The continuation of the current threshold of 7.5 percent of AGI that applies if the taxpayer or the taxpayer's spouse is age 65 or older applies to taxable years beginning after December 31, 2012 and ending before January 1, 2017.

Sec. 6014. Limitation on Deduction for Remuneration Paid by Health Insurance Providers.

Present Law

An employer generally may deduct reasonable compensation for personal services as an ordinary and necessary business expense. Section 162(m) provides explicit limitations on the deductibility of compensation expenses in the case of corporate employers.

Section 162(m)

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[111] Sec. 213.

In general. The otherwise allowable deduction for compensation paid or accrued with respect to a covered employee of a publicly held corporation[112] is limited to no more than $1 million per year.[113] The deduction limitation applies when the deduction would otherwise be taken. Thus, for example, in the case of compensation resulting from a transfer of property in connection with the performance of services, such compensation is taken into account in applying the deduction limitation for the year for which the compensation is deductible under section 83 (i.e., generally the year in which the employee's right to the property is no longer subject to a substantial risk of forfeiture).

Covered employees. Section 162(m) defines a covered employee as (1) the chief executive officer of the corporation (or an individual acting in such capacity) as of the close of the taxable year and (2) the four most highly compensated officers for the taxable year (other than the chief executive officer). Treasury regulations under section 162(m) provide that whether an employee is the chief executive officer or among the four most highly compensated officers should be determined pursuant to the executive compensation disclosure rules promulgated under the Securities Exchange Act of 1934 ("Exchange Act").

In 2006, the Securities and Exchange Commission amended certain rules relating to executive compensation, including which executive officers' compensation must be disclosed under the Exchange Act. Under the new rules, such officers consist of (1) the principal executive officer (or an individual acting in such capacity), (2) the principal financial officer (or an individual acting in such capacity), and (3) the three most highly compensated executive officers, other than the principal executive officer or financial officer. In response to the Securities and Exchange Commission's new disclosure rules, the Internal Revenue Service issued updated guidance on identifying which employees are covered by section 162(m).[114]

Remuneration subject to the limit. Unless specifically excluded, the deduction limitation applies to all remuneration for services, including cash and the cash value of all remuneration (including benefits) paid in a medium other than cash. If an individual is a covered employee for a taxable year, the deduction limitation applies to all compensation not explicitly excluded from the deduction limitation, regardless of whether the compensation is for services as a covered employee and regardless of when the compensation was earned. The $1 million cap is reduced by excess parachute payments (as defined in sec. 280G, discussed below) that are not deductible by the corporation.

Certain types of compensation are not subject to the deduction limit and are not taken into account in determining whether other compensation exceeds $1 million. The following types of compensation are not taken into account: (1) remuneration payable on a commission basis; (2) remuneration payable solely on account of the attainment of one or more performance goals if certain outside director and shareholder approval requirements are met ("performance-based compensation"); (3) payments to a tax-qualified retirement plan (including salary reduction

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[112] A corporation is treated as publicly held if it has a class of common equity securities that is required to be registered under section 12 of the Securities Exchange Act of 1934.

[113] Sec. 162(m). This deduction limitation applies for purposes of the regular income tax and the alternative minimum tax.

[114] Notice 2007-49, 2007-25 I.R.B. 1429.

contributions); (4) amounts that are excludable from the executive's gross income (such as employer-provided health benefits and miscellaneous fringe benefits[115]); and (5) any remuneration payable under a written binding contract which was in effect on February 17, 1993.

Remuneration does not include compensation for which a deduction is allowable after a covered employee ceases to be a covered employee. Thus, the deduction limitation often does not apply to deferred compensation that is otherwise subject to the deduction limitation (e.g., is not performance-based compensation) because the payment of compensation is deferred until after termination of employment.

Executive Compensation of Employers Participating in the Troubled Assets Relief Program

In general. Under section 162(m)(5), the deduction limit is reduced to $500,000 in the case of otherwise deductible compensation of a covered executive for any applicable taxable year of an applicable employer.

An applicable employer means any employer from which one or more troubled assets are acquired under the "troubled assets relief program" ("TARP") established by the Emergency Stabilization Act of 2008[116] ("EESA") if the aggregate amount of the assets so acquired for all taxable years (including assets acquired through a direct purchase by the Treasury Department, within the meaning of section 113(c) of Title I of EESA) exceeds $300,000,000. However, such term does not include any employer from which troubled assets are acquired by the Treasury Department solely through direct purchases (within the meaning of section 113(c) of Title I of EESA). For example, if a firm sells $250,000,000 in assets through an auction system managed by the Treasury Department, and $100,000,000 to the Treasury Department in direct purchases, then the firm is an applicable employer. Conversely, if all $350,000,000 in sales take the form of direct purchases, then the firm would not be an applicable employer.

Unlike section 162(m), an applicable employer under this provision is not limited to publicly held corporations (or even limited to corporations). For example, an applicable employer could be a partnership if the partnership is an employer from which a troubled asset is acquired. The aggregation rules of Code section 414(b) and (c) apply in determining whether an employer is an applicable employer. However, these rules are applied disregarding the rules for brother-sister controlled groups and combined groups in sections 1563(a)(2) and (3). Thus, this aggregation rule only applies to parent-subsidiary controlled groups. A similar controlled group rule applies for trades and businesses under common control.

The result of this aggregation rule is that all corporations in the same controlled group are treated as a single employer for purposes of identifying the covered executives of that employer and all compensation from all members of the controlled group are taken into account for purposes of applying the $500,000 deduction limit. Further, all sales of assets under the TARP from all members of the controlled group are considered in determining whether such sales exceed $300,000,000.

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[115] Sec. 132.
[116] Pub. L. No. 110-343.

An applicable taxable year with respect to an applicable employer means the first taxable year which includes any portion of the period during which the authorities for the TARP established under EESA are in effect (the "authorities period") if the aggregate amount of troubled assets acquired from the employer under that authority during the taxable year (when added to the aggregate amount so acquired for all preceding taxable years) exceeds $300,000,000, and includes any subsequent taxable year which includes any portion of the authorities period.

A special rule applies in the case of compensation that relates to services that a covered executive performs during an applicable taxable year but that is not deductible until a later year ("deferred deduction executive remuneration"), such as nonqualified deferred compensation. Under the special rule, the unused portion (if any) of the $500,000 limit for the applicable tax year is carried forward until the year in which the compensation is otherwise deductible, and the remaining unused limit is then applied to the compensation.

For example, assume a covered executive is paid $400,000 in cash salary by an applicable employer in 2008 (assuming 2008 is an applicable taxable year) and the covered executive earns $100,000 in nonqualified deferred compensation (along with the right to future earnings credits) payable in 2020. Assume further that the $100,000 has grown to $300,000 in 2020. The full $400,000 in cash salary is deductible under the $500,000 limit in 2008. In 2020, the applicable employer's deduction with respect to the $300,000 will be limited to $100,000 (the lesser of the $300,000 in deductible compensation before considering the special limitation, and $500,000 less $400,000, which represents the unused portion of the $500,000 limit from 2008).

Deferred deduction executive remuneration that is properly deductible in an applicable taxable year (before application of the limitation under the provision) but is attributable to services performed in a prior applicable taxable year is subject to the special rule described above and is not double-counted. For example, assume the same facts as above, except that the nonqualified deferred compensation is deferred until 2009 and that 2009 is an applicable taxable year. The employer's deduction for the nonqualified deferred compensation for 2009 would be limited to $100,000 (as in the example above). The limit that would apply under the provision for executive remuneration that is in a form other than deferred deduction executive remuneration and that is otherwise deductible for 2009 is $500,000. For example, if the covered executive is paid $500,000 in cash compensation for 2009, all $500,000 of that cash compensation would be deductible in 2009 under the provision.

Covered executive. The term covered executive means any individual who is the chief executive officer or the chief financial officer of an applicable employer, or an individual acting in that capacity, at any time during a portion of the taxable year that includes the authorities period. It also includes any employee who is one of the three highest compensated officers of the applicable employer for the applicable taxable year (other than the chief executive officer or the chief financial officer and only taking into account employees employed during any portion of the taxable year that includes the authorities period).[117]

[117] The determination of the three highest compensated officers is made on the basis of the shareholder disclosure rules for compensation under the Exchange Act, except to the extent that the shareholder disclosure rules are inconsistent with the provision. Such shareholder disclosure rules are applied without regard to whether those rules

Executive remuneration. The provision generally incorporates the present law definition of applicable employee remuneration. However, the present law exceptions for remuneration payable on commission and performance-based compensation do not apply for purposes of the $500,000 limit. In addition, the $500,000 limit only applies to executive remuneration which is attributable to services performed by a covered executive during an applicable taxable year. For example, assume the same facts as in the example above, except that the covered executive also receives in 2008 a payment of $300,000 in nonqualified deferred compensation that was attributable to services performed in 2006. Such payment is not treated as executive remuneration for purposes of the $500,000 limit.

Taxation of insurance companies. Present law provides special rules for determining the taxable income of insurance companies (subchapter L of the Code). Separate sets of rules apply to life insurance companies and to property and casualty insurance companies. Insurance companies are subject to Federal income tax at regular corporate income tax rates. An insurance company generally may deduct compensation paid in the course of its trade or business.

Committee Bill

Under the Committee Bill, no deduction is allowed for remuneration which is attributable to services performed by an applicable individual for a covered health insurance provider during an applicable taxable year to the extent that such remuneration exceeds $500,000. As under section 162(m)(5) for remuneration from TARP participants, the exceptions for performance based remuneration, commissions, or remuneration under existing binding contracts do not apply. This $500,000 deduction limitation applies without regard to whether such remuneration is paid during the taxable year or a subsequent taxable year. In applying this rule, rules similar to those in section 162(m)(5)(A)(ii) apply. Thus in the case of remuneration that relates to services that an applicable individual performs during a taxable year but that is not deductible until a later year, such as nonqualified deferred compensation, the unused portion (if any) of the $500,000 limit for the year is carried forward until the year in which the compensation is otherwise deductible, and the remaining unused limit is then applied to the compensation.

In determining whether the remuneration of an applicable individual for a year exceeds $500,000, all remuneration from all members of any controlled group of corporations (within the meaning of section 414(b)), other businesses under common control (within the meaning of section 414(c)), or affiliated service group (within the meaning of sections 414(m) and (o)) are aggregated.

Covered health insurance provider and applicable taxable year. An insurance provider is a covered health 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

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actually apply to the employer under the Exchange Act. If an employee is a covered executive with respect to an applicable employer for any applicable taxable year, the employee will be treated as a covered executive for all subsequent applicable taxable years (and will be treated as a covered executive for purposes of any subsequent taxable year for purposes of the special rule for deferred deduction executive remuneration).

minimum creditable coverage requirements in the bill ("covered health insurance provider"). A taxable year is an applicable taxable year for an insurance provider if an insurance provider is a covered insurance provider for any portion of the taxable year. Employers with self-insured plans are excluded from the definition of covered health insurance provider.

Applicable individual. Applicable individuals include all officers, employees, directors, and other workers or service providers (such as consultants) performing services for or on behalf of a covered health insurance provider. Thus, in contrast to the general rules under section 162(m) and the special rules executive compensation of employers participating in the TARP program, the limitation on the deductibility of remuneration from a covered health insurance provided is not limited to a small group of officers and covered executives but generally applies to remuneration of all employees and service providers. If an individual is an applicable individual with respect to a covered health insurance provider for any taxable year, the individual is treated as an applicable individual for all subsequent taxable years (and is treated as an applicable individual for purposes of any subsequent taxable year for purposes of the special rule for deferred remuneration).

Effective Date

The Committee Bill is effective for remuneration paid in taxable years beginning after 2012 with respect to services performed after 2009.

Sec. 6021. Provide Income Exclusion for Indian Tribe Health Benefits.

Present Law

Present law generally provides that gross income includes all income from whatever source derived.[118] Exclusions from income are provided, however, for certain health care benefits.

Exclusion from income for employer-provided health coverage. Employees generally may exclude from gross income the value of employer-provided health coverage under an accident or health plan.[119] In addition, any reimbursements under an accident or health plan for medical care expenses for employees, their spouses, and their dependents generally are excluded from gross income.[120] As with cash or other compensation, the amount paid by employers for employer-provided health coverage is a deductible business expense. Unlike other forms of compensation, however, if an employer contributes to a plan providing health coverage for employees, their spouses and dependents, the value of the coverage and all medical care benefits (including reimbursements) under the plan are excludable from the employees' income for income tax purposes.[121] The exclusion applies both to health coverage in the case in which an employer

[118] Sec. 61.
[119] Sec. 106.
[120] Sec. 105(b).
[121] Secs. 104, 105, 106, and 125. A similar rule excludes employer-provided health insurance coverage and reimbursements for medical expenses from the employees' wages for payroll tax purposes under sections 3121(a)(2) and 3306(a)(2). Health coverage provided to active members of the uniformed services, military retirees, and their dependents are excludable under section 134. That section provides an exclusion for "qualified military benefits," defined as benefits received by reason of status or service as a member of the uniformed services and which were

absorbs the cost of employees' medical expenses not covered by insurance (i.e., a self-insured plan) as well as in the case in which the employer purchases health insurance coverage for its employees. There is no limit on the amount of employer-provided health coverage that is excludable.

In addition, employees participating in a cafeteria plan may be able to pay the portion of premiums for health insurance coverage not otherwise paid for by their employers on a pre-tax basis through salary reduction.[122] Such salary reduction contributions are treated as employer contributions and thus also are excluded from gross income.

Employers may agree to reimburse medical expenses of their employees (and their spouses and dependents), not covered by a health insurance plan, through flexible spending arrangements which allow reimbursement not in excess of a specified dollar amount (either elected by an employee under a cafeteria plan or otherwise specified by the employer). Reimbursements under these arrangements are also excludible from gross income as employer-provided health coverage.

The general welfare exclusion. Under the general welfare exclusion doctrine, certain payments made to individuals have been excluded from gross income. The exclusion has been interpreted to cover payments by governmental units under legislatively provided social benefit programs for the promotion of the general welfare.[123]

The general welfare exclusion generally applies if the payments: (1) are made from a governmental fund, (2) are for the promotion of general welfare (on the basis of the need of the recipient), and (3) do not represent compensation for services.[124] A representative of the IRS has

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excludable from gross income on September 9, 1986, under any provision of law, regulation, or administrative practice then in effect.

[122] Sec. 125.

[123] See, e.g., Rev. Rul. 78-170, 1978-1 C.B. 24 (government payments to assist low-income persons with utility costs are not income); Rev. Rul. 76-395, 1976-2 C.B. 16, 17 (government grants to assist low-income city inhabitants to refurbish homes are not income); Rev. Rul. 76-144, 1976-1 C.B. 17 (government grants to persons eligible for relief under the Disaster Relief Act of 1974 are not income); Rev. Rul. 74-153, 1974-1 C.B. 20 (government payments to assist adoptive parents with support and maintenance of adoptive children are not income); Rev. Rul. 74-205, 1974-1 C.B. 20 (replacement housing payments received by individuals under the Housing and Urban Development Act of 1968 are not includible in gross income); Gen. Couns. Mem. 34506 (May 26, 1971) (Federal mortgage assistance payments excluded from income under general welfare exception); Rev. Rul. 57-102, 1957-1 C.B. 26 (government benefits paid to blind persons are not income). The courts have also acknowledged the existence of this doctrine. See, e.g., *Bailey v. Commissioner*, 88 T.C. 1293, 1299-1301 (1987) (new building façade paid for by urban renewal agency on taxpayer's property under facade grant program not considered payments under general welfare doctrine because awarded without regard to any need of the recipients); *Graff v. Commissioner*, 74 TC 743, 753-754 (1980) (court acknowledged that rental subsidies under Housing Act were excludable under general welfare doctrine but found that payments at issue made by HUD on taxpayer landlord's behalf were taxable income to him), *affd. per curiam* 673 F.2d 784 (5th Cir. 1982).

[124] See Rev. Rul. 98-19, 1998-1 C.B. 840 (excluding relocation payments made by local governments to those whose homes were damaged by floods). Recent guidance as to whether the need of the recipient (taken into account under the second requirement of the general welfare exclusion) must be based solely on financial means or whether the need can be based on a variety of other considerations including health, educational background, or employment status, has been mixed. Chief Couns. Adv. 200021036 (May 25, 2000) (excluding state adoption assistant payments made to individuals adopting special needs children without regard to financial means of parents; the children were considered to be the recipients); Priv. Ltr. Rul. 200632005 (April 13, 2006) (excluding payments made by Tribe to members based on multiple factors of need pursuant to housing assistance program); Chief Couns. Adv. 200648027

recently stated that the general welfare exclusion does not apply to persons with significant income or assets, and that any such extension would represent a departure from well-established administrative practice.[125] A representative of the IRS further stated that application of the general welfare exclusion to a tribal government providing coverage or benefits to tribal members is dependent upon the structure and administration of the particular program.[126]

Committee Bill

The Committee Bill establishes an exclusion from gross income the value of specified Indian tribe health benefits. The exclusion applies to the value of: (1) health services or benefits provided or purchased by the Indian Health Service ("IHS"), either directly or indirectly, through a grant to or a contract or compact with an Indian tribe or tribal organization or through programs of third parties funded by the IHS;[127] (2) medical care services (in the form of provided or purchased medical care services, accident or health insurance or an arrangement having the same effect, or amounts paid directly or indirectly, to reimburse the member for expenses incurred for medical care) provided by an Indian tribe or tribal organization to a member of an Indian tribe, including the member's spouse or dependents;[128] (3) accident or health plan coverage (or an arrangement having the same effect) provided by an Indian tribe or tribal organization for medical care to a member of an Indian tribe and the member's spouse or dependents; and (4) any other medical care provided by an Indian tribe that supplements, replaces, or substitutes for the programs and services provided by the Federal government to Indian tribes or Indians.

Under the Committee Bill, no inference is intended as to the tax treatment of health benefits or coverage prior to the effective date. Additionally, no inference is intended with respect to the tax treatment of other benefits provided by Indian tribes not covered by the provision.

Effective Date

(July 25, 2006) (excluding subsidy payments based on financial need of recipient made by state to certain participants in state health insurance program to reduce cost of health insurance premiums).

[125] Testimony of Sarah H. Ingram, Commissioner, Tax Exempt and Government Entities, Internal Revenue Service, before the Senate Committee on Indian Affairs, *Oversight Hearing to Examine the Federal Tax Treatment of Health Care Benefits Provided by Tribal Governments to Their Citizens*, September 17, 2009.

[126] *Ibid*.

[127] The term "Indian tribe" means any Indian tribe, band, nation, pueblo, or other organized group or community, including any Alaska Native village, or regional or village corporation, as defined by, or established pursuant to, the Alaska Native Claims Settlement Act (43 U.S.C. 1601 et. seq.), which is recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians. The term "tribal organization" has the same meaning in section 4(l) of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450b(1)).

[128] The terms "accident or health insurance" and "accident or health plan" have the same meaning in sections 104 and 106. The term "medical care" is the same as the definition under section 213. For purposes of the provision, dependents are determined under section 152, but without regard to subsections (b)(1), (b)(2), and (d)(1)(B). Section 152(b)(1) generally provides that if an individual is a dependent of another taxpayer during a taxable year such individual is treated as having no dependents for such taxable year. Section 152(b)(2) provides that a married individual filing a joint return with his or her spouse is not treated as a dependent of a taxpayer. Section 152(d)(1)(B) provides that a "qualifying relative" (i.e., a relative that qualifies as a dependent) does not include a person whose gross income for the calendar year in which the taxable year begins equals or exceeds the exempt amount (as defined under section 151).

The Committee Bill is effective for health benefits and coverage provided after the date of enactment.

Sec. 6022. Establishment of SIMPLE Cafeteria Plans for Small Businesses

Present Law

Definition of a cafeteria plan. If an employee receives a qualified benefit (as defined below) based on the employee's election between the qualified benefit and a taxable benefit under a cafeteria plan, the qualified benefit generally is not includable in gross income.[129] However, if a plan offering an employee an election between taxable benefits (including cash) and nontaxable qualified benefits does not meet the requirements for being a cafeteria plan, the election between taxable and nontaxable benefits results in gross income to the employee, regardless of what benefit is elected and when the election is made.[130] A cafeteria plan is a separate written plan under which all participants are employees, and participants are permitted to choose among at least one permitted taxable benefit (for example, current cash compensation) and at least one qualified benefit. Finally, a cafeteria plan must not provide for deferral of compensation, except as specifically permitted in sections 125(d)(2)(B), (C), or (D).

Qualified benefits. Qualified benefits under a cafeteria plan are generally employer-provided benefits that are not includable in gross income under an express provision of the Code. Examples of qualified benefits include employer-provided health insurance coverage, group term life insurance coverage not in excess of $50,000, and benefits under a dependent care assistance program. In order to be excludable, any qualified benefit elected under a cafeteria plan must independently satisfy any requirements under the Code section that provides the exclusion. However, some employer-provided benefits that are not includable in gross income under an express provision of the Code are explicitly not allowed in a cafeteria plan. These benefits are generally referred to as nonqualified benefits. Examples of nonqualified benefits include scholarships;[131] employer-provided meals and lodging;[132] educational assistance;[133] and fringe benefits.[134] A plan offering any nonqualified benefit is not a cafeteria plan.[135]

Flex-credits under a cafeteria plan. Employer "flex-credits" are non-elective employer contributions that an employer makes available for every employee eligible to participate in the cafeteria plan, to be used at the employee's election only for one or more qualified benefits (but not as cash or other taxable benefits).

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[129] Sec. 125(a).
[130] Proposed Treas. Reg. sec. 1.125-1(b).
[131] Sec. 117.
[132] Sec. 119.
[133] Sec.127.
[134] Sec. 132.
[135] Proposed Treas. Reg. sec. 1.125-1(q). Long-term care services, contributions to Archer Medical Savings Accounts, group term life insurance for an employee's spouse, child or dependent, and elective deferrals to section 403(b) plans are also nonqualified benefits.

Employer contributions through salary reduction. Employees electing a qualified benefit through salary reduction are electing to forego salary and instead to receive a benefit that is excludible from gross income because it is provided by employer contributions. Section 125 provides that the employee is treated as receiving the qualified benefit from the employer in lieu of the taxable benefit. For example, active employees participating in a cafeteria plan may be able to pay their share of premiums for employer-provided health insurance on a pre-tax basis through salary reduction.[136]

Nondiscrimination 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 nondiscrimination 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 are also rules to prevent the provision of disproportionate benefits to key employees (within the meaning of section 416(i)) through a cafeteria plan.[137] Although the basic purpose of each of the nondiscrimination rules is the same, the specific rules for satisfying the relevant nondiscrimination requirements, including the definition of highly compensated individual,[138] vary for cafeteria plans generally and for each qualified benefit. An employer maintaining a cafeteria plan in which any highly compensated individual participates must make sure that both the cafeteria plan and each qualified benefit satisfies the relevant nondiscrimination requirements, as a failure to satisfy the nondiscrimination rules generally results in a loss of the tax exclusion by the highly compensated individuals.

Committee Bill

Under the Committee Bill, an eligible small employer is provided with a safe harbor from the nondiscrimination requirements for cafeteria plans as well as from the nondiscrimination requirements for specified qualified benefits offered under a cafeteria plan, including group term life insurance, coverage under a self-insured group health plan, and benefits under a dependent care assistance program. Under the safe harbor, a cafeteria plan and the specified qualified benefits will be treated as meeting the nondiscrimination rules if the cafeteria plan satisfies minimum eligibility and participation requirements and minimum contribution requirements.

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[136] Sec. 125.

[137] A key employee generally is an employee who, at any time during the year is (1) a five-percent owner of the employer, or (2) a one-percent owner with compensation of more than $150,000 (not indexed for inflation), or (3) an officer with compensation more than $160,000 (for 2009). A special rule limits the number of officers treated as key employees. If the employer is a corporation, a five-percent owner is a person who owns more than five percent of the outstanding stock or stock possessing more than five percent of the total combined voting power of all stock. If the employer is not a corporation, a five-percent owner is a person who owns more than five percent of the capital or profits interest. A one-percent owner is determined by substituting one percent for five percent in the preceding definitions. For purposes of determining employee ownership in the employer, certain attribution rules apply.

[138] For cafeteria plan purposes, a "highly compensated individual" is (1) an officer, (2) a five-percent shareholder, (3) an individual who is highly compensated, or (4) the spouse or dependent of any of the preceding categories. A "highly compensated participant" is a participant who falls in any of those categories. "Highly compensated" is not defined for this purpose. Under section 105(h), a self-insured health plan must not discriminate in favor of a "highly compensated individual," defined as (1) one of the five highest paid officers, (2) a 10-percent shareholder, or (3) an individual among the highest paid 25 percent of all employees. Under section 129 for a dependent care assistance program, eligibility for benefits, and the benefits and contributions provided, generally must not discriminate in favor of highly compensated employees within the meaning of section 414(q).

Eligibility requirement. 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 (subject to the terms and conditions applicable to all participants). However, 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) have 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 that 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) (relating to nonresident aliens working outside the United States).

Minimum contribution requirement. The minimum contribution requirement 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 employee (within the meaning of section 414(q))[139] or is not a key employee (within the meaning of section 416(i)) 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 nonelective contributions. However, the contribution requirement is not satisfied if the matching contributions with respect to salary reduction contributions for any highly compensated or key employee are made at a greater rate than the matching contributions for any employee who is not a highly compensated or key employee.

Eligible employer. An eligible small employer under the Committee Report is, with respect to any year, an employer who employed an average of 100 or fewer employees on business days during either of the two preceding years. For purposes of the provision, 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.

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[139] Section 414(q) generally defines a highly compensated employee as an employee (1) who was a five-percent owner during the year or the preceding year, or (2) who had compensation of $110,000 (for 2009) or more for the preceding year. An employer may elect to limit the employees treated as highly compensated employees based upon their compensation in the preceding year to the highest paid 20 percent of employees in the preceding year. Five-percent owner is defined by cross-reference to the definition of key employee in section 416(i).

The determination of whether an employer is an eligible small employer is determined by applying the controlled group rules of sections 52(a) and (b) under which all members of the controlled group are treated as a single employer. In addition, the definition of employee includes leased employees within the meaning of sections 414(n) and (o). [140]

Effective Date

The Committee Report is effective for taxable years beginning after December 31, 2010.

Sec. 6023. Investment Credit for Qualifying Therapeutic Discovery Projects

Present Law

Present law provides for a research credit equal to 20 percent (14 percent in the case of the alternative simplified credit) of the amount by which the taxpayer's qualified research expenses for a taxable year exceed its base amount for that year.[141] Thus, the research credit is generally available with respect to incremental increases in qualified research.

A 20 percent research tax credit is also available with respect to the excess of (1) 100 percent of corporate cash expenses (including grants or contributions) paid for basic research conducted by universities (and certain nonprofit scientific research organizations) over (2) the sum of (a) the greater of two minimum basic research floors plus (b) an amount reflecting any decrease in nonresearch giving to universities by the corporation as compared to such giving during a fixed-base period, as adjusted for inflation. This separate credit computation is commonly referred to as the "university basic research credit."[142]

Finally, a research credit is available for a taxpayer's expenditures on research undertaken by an energy research consortium. This separate credit computation is commonly referred to as the "energy research credit." Unlike the other research credits, the energy research credit applies to all qualified expenditures, not just those in excess of a base amount.

The research credit, including the university basic research credit and the energy research credit, expires for amounts paid or incurred after December 31, 2009.[143]

Qualified research expenses eligible for the research tax credit consist of: (1) in-house expenses of the taxpayer for wages and supplies attributable to qualified research; (2) certain time-sharing

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[140] Section 52(b) provides that, for specified purposes, all employees of all corporations which are members of a controlled group of corporations are treated as employed by a single employer. However, section 52(b) provides certain modifications to the control group rules including substituting 50 percent ownership for 80 percent ownership as the measure of control. There is a similar rule in section 52(c) under which all employees of trades or businesses (whether or not incorporated) which are under common control are treated under regulations as employed by a single employer. Section 414(n) provides rules for specified purposes when leased employees are treated as employed by the service recipient and section 414(o) authorizes the Treasury to issue regulations to prevent avoidance of the requirements of section 414(n).

[141] Sec. 41.

[142] Sec. 41(e).

[143] Sec. 41(h).

costs for computer use in qualified research; and (3) 65 percent of amounts paid or incurred by the taxpayer to certain other persons for qualified research conducted on the taxpayer's behalf (so-called contract research expenses).[144] Notwithstanding the limitation for contract research expenses, qualified research expenses include 100 percent of amounts paid or incurred by the taxpayer to an eligible small business, university, or Federal laboratory for qualified energy research.

Present law also provides a 50 percent credit[145] for expenses related to human clinical testing of drugs for the treatment of certain rare diseases and conditions, generally those that afflict less than 200,000 persons in the United States. Qualifying expenses are those paid or incurred by the taxpayer after the date on which the drug is designated as a potential treatment for a rare disease or disorder by the Food and Drug Administration ("FDA") in accordance with section 526 of the Federal Food, Drug, and Cosmetic Act.

Present law does not provide a credit specifically designed to encourage investment in new therapies relating to diseases.

Committee Bill

In general. The Committee Bill establishes a 50 percent investment tax credit for qualified investments in qualifying therapeutic discovery projects. The provision allocates $1 billion during the 2-year period 2009 through 2010 for the program. The Secretary, in consultation with the Secretary of Health and Human Services, will award certifications for qualified investments. The credit is available only to companies having 250 or fewer employees.[146]

A "qualifying therapeutic discovery project" is a project which is designed to develop a product, process, or therapy to diagnose, treat, or prevent diseases and afflictions by (1) conducting pre-clinical activities, clinical trials, clinical studies, and research protocols, or (2) by developing technology or products designed to diagnose diseases and conditions, including molecular and companion drugs and diagnostics, or to further the delivery or administration of therapeutics.

The qualified investment for any taxable year is the aggregate amount of the costs paid or incurred in such taxable year for expenses necessary for and directly related to the conduct of a qualifying therapeutic discovery project. The qualified investment for any taxable year with respect to any qualifying therapeutic discovery project does not include any cost for—(1) remuneration for an employee described in section 162(m)(3), (2) interest expense, (3) facility

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[144] Under a special rule, 75 percent of amounts paid to a research consortium for qualified research are treated as qualified research expenses eligible for the research credit (rather than 65 percent under the general rule of section 41(b)(3) governing contract research expenses) if (1) such research consortium is a tax-exempt organization that is described in section 501(c)(3) (other than a private foundation) or section 501(c)(6) and is organized and operated primarily to conduct scientific research, and (2) such qualified research is conducted by the consortium on behalf of the taxpayer and one or more persons not related to the taxpayer. Sec. 41(b)(3)(C).

[145] Sec. 45C.

[146] The number of employees is determined taking into account all businesses of the taxpayer at the time it submits an application, and is determined taking into account the rules for determining a single employer under section 52(a) or (b) or section 414(m) or (o).

maintenance expenses, (4) a service cost identified under Treas. Reg. Sec. 1.263A-1(e)(4), or (5) any other expenditure as determined by the Secretary as appropriate to carry out the purposes of the provision. For example, the Secretary may exclude other similar expenditures not directly related to the qualifying therapeutic discovery project.[147]

Companies must apply to the Secretary to obtain certification for qualifying investments.[148] The Secretary, in determining qualifying projects, will consider only those projects that show reasonable potential to — (1) result in new therapies to treat areas of unmet medical need or to prevent, detect, or treat chronic or acute disease and conditions, (2) reduce long-term health care costs in the United States, or (3) significantly advance the goal of curing cancer within a 30-year period. Additionally, the Secretary will take into consideration which projects would have the greatest potential to — (1) create and sustain (directly or indirectly) high quality, high paying jobs in the United States, and (2) advance the United States' competitiveness in the fields of life, biological, and medical sciences.

Qualified therapeutic discovery project expenditures do not qualify for the research credit, orphan drug credit, or bonus depreciation.[149] If a credit is allowed for an expenditure related to property subject to depreciation, the basis of the property is reduced by the amount of the credit. Additionally, expenditures taken into account in determining the credit are nondeductible to the extent of the credit claimed that is attributable to such expenditures.

Election to receive loans in lieu of tax credit. Taxpayers may elect to receive credits that have been allocated to them in the form of Treasury loans equal to 50 percent of the qualifying investment. The Secretary is required to prescribe rules governing the administration of the loan program.[150]

Effective Date

The Committee Bill applies to expenditures paid or incurred after December 31, 2008, in taxable years beginning after December 31, 2008

BUDGET EFFECTS OF THE BILL

Information Relating to Unfunded Mandates

This information is provided in accordance with section 423 of the Unfunded Mandates Act of 1995 (P.L. 104-4).

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[147] As appropriate to carry out the purposes of this provision, it is intended that the Secretary exclude expenditures related to activities similar to those described in section 41(d)(4).

[148] The Secretary must take action to approve or deny an application within 30 days of the submission of such application.

[149] Any expenses for the taxable year that are qualified research expenses under section 41(b) are taken into account in determining base period research expenses for purposes of computing the research credit under section 41 for subsequent taxable years.

[150] It is intended that any guidance issued by the Secretary will provide for the issuance of 20-year senior notes with an interest rate equal to the long-term applicable Federal rate. The interest on the loans will be deductible by the borrower.

The Committee has determined that the bill contains ten private sector mandates: (i) 40 percent excise tax on health coverage in excess of $8,000/$21,000 indexed for inflation by CPI-U plus 1 percent and increased thresholds for over age 55 retirees or certain high-risk professions; (ii) Conform the definition of medical expenses for health flexible spending arrangements to the definition of the itemized deduction for medical expenses; (iii) Increase the penalty for nonqualified health savings account distributions to 20 percent; (iv) Limit health flexible spending arrangements in cafeteria plans to $2,500; (v) Corporate information reporting; (vi) Impose annual fee on manufacturers and importers of branded drugs; (vii) Impose annual fee on manufacturers and importers of certain medical devices; (viii) Impose annual fee on health insurance providers; (ix) Eliminate deduction for fee expenses allocable to Medicare Part D subsidy; and (x) Raise 7.5 percent AGI floor on medical expenses deduction to 10 percent.

The Committee has determined that the bill contains no intergovernmental mandate.

Tax Complexity Analysis

Section 4022(b) of the Internal Revenue Service Reform and Restructuring Act of 1998 (the "IRS Reform Act") requires the staff of the Joint Committee on Taxation (in consultation with the Internal Revenue Service and the Treasury Department) to provide a tax complexity analysis. The complexity analysis is required for all legislation reported by the Senate Committee on Finance, the House Committee on Ways and Means, or any committee of conference if the legislation includes a provision that directly or indirectly amends the Internal Revenue Code and has widespread applicability to individuals or small businesses. For each such provision identified by the staff of the Joint Committee on Taxation a summary description of the provision is provided along with an estimate of the number and type of affected taxpayers, and a discussion regarding the relevant complexity and administrative issues.

Following the analysis of the staff of the Joint Committee on Taxation are the comments of the IRS and Treasury regarding each of the provisions included in the complexity analysis.

1. **Modify the definition of qualified medical expenses**

Summary description of the provision. The Committee Bill generally changes the definition of "medical expense" for purposes of employer-provided health coverage such that the cost of over-the-counter medicines (other than doctor prescribed) may no longer be reimbursed through a health flexible spending arrangement ("Health FSA") or a health reimbursement arrangement ("HRA"). In addition, the cost of over-the-counter medicines (other than doctor prescribed) may no longer be reimbursed on a tax-free basis through a health savings account ("HSA") or Archer MSA.

Number of affected taxpayers. It is estimated that the Committee Bill will affect more than ten percent of individual tax returns.

Discussion. Many taxpayers currently use account balances in Health FSAs, HRAs, HSAs, and Archer MSAs to purchase over-the-counter medicine such as ibuprofen, acetaminophen, cold medicine, and suntan lotion with pre-tax dollars. Some taxpayers make these purchases at the end of the year, or the end of the grace period, to avoid forfeiting amounts in Health FSAs.

Taxpayers will no longer be able to use these amounts in these accounts for this purpose (except to the extent the over-the-counter medication is doctor prescribed). As a result, less money will be allocated to these accounts and more money will be allocated to taxable wages. This change will also increase the amount of compensation subject to payroll taxes.

It is anticipated that the IRS will be required to revise the instructions to several forms and to revise several publications to reflect the changes to present law made by the provision. In addition, guidance will need to be issued withdrawing at least one Revenue Ruling and guidance may need to be issued on substantiation rules for reimbursement arrangements.

2. Require information reporting on payments to corporations

Summary description of provision. Under the Committee Bill, information reporting is expanded in two ways. First, taxpayers are required to file an information return for all payments aggregating $600 or more in a calendar year to any single payee (except a tax-exempt corporation), notwithstanding any regulation promulgated prior to the date of enactment. Second, the payments to be reported include gross proceeds paid in consideration for property or services.

Number of affected taxpayers. It is estimated that the Committee Bill will affect more than ten percent of individual or small business tax returns.

Discussion. According to the GAO, only eight percent of approximately 50 million small businesses with less than $10 million in assets filed miscellaneous information return Form 1099-MISC.[151] If greater reporting from small businesses were available, the Committee believes that the IRS could more readily identify areas of underreported income of the payees. In general, the more payments to which information reporting and/or withholding applies, the greater the improvement in compliance.[152] Thus, requiring information reporting for all payments aggregating $600 or more in a calendar year to a corporation could enhance taxpayer compliance and IRS enforcement efforts.

The compliance benefits from the provision may be limited due to inconsistencies with the manner in which many corporations compute taxable income. For example, many corporations compute taxes on a fiscal year basis, whereas the provision requires calendar year reporting for payments to corporations. To the extent a corporate taxpayer computes income on a fiscal year basis, calendar year information reporting may not accurately reflect income received during the corporation's taxable year. Similarly, a significant number of corporations report income on an accrual basis, rather than a cash basis. For accrual basis taxpayers, the year in which the taxpayer receives a payment may not correspond to the year in which the taxpayer must include such payment in income.

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[151] Government Accountability Office, *IRS Could Do More to Promote Compliance by Third Parties with Miscellaneous Income Reporting Requirements*, GAO-09-238 (January 2009).

[152] See e.g., "Tax Year 2001 Individual Income Tax Underreporting Gap," <http://www.irs.gov/pub/irs-utl/tax_gap_update_070212.pdf> at 2, finding that information reporting is the primary differentiator in compliance rates. See also, Joseph Bankman, "Eight Truths About Collecting Taxes from the Cash Economy," 117 *Tax Notes* 506, 511 (2007).

Imposing additional information reporting requirements also will impose additional costs on businesses that should be weighed against the potential compliance benefits. The additional reporting requirements will increase the administrative burden on payers subject to the provision. The extent of this additional burden may depend on the extent to which taxpayers subject to the provision have procedures and systems in place to meet present-law information reporting requirements that can be adapted to comply with the provision. The widespread use of computer technology to process and store business information should minimize the burden associated with generating and transmitting the information necessary to comply with the provision, regardless of the extent to which the taxpayer is currently subject to information reporting.[153] Moreover, because payments to corporations are generally excepted from information reporting requirements under present law, payers are already required to determine whether a payee is a corporate or non-corporate taxpayer. To the extent the provision reduces the instances in which payers must determine the payee's status or the portion of the payment that represents income, the provision may simplify present-law reporting requirements.

The extent of the burdens imposed on small businesses may be ameliorated if the IRS issues expeditious guidance designed to identify and avoid double reporting of payments (for example, payments reportable under rules applicable to merchant credit cards) and to revise forms and instructions to avoid confusion about what payments are excepted from reporting.

3. Employer health insurance reporting

Summary description of the provision. Under the Committee Bill, an employer is required to disclose on each employee's annual Form W-2 the value of the employee's health insurance coverage sponsored by the employer. If an employee enrolls in employer-sponsored health insurance coverage under multiple plans, the employer must disclose the aggregate value of all such health coverage (excluding the value of a health flexible spending arrangement).

The employer calculates the value of employer-sponsored health insurance coverage using the rules for determining the employer-provided portion of the applicable premiums for COBRA continuation coverage, 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.

Number of affected taxpayers. It is estimated that the Committee Bill will affect more than ten percent of individual and small business tax returns.

Discussion. The Committee Bill creates an additional reporting requirement for employers who sponsor health insurance for employees. The reporting requirement obliges the provision of the value of each employee's employer-sponsored health insurance to both the insured individual and the IRS. It is anticipated that small businesses will have to perform additional analysis to comply with the new reporting requirement, including calculating the separate values of

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[153] See e.g., Government Accountability Office, *Costs and Uses of Third-Party Information Returns*, November 2007, GAO-08-266, available at <http://www/gao.gov/new.items/d08266.pdf>, wherein the GAO, based on its case studies, found the compliance costs associated with filing information returns to be "relatively low."

individual and family premiums. It is also anticipated that the IRS will have to amend the existing Form W-2 to capture the value of employer-sponsored health insurance, and to revise the instructions to the Form W-2 to reflect the change. Computer programming changes will be required to accommodate the amended Form W-2 that will be filed with the IRS by employers.

4. Modify definition of income qualifying for exchange subsidies

Summary description of the provision. The Committee Bill provides a refundable credit for eligible individuals and families who purchase health insurance through the state exchanges. The credit is payable in advance directly to the insurer, although individuals may elect to purchase health insurance out-of-pocket and apply to the Internal Revenue Service for a tax credit at the end of the taxable year, in which case the credit is payable to the individual.

The credit is available for individuals with modified gross incomes ("MGI") up to 300 percent of the Federal poverty level ("FPL"). MGI is defined as an individual's (or couple's) total income without regard to exclusions from gross income under sections 911 (regarding citizen or residents living abroad), 931 (regarding residents of specified possessions), and 933 (regarding residents of Puerto Rico), plus any tax-exempt interest received during the tax year, plus the MGI of dependents listed on the return. In addition, certain deductions from gross income that are allowed in determining adjusted gross income, such as the deduction for contributions to an individual retirement arrangement, are disregarded.

In all cases, income eligibility will be reconciled annually on the individual's Federal income tax return and individuals will be required to repay any excess tax credit received, subject to a "safe harbor" for filers whose current income is less than 300 percent of FPL. For these taxpayers, the "safe harbor" limits the amount of any excess tax credit received to $250 for single filers and $400 for joint filers and for those filing as a head of household.

The tax credits are available on a sliding scale basis from two to twelve percent of income beginning on July 1, 2013 for individuals and families between 134-300 percent of FLP and for individuals subject to a five-year waiting period under Medicaid or the Children's Health Insurance Program. These individuals are therefore eligible for a tax credit with respect to health insurance purchased during the final six months of 2013. Beginning in 2014, the credits are also available to individuals and families between 100-133 percent of FPL.

Number of affected taxpayers. It is estimated that the Committee Bill will affect more than ten percent of individual tax returns.

Discussion. To determine whether they are eligible for the credit, taxpayers will have to first ascertain what their MGI is. The calculation of MGI introduces some complexity for taxpayers. Taxpayers will have to calculate their MGI by adding certain items to income that ordinarily would be excluded and foregoing certain deductions that would ordinarily be allowed. In addition to their own information, taxpayers must obtain the income information of dependents listed on the return for purposes of calculating MGI. For determining both eligibility of the credit and whether the taxpayer is within the safe harbor with regard to excess tax credit received, taxpayers will need to ascertain whether their MGI is less than 300 percent of FPL, another item not found on the return and possibly not one with which taxpayers are familiar.

It is anticipated that the IRS will have to amend existing forms and develop new forms to accommodate the refundable tax credit. The IRS will have to develop new procedures for compiling information relating to taxpayers' eligibility for the credit, including computing individual and household MGI. Although the credit is generally payable in advance directly to the insurer, the IRS will have to develop, and taxpayers will have to familiarize themselves with, procedures allowing individuals who elect to purchase health insurance out-of-pocket to apply to the IRS for the credit at the end of the taxable year. The IRS also will have to administer the end-of-year reconciliation of income eligibility on individual's Federal income tax returns and the repayment of the credit amount by individuals who received any excess tax credit subject to the "safe harbor" for filers whose current income is less than 300 percent of FPL.

The IRS will be required to provide information verifying the eligibility of individuals for the refundable tax credit. As a result, the IRS will have to develop new procedures and reprogram its computers to facilitate this information sharing, and expend resources for proper oversight to ensure the security of the private taxpayer information disclosed.

The IRS will be required to prescribe regulations to carry out the provision, including regulations which provide for (1) the coordination of the credit with the program for advance payment of the credit under section 2248 of the Social Security Act, (2) requirements for information required to be included on a return of tax with respect to the MGI of individuals other than the taxpayer, and (3) procedures for situations when the filing status of the taxpayer for a taxable year is different from such status used for determining the advance payment of the credit.

5. Employer responsibility

Summary description of the provision. Under the Committee Bill, as under Present Law, an employer is not required to offer health insurance coverage. However, any employer with more than 50 employees that does not offer coverage for all its full-time employees, does not provide coverage that is affordable, or does not provide coverage with an actuarial value of at least 65 percent, is required to pay a penalty. The penalty is an excise tax that is imposed for each employee who receives a premium tax credit for health insurance purchased through a state exchange. The number of employees is determined based on the number of full-time employees during the most recent year using the definition of employee that applies for purposes of determining if an employer is eligible for the small employer exception from COBRA continuation coverage. Coverage is not affordable if the premium required to be paid by the employee (including any required salary reduction contributions) is more than 10 percent or more of the employee's household MGI. This income limit is indexed to the per capita growth in premiums for the insured market as determined by the Secretary of Health and Human Services.

The penalty paid by an employer would be equal to the lesser of (1) a flat dollar amount multiplied by the number of full-time employees (defined as working 30 hours or more each week) enrolled in a state exchange and receiving a tax credit or (2) an amount equal to $400 multiplied by the number of full-time employees (regardless of how many employees receive the state exchange credit). The flat dollar amount is equal to the national average tax credit, as set by the Secretary of Health and Human Services and published in a schedule each year.

The penalties assessed under this provision are not deductible under section 162 as a business expense.

Number of affected taxpayers. It is estimated that the Committee Bill will affect more than 10 percent of business tax returns.

Discussion. Any employer with more than 50 employees will only be liable for a penalty if one or more full-time employees receives a tax credit for health insurance purchased through a state exchange. Therefore, the IRS must determine whether any employer with more than 50 employees has any employee that has received a low income tax credit and must then inform the employer of the resultant liability. While some employers will realize they are liable for the penalty, other employers may be liable without being aware of the liability because they both offer health insurance coverage and make a substantial contribution toward the coverage. Employees offered health insurance by an employer may be eligible for tax credits if the employer insurance exceeds ten percent of the total household income of the employee. The IRS must match an employee receiving a tax credit to any employer for which the employee works more than 30 hours per week. This will result in an increase in filings and collections for the IRS. In addition, because employers offering health insurance may be liable for the tax due to the incomes of some employees' households, appeals are expected as well.

COMPLEXITY ANALYSIS

1. Employer health insurance reporting

The Committee Bill requires an employer 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 an employee receives health insurance coverage under multiple employer-provided plans, the employer would disclose the aggregate value of all such health coverage (excluding the value of a health flexible spending arrangement).

The employer calculates the value of employer-provided health insurance coverage using the rules for determining the employer-provided portion of the applicable premiums for COBRA continuation coverage, 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.

IRS and Treasury Comments:

- For calendar years beginning after 2009, Forms W-2, W-2C, W-3, W-3C, W-2AS, W-2GU, W-2VI, and W-3SS would need to be revised by adding a new box, changing an existing box, and/or revising codes to report the value of the health insurance coverage provided by the employer to the employee.
- IRS would need to make computer programming changes to its existing tax systems to accept this additional data.

2. Modify the definition of qualified medical expenses

The proposal generally changes the definition of "medical expense" for purposes of employer-provided health coverage such that the cost of over-the-counter medicines (other than doctor prescribed) may no longer be reimbursed through a health flexible spending arrangement or a health reimbursement arrangement. In addition, the cost of over-the counter medicines (other than doctor prescribed) may no longer be reimbursed on a tax-free basis through a health savings account or Archer MSA.

IRS and Treasury Comments:

- Guidance would need to be issued on employer-provided reimbursements for over the counter medicine, including withdrawing Rev. Rul. 2003-102, and additional guidance may need to be issued on substantiation rules for reimbursement arrangements, including FSA debit cards.
- For tax years beginning after 2009, the instructions for Forms 8853 and 8889 and Publications 969 and 15-B would be revised to reflect the change in the law.
- These changes will not require programming.
- The same records as under Present Law would need to be maintained (but fewer items would be eligible for reimbursement).
- Issues may arise between IRS and taxpayers regarding the scope of the provision.

3. Information reporting for payments to corporations

Under the proposal, information reporting is expanded in two ways. First, taxpayers engaged in a trade or business are required to file an information return for all payments (including all purchases of property and services) aggregating $600 or more in a calendar year to any single payee (except a tax-exempt corporation), notwithstanding any regulation promulgated prior to the date of enactment. Second, the payment to be reported includes gross proceeds paid in consideration for property or services.

IRS and Treasury Comments:

- Guidance would be required to prevent double reporting of payments (i.e. coordinating this provision with merchant credit card reporting, three percent withholding on certain government payments to contractors).
- For calendar years beginning after 2011, the general instructions for Forms 1099, 1098, 3921, 3922, 5498, and W-2G and the instructions for certain other information returns and publications would need to be revised to reflect the elimination of the exception for payments to corporations and the exception for payments other than for services.
- IRS would need to modify existing tax systems to reflect this provision.

4. Definition of income qualifying for exchange subsidies

The proposal provides a refundable tax credit for eligible individuals and families who purchase health insurance through the state exchanges. The credit is payable in advance directly to the insurer.

The tax credit is available for individuals (single or joint filers) with modified gross incomes ("MGI") up to 300 percent of the Federal poverty level ("FPL"). MGI is defined as an individual's (or couple's) total income without regard to sections 911 (regarding the exclusion from gross income for citizens or residents living abroad), 931 (regarding the exclusion for residents of specified possessions), and 933 (regarding the exclusion for residents of Puerto Rico), plus any tax-exempt interest received during the tax year, plus the MGI of dependents listed on the return. In addition, certain deductions from gross income that are allowed in determining adjusted gross income, such as the deduction for contributions to an individual retirement arrangement, are disregarded.

In all cases, income eligibility will be reconciled annually on the individual's Federal income tax return and individuals will be required to repay any excess tax credit received, subject to a "safe harbor" for filers whose current income is less than 300 percent of FPL. For those taxpayers, the "safe harbor" limits the amount of any excess tax credit received to $250 for single filers and $400 for joint filers (and for those filing as a head of household).

The tax credits are available on a sliding scale basis from two to twelve percent of income beginning on July 1, 2013 for individuals and families between 134-300 percent of FLP and for individuals subject to a five-year waiting period under Medicaid or the Children's Health Insurance Program. These individuals are therefore eligible for a tax credit with respect to health insurance purchased during the final six months of 2013. Beginning in 2014, the credits are also available to individuals and families between 100-133 percent of FPL.

IRS and Treasury Comments:

- For tax years that include July 1, 2013, a new form would need to be developed to reconcile the premium credits paid by Treasury or through the taxpayer's employer to the taxpayer's insurance plan and the amount of credit to which the taxpayer is entitled for the year.
- Recapture of any credit paid in excess of the amount to which the taxpayer is entitled would be accomplished through Form 1040, 1040A, or 1040EZ, subject to the caps included in the Chairman's Mark. An additional line or write-in entry would be added on these forms to report the recaptured credit.
- Any credit paid that is less than the amount to which the taxpayer is entitled would be allowed as a refundable credit on Form 1040, 1040A, or 1040EZ. An additional line or box would be added on these forms to report the refundable credit.
- The Modified Gross Income ("MGI") definition in the Chairman's Mark is novel in that it includes the income of dependents included on the tax return. While a number of families have consistent dependent relationships, as reported on their tax returns, it is common for other dependent relationships to change year to year. For example, it is not uncommon for divorced parents to alternate years claiming children as dependents. Guidance may need to be issued to address the application of the MGI definition.
- The IRS would also anticipate questions from taxpayers as to whether it would now be required that dependents be listed on the tax return (which is not currently a requirement).

- The Chairman's Mark includes the concept of regional variations in the amount of the premium credit (insofar as the amount of an individual's premium credit is tied to the local benchmark premium). The IRS would need to develop forms and instructions to ensure that taxpayers are reconciling against the proper credit amount based on the premium in their geographic location.
- The IRS would need to work with the Department of Health & Human services to develop procedures for taxpayers who move between regions within a given tax year, if the amount of the premium subsidy varies across those regions.
- The IRS would need to work with the Department of Health & Human Services (HHS) to develop procedures for accepting alternative income documentation where individuals and families have not filed a tax return in the previous year.
- If the new legislation requires any individuals who are currently non-filers to file a tax return for the purposes of reconciliation, the IRS would need to develop or amend forms and instructions, answer questions, and partner with other relevant agencies to reach out to those individuals and inform them of the filing requirement.
- Issues could arise between the IRS and taxpayers relating to the reconciliation of the credit, including which dependents' income should count toward premium credit eligibility, how regional movements may affect the size of the credit, and other administrative provisions that affect the calculation of the credit.
- IRS would need to develop a number of new systems, build new interfaces with exchanges and insurance providers, and modify existing tax systems to reflect this provision.

5. Employer responsibility

Under the proposal, as under Present Law, an employer is not required to offer health insurance coverage. However, any employer with more than 50 employees that does not offer health insurance coverage or that offers health coverage that is not affordable for all its full-time employees is required to pay a fee to the Internal Revenue Service for each employee who receives a premium tax credit for health insurance purchased through a state exchange. Coverage is not affordable if the premium required to be paid by the employee (including any required salary reduction contributions) is ten percent or more of the employee's income. This income limit is indexed to the per capita growth in premiums for the insured market as determined by the Secretary of Health and Human Services.

The fee paid by an employer would be equal to the lesser of (1) a flat dollar amount multiplied by the number of full-time employees (defined as working 30 hours or more each week) enrolled in a state exchange and receiving a tax credit or (2) an amount equal to $400 multiplied by the number of full-time employees (regardless of how many employees receive the state exchange credit). The flat dollar amount is equal to the national average tax credit, as set by the Secretary of Health and Human Services and published in a schedule each year.

The fees assessed under this provision are not deductible under section 162 as a business expense.

IRS and Treasury Comments:

- For tax years that include July 1, 2013, a new form would need to be developed for employers to report and pay the fee for employees who receive a tax credit through a state exchange.
- IRS would need to advise businesses on how to record and report how many employees are receiving subsidized health care through the exchange (presumably this would be determined via payroll deductions or through the presence of an affordability waiver).
- The Chairman's Mark does not make entirely clear what information may be available to the employer showing which employees are receiving the subsidy. Should it be left to the employer's due diligence, the IRS would expect to issue guidance clarifying what constitutes sufficient due diligence.
- IRS would need to issue implementing guidance to make clear which employees are covered, whether employers are subject to the fees, and the amount of the fee.
- IRS would need to develop new systems and modify existing systems to reflect this provision.

IV. VOTES OF THE COMMITTEE

In compliance with paragraph 7(b) of rule XXVI of the standing rules of the Senate, the Committee states that, with a majority and quorum present, the "America's Healthy Future Act of 2009" was amended and ordered favorably reported as follows:

The Committee on Finance met on Tuesday, September 22, 2009 to consider an original bill entitled, "Americas Healthy Future Act of 2009."

The Chairman's Mark was modified and amended as follows:

Amendment 345, Hatch C4
Make personal responsibility requirement a state option.
This amendment was accepted in the Modification. Hatch C4 and Kyl C6 were struck from the modification.

Amendment 15, Conrad D3
Centers for Medicare and Medicaid Services Innovation Center
Accepted by unanimous consent

Amendment 29, Kerry/Stabenow D2
Easing the Impact of Home Health Cuts
Amendment Withdrawn

The Committee on Finance met on Wednesday, September 23, 2009 to resume consideration of an original bill entitled, "Americas Healthy Future Act of 2009, and considered the following amendments:

Amendment 397 – Bunning/Hatch/Cornyn - C4, as modified
Transparency Amendment
Failed by roll call vote, 11 ayes, 12 nays
Ayes: Lincoln, Grassley, Hatch, Snowe, Kyl, Bunning, Crapo, Roberts, Ensign, Enzi, Cornyn
Nays: Baucus, Rockefeller, Conrad, Bingaman (proxy), Kerry (proxy), Wyden, Schumer (proxy), Stabenow, Cantwell, Nelson, Menendez (proxy), Carper

Baucus Side-by-Side to Amendment 397, Bunning/Cornyn - C4
Transparency Amendment
Approved by roll call vote, 13 ayes, 10 nays
Ayes: Baucus, Rockefeller, Conrad, Bingaman (proxy), Kerry (proxy), Lincoln, Wyden, Schumer (proxy), Stabenow, Cantwell, Nelson, Menendez (proxy), Carper
Nays: Grassley, Hatch, Snowe, Kyl, Bunning, Crapo, Roberts, Ensign, Enzi, Cornyn,

Amendment 124, Kyl D1, as modified
Protecting Seniors access to Medicare Benefits and Health Care Providers
Chairman ruled the amendment non-germane. Senator Kyl moved to appeal the ruling of the Chair. The ruling of the Chair was sustained by roll call vote: 8 ayes, 8 nays
Ayes: Grassley, Snowe, Kyl, Bunning, Roberts, Ensign, Enzi, Cornyn

Nays: Baucus, Rockefeller, Bingaman, Lincoln, Wyden, Stabenow, Cantwell, Carper

Amendment 145, Roberts D9, as modified
To prevent health care reform from being paid for on the backs of seniors
Chairman ruled the amendment non-germane. Senator Roberts moved to appeal the ruling of the Chair. The ruling of the Chair was sustained by roll call vote: 10 Ayes, 11 Nays.
Ayes: Grassley, Hatch, Snowe, Kyl, Bunning, Crapo, Roberts, Ensign, Enzi, Cornyn
Nays: Baucus, Rockefeller, Conrad, Bingaman, Lincoln, Wyden, Stabenow, Cantwell, Nelson, Menendez, Carper

Amendment 117, Hatch/Grassley/Crapo/Cornyn D7
Medicare Advantage Restoration Act, as modified.
Failed by roll call vote: 9 ayes, 14 nays
Ayes: Grassley (proxy), Hatch, Kyl, Bunning, Crapo, Roberts (proxy), Ensign, Enzi, Cornyn
Nays: Baucus, Rockefeller, Conrad, Bingaman (proxy), Kerry (proxy), Lincoln (proxy), Wyden, Schumer (proxy), Stabenow, Cantwell, Nelson, Menendez (proxy), Carper (proxy), Snowe

Baucus Side-by-Side to Hatch 117
Medicare Advantage Restoration Act
Approved by roll call vote, 14 ayes, 9 nays
Ayes: Baucus, Rockefeller, Conrad, Bingaman (proxy), Kerry (proxy), Lincoln (proxy), Wyden, Schumer (proxy), Stabenow, Cantwell, Nelson, Menendez (proxy), Carper (proxy), Snowe
Nays: Grassley (proxy), Hatch, Kyl, Bunning, Crapo, Roberts (proxy), Ensign, Enzi, Cornyn

Amendment 129, Kyl/Enzi/Roberts/Crapo/Bunning/Cornyn/Hatch/
Ensign D6
First Amendment Rights of Health Plans
Failed by roll call vote, 10 ayes, 13 nays
Ayes: Grassley, Hatch, Snowe, Kyl, Bunning, Crapo, Roberts, Ensign, Enzi, Cornyn
Nays: Baucus, Rockefeller, Conrad (proxy), Bingaman, Kerry (proxy), Lincoln (proxy), Wyden (proxy), Schumer, Stabenow, Cantwell, Nelson (proxy), Menendez, Carper (proxy)

Amendment 99, Menendez D2, as modified
Proposed amendment requiring the Secretary of Health and Human Services to Conduct a Study Regarding Urban Medicare Dependent Hospitals
Accepted by Unanimous Consent

Amendment 151, Ensign D6, as modified
Medicare Savings Should Be Kept within Medicare, Approved by roll call vote, 22 Ayes, 1 pass
Ayes: Baucus, Rockefeller, Conrad, Bingaman (proxy), Lincoln (proxy), Wyden, Schumer (proxy), Stabenow, Cantwell, Nelson, Menendez (proxy), Carper (proxy), Grassley, Hatch, Snowe, Kyl, Bunning, Crapo, Roberts, Ensign, Enzi, Cornyn
Pass: Kerry

Amendment 165, Cornyn D6, as modified
Ensuring Spending Accountability

Failed by roll call vote, 8 ayes, 14 nays
Ayes: Grassley, Hatch (proxy), Kyl, Bunning, Crapo, Roberts (proxy), Enzi, Cornyn
Nays: Baucus, Rockefeller, Conrad, Bingaman (proxy), Kerry (proxy), Lincoln (proxy), Wyden, Schumer (proxy), Stabenow, Cantwell, Nelson (proxy), Menendez (proxy), Carper, Snowe

Amendment 130, Kyl D7
Partial Strike of Medicare Commission
Chairman ruled the amendment non-germane. Senator Kyl moved to appeal the ruling of the Chair. The ruling of the Chair was sustained by roll call vote, 6 ayes, 8 nays
Ayes: Grassley, Hatch, Snowe, Kyl, Bunning, Crapo
Nays: Baucus, Rockefeller, Conrad, Bingaman, Wyden, Schumer, Cantwell, Carper

Amendment 110, Grassley D4
Remove government officials from Patient Covered Outcomes Research Institute
Accepted without objection

Amendment 84, Stabenow D19
Nursing Home Abuse
Accepted without objection

Amendment 148, Ensign D3, as modified
Medical Care Access Protection Act
Ruled not germane

Amendment 39, Lincoln D7
Home Infusion
Amendment withdrawn

Amendment 149, Ensign D4
Increased Federal Medical Assistance Percentages for Medical Liability Reform
Chairman ruled the amendment non-germane. Senator Ensign moved to appeal the ruling of the Chair. The ruling of the Chair was sustained by roll call vote, 6 ayes, 10 nays.
Ayes: Grassley, Snowe, Kyl, Bunning, Ensign, Cornyn
Nays: Baucus, Rockefeller, Conrad, Bingaman, Lincoln, Wyden, Schumer, Stabenow, Nelson, Menendez

Amendment 172, Cornyn D13, as modified
Limiting Non-Economic Damages in Medical Liability Lawsuits
Chairman ruled the amendment non-germane. Senator Cornyn moved to appeal the ruling of the Chair. The ruling of the Chair was sustained by roll call vote, 6 ayes, 11 nays
Ayes: Grassley, Snowe, Kyl, Bunning, Ensign, Cornyn
Nays: Baucus, Rockefeller, Conrad, Bingaman, Lincoln, Wyden, Schumer, Stabenow, Nelson, Menendez, Carper

Amendment 392, Kyl C25
Limit non-economic damages

Chairman ruled the amendment non-germane. Senator Kyl moved to appeal the ruling of the Chair. The ruling of the Chair was sustained by roll call vote, 7 Ayes, 10 Nays
Ayes: Grassley, Hatch, Snowe, Kyl, Bunning, Ensign, Cornyn
Nays: Baucus, Rockefeller, Conrad, Bingaman, Wyden, Schumer, Stabenow, Nelson, Menendez, Carper

Amendment 104, Carper/Rockefeller D3, as modified
To extend the length of time states have to repay the federal share of a Medicaid overpayment.
Approved by unanimous voice vote

Amendment 334, Grassley C9
Improve access for children in Medicaid
Withdrawn

Amendment 61, Schumer/Enzi/Stabenow/Hatch/Kerry/ Menendez D1
Part B Drug Reimbursement for Biosimilars
Approved by unanimous voice vote

Amendment 219, Bingaman C7
Removes requirement that individuals must present affordability waivers to employers
Approved by voice vote

Amendment 274, Stabenow/Wyden/Kerry C2
Parity for Mental Health in Exchange
Approved by unanimous voice vote

Amendment 161, Cornyn D2
Ensuring Medicaid beneficiaries have access to a doctor
Failed by voice vote

Amendment 163, Cornyn D4
Zero percent update to Medicare Fee Schedule
Failed by voice vote

Amendment 164, Cornyn D5
Access to Medicare Data Claims
Withdrawn

Amendment 58, Wyden D15, as modified
Requiring the Medicare Payment Advisory Commission to consider Medicaid payments when making recommendations to Congress on Medicare Reimbursement for Skilled Nursing Facilities
Approved by unanimous voice vote

The Committee on Finance met on Thursday, September 24, 2009 to resume consideration of an original bill entitled, “Americas Healthy Future Act of 2009” and considered the following amendments:

Amendment 343, Hatch C2

Ensure Americans can keep coverage they have
Failed by roll call vote, 10 Ayes, 13 Nays
Ayes: Grassley, Hatch, Snowe, Kyl, Bunning, Crapo, Roberts, Ensign, Enzi, Cornyn
Nays: Baucus, Rockefeller, Conrad, Bingaman, Kerry (proxy), Lincoln, Wyden, Schumer (proxy), Stabenow, Cantwell, Nelson, Menendez, Carper (proxy)

Amendment 246, Lincoln C2
Modification of small business tax credit wage threshold
Withdrawn

Amendment 136, Crapo/Kyl/Roberts/Hatch D1, as modified
To preserve choice of plans for seniors under Medicare A Chairman ruled the amendment non-germane. Senator Crapo moved to appeal the ruling of the Chair. The ruling of the Chair was sustained by roll call vote, 9 ayes, 9 nays.
Ayes: Grassley, Hatch, Kyl, Bunning, Crapo, Roberts, Ensign, Enzi, Cornyn
Nays: Baucus, Rockefeller, Conrad, Lincoln, Schumer, Stabenow, Nelson, Menendez, Snowe

Amendment 430, Cornyn C1
Ensuring that nothing requires individual employees to change the coverage they have
Amendment failed by roll call vote, 10 ayes, 13 nays
Ayes: Grassley, Hatch (proxy), Snowe, Kyl, Bunning, Crapo, Roberts (proxy), Ensign, Enzi, Cornyn
Nays: Baucus, Rockefeller, Conrad, Bingaman, Kerry (proxy), Lincoln, Wyden, Schumer, Stabenow, Cantwell, Nelson (proxy), Menendez (proxy), Carper (proxy)

Amendment 88, Nelson/Rockefeller/Kerry/Stabenow/
Schumer - D1
Eliminate Part D Coverage Gap and require drug maker rebates for full-benefit dual eligible individuals
Failed by roll call vote, 10 ayes, 13 nays
Ayes: Rockefeller, Conrad (proxy), Bingaman, Kerry (proxy), Lincoln, Wyden, Schumer, Stabenow, Cantwell, Nelson
Nays: Baucus, Menendez, Carper, Grassley, Hatch, Snowe, Kyl (proxy), Bunning, Crapo, Roberts (proxy), Ensign, Enzi (proxy), Cornyn

Amendment 279, Stabenow/Lincoln C7, as modified
Allow stand-alone dental and vision plans to offer the required pediatric dental and vision services to be offered in the individual and small group markets including within the insurance exchanges
Accepted without objection

Amendment 436, Cornyn C7
Ensuring the accuracy of punitive taxes
Chairman ruled the amendment non-germane. Senator Kyl moved to appeal the ruling of the Chair. The ruling of the Chair was sustained by roll call vote, 8 ayes, 8 nays
Ayes: Grassley, Hatch, Snowe, Kyl, Bunning, Crapo, Ensign, Cornyn
Nays: Baucus, Rockefeller, Conrad, Bingaman, Stabenow, Nelson, Menendez, Carper,

Amendment 278, Stabenow C6

Ensure high quality, specialized care for children and youth with special medical, psychological, social and emotion needs who can accept and respond to the close relationship within a family setting, but whose special needs require more intensive or therapeutic services than are found in traditional foster care
Accepted without objection

Amendment 396, Bunning C3
Excise Tax Exemption
Failed by roll call vote, 9 Ayes, 14 Nays
Ayes: Grassley, Hatch (proxy), Kyl, Bunning, Crapo, Roberts (proxy), Ensign, Enzi (proxy), Cornyn
Nays: Rockefeller, Conrad (proxy), Bingaman (proxy), Kerry, Lincoln, Wyden, Schumer (proxy), Stabenow, Cantwell, Nelson, Menendez (proxy), Carper (proxy), Snowe

Amendment 10, Rockefeller D10, as modified
Amendment to the Medicare Commission Provision
Approved by roll call vote, 15 ayes, 3 nays, 5 pass
Ayes: Baucus, Rockefeller, Conrad (proxy), Bingaman, Kerry, Lincoln, Wyden, Schumer, Stabenow, Cantwell, Nelson, Menendez (proxy), Carper (proxy), Snowe, Ensign
Nays: Hatch, Bunning, Cornyn
Pass: Grassley, Kyl, Crapo, Roberts, Enzi

Amendment 334, Grassley C9, as modified
To improve access to care for children in Medicaid
Failed by roll call vote, 10 ayes, 13 nays
Ayes: Cantwell, Grassley, Hatch, Kyl (proxy), Bunning, Crapo (proxy), Roberts (proxy), Ensign (proxy), Enzi (proxy), Cornyn (proxy)
Nays: Baucus, Rockefeller, Conrad, Bingaman, Kerry, Lincoln, Wyden (proxy), Schumer, Stabenow, Nelson (proxy), Menendez (proxy), Carper, Snowe

Amendment 226, Kerry/Schumer C1
Replace Free Rider Provision with Employer Mandate
Withdrawn

Amendment 90, Nelson D3
Inspector General Report Comparing Prices
Accepted by unanimous consent

Amendment 297, Nelson/Kerry C1
Strike Interstate Sale of Insurance
Withdrawn

By unanimous consent, the Committee adopted the Chairman's amendment of the mark indicating that interstate compacts would need to be enacted by the relevant state legislatures.

Amendment 417, Enzi C3, as Modified
Ensure Americans are protected from dramatic cost increases.
Accepted by roll call vote, 21 ayes, 2 pass

Ayes: Baucus, Rockefeller, Conrad, Kerry, Wyden, Schumer, Stabenow, Cantwell, Nelson, Menendez (proxy), Carper (proxy), Grassley, Hatch, Snowe, Kyl, Bunning, Crapo, Roberts (proxy), Ensign, Enzi, Cornyn
Pass: Bingaman, Lincoln

Amendment 423, Enzi C9
To exempt any state that the States revenue have decline for 2 consecutive fiscal quarters from mandatory Medicaid expansions.
Failed by roll call vote, 10 ayes, 13 nays
Ayes: Grassley, Hatch, Snowe, Kyl, Bunning, Crapo, Roberts (proxy), Ensign, Enzi, Cornyn
Nays: Baucus, Rockefeller (proxy), Conrad, Bingaman (proxy), Kerry, Lincoln (proxy), Wyden (proxy), Schumer, Stabenow, Cantwell, Nelson (proxy), Menendez (proxy), Carper

Amendment 399, Crapo/Roberts C2, as modified
To prohibit unfunded federal mandates on states
Failed by roll call vote, 10 ayes, 13 nays
Ayes: Grassley, Hatch, Snowe, Kyl, Bunning, Crapo, Roberts (proxy), Ensign, Enzi, Cornyn
Nays: Baucus, Rockefeller, Conrad, Bingaman, Kerry, Lincoln, Wyden, Schumer, Stabenow, Cantwell, Nelson (proxy), Menendez (proxy), Carper

Amendment 267, Schumer/Menendez/Bingaman C8
Inclusion of Puerto Rico and the Territories in the Exchange
Withdrawn

Amendment 452, Cornyn C23, as modified
To promote transparency and accountability with taxpayer dollars
Withdrawn

Amendment 308, Menendez C9, as modified
Ensuring quality health care for those with autism and other behavior health conditions
Approved by voice vote

Amendment 413, Ensign C14, as modified
Protecting States from an Unfunded Mandate
Failed by roll call vote, 10 ayes, 13 nays
Ayes: Grassley, Hatch, Snowe, Kyl, Bunning, Crapo (proxy), Roberts (proxy), Ensign, Enzi, Cornyn
Nays: Baucus, Rockefeller, Conrad, Bingaman, Kerry, Lincoln, Wyden, Schumer, Stabenow, Cantwell, Nelson (proxy), Menendez, Carper

Amendment 420, Enzi C6
Provide additional choices to individuals who would otherwise be enrolled in Medicaid through expansions in the bill.
Failed by roll call vote, 10 ayes, 13 nays
Ayes: Wyden, Grassley, Hatch (proxy), Kyl, Bunning, Crapo, Roberts (proxy), Ensign, Enzi, Cornyn
Nays: Baucus, Rockefeller, Conrad, Bingaman, Kerry, Lincoln, Schumer, Stabenow, Cantwell, Nelson (proxy), Menendez, Carper (proxy), Snowe

Amendment 303, Menendez C4, as modified
Ensure and clarify that children qualify as exchange eligible individuals and that there shall be the option of a child-only health insurance option and subsidies in the exchanges
Approved by voice vote

Amendment 453, Cornyn C24
Promoting equality between low income Americans and their elected officials
Failed by roll call vote, 6 ayes, 16 nays, 1 pass
Ayes: Grassley, Hatch (proxy), Crapo, Roberts (proxy), Enzi, Cornyn
Nays: Baucus, Rockefeller, Conrad, Bingaman, Kerry (proxy), Lincoln, Wyden, Schumer, Stabenow, Cantwell, Nelson (proxy), Menendez, Carper (proxy), Snowe, Kyl, Bunning
Pass: Ensign (proxy)

The Committee on Finance met on Friday, September 25, 2009 to resume consideration of an original bill entitled, "Americas Healthy Future Act of 2009" and considered the following amendments:

Amendment 409, Ensign C10
Transparency in Czars
Failed by roll call vote, 10 ayes, 13 nays
Ayes: Grassley, Hatch (proxy), Snowe, Kyl, Bunning (proxy), Crapo (proxy), Roberts, Ensign, Enzi, Cornyn
Nays: Baucus, Rockefeller, Conrad, Bingaman, Kerry, Lincoln, Wyden, Schumer, Stabenow, Cantwell, Nelson, Menendez (proxy), Carper

Amendment 240, Kerry C15
Narrow the age rating band
Withdrawn

Amendment 452, Cornyn C23, as modified
To promote transparency and accountability with taxpayer dollars
Failed by roll call vote, 11 ayes, 12 nays
Ayes: Lincoln, Grassley (proxy), Hatch, Snowe, Kyl, Bunning (proxy), Crapo, Roberts, Ensign, Enzi, Cornyn
Nays: Baucus, Rockefeller (proxy), Conrad, Bingaman (proxy), Kerry, Wyden, Schumer, Stabenow, Cantwell, Nelson (proxy), Menendez, Carper

Amendment 283, Cantwell C2, as modified
Pharmacy Benefit Manager (PBM) Transparency for Health Plans Operating in Medicare Part D and the Health Insurance Exchanges
Agreed to by voice vote

Amendment 377, Kyl C10
Ensuring consumer choices of health plans
Failed by roll call vote, 9 ayes, 14 nays
Ayes: Grassley (proxy), Hatch (proxy), Kyl, Bunning (proxy), Crapo, Roberts, Ensign (proxy), Enzi, Cornyn (proxy)
Nays: Baucus, Rockefeller, Conrad, Bingaman, Kerry (proxy), Lincoln (proxy), Wyden, Schumer, Stabenow, Cantwell, Nelson (proxy), Menendez, Carper (Proxy), Snowe

The Committee on Finance met on Tuesday, September 29, 2009 to resume consideration of an original bill entitled, "Americas Healthy Future Act of 2009" and considered the following amendments:

Amendment 186, Rockefeller C6
Consumers Health Care Act, S. 1278, as modified
Failed by roll call vote, 8 ayes, 15 nays
Ayes: Rockefeller, Bingaman, Kerry, Wyden, Schumer, Stabenow, Cantwell, Menendez
Nays: Baucus, Conrad, Lincoln, Nelson, Carper, Grassley, Hatch (proxy), Snowe, Kyl, Bunning, Crapo, Roberts (proxy), Ensign (proxy), Enzi (proxy), Cornyn

Amendment 260, Schumer/Bingaman/Stabenow/ Menendez/Cantwell/Rockefeller C1, as modified
Level Playing Field Public Option
Failed by roll call vote, 10 ayes, 13 nays
Ayes: Rockefeller, Bingaman, Kerry (proxy), Wyden, Schumer, Stabenow, Cantwell, Nelson, Menendez, Carper (proxy)
Nays: Baucus, Conrad, Lincoln (proxy), Grassley, Hatch (proxy), Snowe, Kyl, Bunning, Crapo (proxy), Roberts, Ensign, Enzi (proxy), Cornyn

Amendment 140, Roberts D4, as modified
To protect patients and doctors
Failed by roll call vote, 9 ayes, 14 nays
Ayes: Grassley, Hatch (proxy), Kyl, Bunning, Crapo, Roberts, Ensign, Enzi (proxy), Cornyn
Nays: Baucus, Rockefeller (proxy), Conrad (proxy), Bingaman, Kerry (proxy), Lincoln (proxy), Wyden (proxy), Schumer (proxy), Stabenow, Cantwell, Nelson (proxy), Menendez (proxy), Carper (proxy), Snowe

Amendment 131, Kyl/Roberts/Crapo/Cornyn D8, as modified
The Patients Act
Failed by roll call vote, 10 ayes, 13 nays
Ayes: Grassley, Hatch (proxy), Snowe (proxy), Kyl, Bunning, Crapo, Roberts, Ensign (proxy), Enzi (proxy), Cornyn (proxy)
Nays: Baucus, Rockefeller, Conrad, Bingaman (proxy), Kerry (proxy), Lincoln (proxy), Wyden, Schumer (proxy), Stabenow, Cantwell, Nelson (proxy), Menendez (proxy), Carper (proxy)

Amendment 141, Roberts D5
To protect patients and doctors
Failed by roll call vote, 8 ayes, 14 nays, 1 pass
Ayes: Grassley, Hatch (proxy), Kyl (proxy), Bunning, Crapo, Roberts, Enzi (proxy), Cornyn (proxy)
Nays: Baucus, Rockefeller, Conrad, Bingaman (proxy), Kerry (proxy), Lincoln (proxy), Wyden, Schumer (proxy), Stabenow, Cantwell, Nelson (proxy), Menendez (proxy), Carper (proxy), Snowe (proxy)
Pass: Ensign

Amendment 108, as modified, Grassley/Hatch D2
Medicare Physician Payment Equity
Accepted by roll call vote, 23 ayes, 0 nays

Ayes: Baucus, Rockefeller, Conrad, Bingaman (proxy), Kerry (proxy), Lincoln (proxy), Wyden, Schumer (proxy), Stabenow, Cantwell, Nelson, Menendez (proxy), Carper (proxy), Grassley, Hatch (proxy), Snowe (proxy), Kyl (proxy), Bunning, Crapo, Roberts (proxy), Ensign (proxy), Enzi (proxy), Cornyn (proxy)

Amendment 280, Stabenow C8, as modified
To ensure all insurance plans confirm to the same consumer protections and market rules
Accepted without objection

Amendment 394, Bunning C1
Equal access to affordable healthcare
Failed by roll call vote, 9 ayes, 14 nays
Ayes: Grassley, Hatch (proxy), Kyl (proxy), Bunning, Crapo, Roberts (proxy), Ensign (proxy), Enzi (proxy), Cornyn (proxy)
Nays: Baucus, Rockefeller, Conrad (proxy), Bingaman (proxy), Kerry (proxy), Lincoln (proxy), Wyden, Schumer (proxy), Stabenow, Cantwell, Nelson, Menendez (proxy), Carper (proxy), Snowe (proxy)

Amendment 59, Wyden D16, as modified
Ensuring Quality Hospice Care
Withdrawn

Amendment 328, Grassley/Bunning C3, as modified
To require Member of Congress and all Congressional staff to purchase coverage through Exchanges
Accepted without objection

Amendment 398
Crapo/Roberts C1, as modified
To amend the employer shared responsibility requirement and protect small business
Failed by roll call vote, 10 ayes, 13 nays
Ayes: Grassley, Hatch, Snowe, Kyl, Bunning, Crapo, Roberts (proxy), Ensign, Enzi (proxy), Cornyn (proxy)
Nays: Baucus, Rockefeller, Conrad, Bingaman, Kerry (proxy), Lincoln, Wyden, Schumer (proxy), Stabenow, Cantwell, Nelson (proxy), Menendez (proxy), Carper

Amendment 404, Ensign C5, as modified
Health Account Balance Protection Act
Chairman ruled the amendment non-germane. Senator Ensign moved to appeal the ruling of the Chair. The ruling of the Chair was sustained by roll call vote: 7 ayes, 7 nays
Ayes: Grassley, Hatch, Snowe, Kyl, Bunning, Crapo, Ensign
Nays: Baucus, Rockefeller, Conrad, Bingaman, Lincoln, Cantwell, Menendez

Amendment 305, Menendez C6, as modified
Protecting consumers when they are in an emergency room
Accepted without objection

Amendment #41, Lincoln D9, as modified
Expand Centers for Medicare and Medicaid Services Innovation Center to consider testing direct access models of care under Medicare

Accepted without objection

Amendment 378, Kyl C11
Ensuring consumers' choice of insurance options that best meet their health needs
Failed by roll call vote, 9 ayes, 14 nays
Ayes: Grassley, Hatch, Kyl, Bunning, Crapo, Roberts (proxy), Ensign, Enzi (proxy), Cornyn (proxy)
Nays: Baucus, Rockefeller, Conrad, Bingaman, Kerry (proxy), Lincoln, Wyden, Schumer (proxy), Stabenow, Cantwell, Nelson (proxy), Menendez (proxy), Carper (proxy), Snowe

Amendment 329, Grassley C4
Providing consumers with the same health insurance options as Members of Congress
Failed by roll call vote, 11 ayes, 12 nays
Ayes: Carper, Grassley, Hatch, Snowe, Kyl, Bunning, Crapo, Roberts (proxy), Ensign, Enzi (proxy), Cornyn (proxy)
Nays: Baucus, Rockefeller (proxy), Conrad, Bingaman (proxy), Kerry (proxy), Lincoln, Wyden, Schumer (proxy), Stabenow, Cantwell, Nelson (proxy), Menendez (proxy)

Amendment 351, Hatch C10, as modified
Restoration of Funding for abstinence education, as modified
Accepted by roll call vote, 12 ayes, 11 nays
Ayes: Conrad, Lincoln, Grassley, Hatch, Snowe, Kyl, Bunning, Crapo (proxy), Roberts (proxy), Ensign, Enzi (proxy), Cornyn (proxy)
Nays: Baucus, Rockefeller (proxy), Bingaman (proxy), Kerry (proxy), Wyden (proxy), Schumer (proxy), Stabenow, Cantwell, Nelson (proxy), Menendez, Carper

Baucus Side-by-Side to Hatch 10
Pre-adulthood training
Accepted by roll call vote, 14 ayes, 9 nays
Ayes: Baucus, Rockefeller (proxy), Conrad, Bingaman (proxy), Kerry (proxy), Lincoln, Wyden (proxy), Schumer (proxy), Stabenow, Cantwell, Nelson (proxy), Menendez, Carper, Snowe
Nays: Grassley, Hatch, Kyl, Bunning, Crapo (proxy), Roberts (proxy), Ensign, Enzi (proxy), Cornyn (proxy)

Amendment 340, Grassley C15, as modified
Failed by roll call vote, 10 ayes, 13 nays
Promoting state flexibility and individual freedom
Ayes: Grassley, Hatch (proxy), Snowe, Kyl, Bunning, Crapo, Roberts (proxy), Ensign, Enzi (proxy), Cornyn (proxy)
Nays: Baucus, Rockefeller (proxy), Conrad, Bingaman (proxy), Kerry (proxy), Lincoln, Wyden, Schumer, Stabenow, Cantwell, Nelson (proxy), Menendez, Carper

Amendment 310, Menendez C11
To guarantee access to maternity care for young adults who are enrolled in Young Invincible Plans
Withdrawn

The Committee on Finance met on Wednesday, September 30, 2009 to consider an original bill entitled, "Americas Healthy Future Act of 2009" and considered the following amendments:

Amendment 469, Kerry, Rockefeller, Schumer, Stabenow, Cantwell, Menendez F1
The amendment would make various changes to the excise tax on high cost insurance. No change would be made to the transition relief.
Withdrawn

Amendment 355, Hatch C14
Prohibits authorized or appropriated Federal Funds under this mark from being used for elective abortions and plans that cover such abortions
Failed by roll call vote, 10 ayes, 13 nays
Ayes: Conrad (proxy), Grassley, Hatch, Kyl, Bunning, Crapo, Roberts, Ensign, Enzi, Cornyn
Nays: Baucus, Rockefeller, Bingaman, Kerry (proxy), Lincoln (proxy), Wyden, Schumer, Stabenow, Cantwell, Nelson, Menendez (proxy), Carper, Snowe

Amendment 354, Hatch C13
Non discrimination on abortion and respect for right of conscience
Failed by roll call vote, 10 ayes, 13 nays
Ayes: Conrad, Grassley, Hatch, Kyl, Bunning, Crapo, Roberts, Ensign, Enzi, Cornyn
Nays: Baucus, Rockefeller (proxy), Bingaman (proxy), Kerry (proxy), Lincoln (proxy), Wyden, Schumer (proxy), Stabenow, Cantwell, Nelson, Menendez (proxy), Carper (proxy), Snowe

Amendment 415, Enzi C1
Lowering the cost of health care increasing benefit flexibility
Failed by roll call vote, 11 ayes, 12 nays
Ayes: Conrad (proxy), Grassley, Hatch (proxy), Snowe, Kyl, Bunning, Crapo (proxy), Roberts (proxy), Ensign, Enzi, Cornyn
Nays: Baucus, Rockefeller (proxy), Bingaman, Kerry (proxy), Lincoln (proxy), Wyden, Schumer (proxy), Stabenow, Cantwell, Nelson (proxy), Menendez, Carper (proxy)

Amendment 333, Grassley C8
Require presentation of identification for Medicaid Benefits
Failed by roll call vote, 10 ayes, 13 nays
Ayes: Grassley, Hatch, Snowe, Kyl, Bunning, Crapo (proxy), Roberts (proxy), Ensign, Enzi, Cornyn (proxy)
Nays: Baucus, Rockefeller (proxy), Conrad, Bingaman, Kerry (proxy), Lincoln, Wyden (proxy), Schumer (proxy), Stabenow, Cantwell, Nelson (proxy), Menendez, Carper (proxy)

Amendment 382, Kyl C15, as modified
Clarification that presentation of identification is required when an individual applies for Medicaid or for the tax subsidy in the state exchange
Failed by roll call vote, 10 ayes, 12 nays, 1 pass
Ayes: Grassley, Hatch (proxy), Snowe (proxy), Kyl, Bunning, Crapo, Roberts (proxy), Ensign, Enzi, Cornyn,
Nays: Baucus, Rockefeller, Conrad (proxy), Bingaman, Kerry (proxy), Lincoln (proxy), Wyden (proxy), Schumer (proxy), Stabenow (proxy), Nelson, Menendez, Carper
Pass: Cantwell

Amendment 478, Nelson/Stabenow F1, as modified

An amendment to prevent the loss of tax benefits for senior citizens
Approved by roll call vote, 14 ayes, 9 nays
Ayes: Baucus, Rockefeller, Conrad (proxy), Bingaman, Kerry (proxy), Lincoln, Wyden, Schumer, Stabenow, Cantwell, Nelson, Menendez (proxy), Carper (proxy), Snowe
Nays: Grassley, Hatch, Kyl, Bunning, Crapo (proxy), Roberts (proxy), Ensign (proxy), Enzi, Cornyn

Amendment 529, Kyl F8, as modified
Prevent increased taxation of catastrophic medical expenses
Failed by roll call vote, 9 ayes, 14 nays
Ayes: Grassley, Hatch, Kyl, Bunning, Crapo, Roberts (proxy), Ensign, Enzi, Cornyn
Nays: Baucus, Rockefeller, Conrad, Bingaman, Kerry (proxy), Lincoln, Wyden, Schumer, Stabenow, Cantwell, Nelson (proxy), Menendez (proxy), Carper (proxy), Snowe

Amendment 483, Grassley F1, as modified
Strike Fees on Health Insurance Providers
Failed by roll call vote, 10 ayes, 13 nays
Ayes: Grassley, Hatch, Snowe, Kyl, Bunning (proxy), Crapo, Roberts (proxy), Ensign, Enzi, Cornyn
Nays: Baucus, Rockefeller, Conrad (proxy), Bingaman, Kerry (proxy), Lincoln (proxy), Wyden, Schumer, Stabenow (proxy), Cantwell, Nelson (proxy), Menendez (proxy), Carper (proxy)

Amendment 418, Enzi C4
Ensuring Americans are protected from dramatic cost increases
Failed by roll call vote, 10 ayes, 13 nays
Ayes: Grassley, Hatch, Snowe, Kyl (proxy), Bunning, Crapo, Roberts (proxy), Ensign, Enzi, Cornyn
Nays: Baucus, Rockefeller, Conrad, Bingaman, Kerry (proxy), Lincoln (proxy), Wyden, Schumer, Stabenow (proxy), Cantwell, Nelson, Menendez (proxy), Carper (proxy)

Amendment 166, Cornyn D7, as modified
Protecting senior's access to care
Failed by roll call vote, 9 ayes, 14 nays
Ayes: Grassley, Hatch, Kyl (proxy), Bunning, Crapo, Roberts (proxy), Ensign (proxy), Enzi, Cornyn
Nays: Baucus, Rockefeller, Conrad, Bingaman (proxy), Kerry (proxy), Lincoln (proxy), Wyden, Schumer, Stabenow, Cantwell, Nelson, Menendez (proxy), Carper (proxy), Snowe

Amendment 507, Hatch F17, as modified
Provide that the annual fees on the three health industry segments not take effect until the General Accountability Office has certified that no portion of the annual fee is likely to be passed on to the consumers of the products manufactured by the companies on which the tax is levied
Failed by roll call vote, 10 ayes 13 nays
Ayes: Grassley, Hatch, Snowe, Kyl (proxy), Bunning, Crapo (proxy), Roberts (proxy), Ensign (proxy), Enzi (proxy), Cornyn (proxy)
Nays: Baucus, Rockefeller, Conrad (proxy), Bingaman (proxy), Kerry (proxy), Lincoln, Wyden (proxy), Schumer (proxy), Stabenow (proxy), Cantwell, Nelson (proxy), Menendez (proxy), Carper (proxy)

Amendment 536, Roberts/Hatch F2
Ensuring individuals and families can keep their health care benefits

Chairman ruled the amendment non-germane. Senator Roberts moved to appeal the ruling of the Chair. The ruling of the Chair was sustained by roll call vote: 5 ayes, 8 nays
Ayes: Snowe, Bunning, Roberts, Ensign, Enzi
Nays: Baucus, Rockefeller, Conrad, Bingaman, Lincoln, Cantwell, Menendez, Carper

Amendment 538, Roberts F4 as modified
Preserving health care benefits for individuals and families
Chairman ruled the amendment non-germane. Senator Roberts moved to appeal the ruling of the Chair. The ruling of the Chair was sustained by roll call vote: 5 ayes, 9 nays
Ayes: Kyl, Bunning, Roberts, Ensign, Enzi
Nays: Baucus, Rockefeller, Conrad, Bingaman, Lincoln, Stabenow, Cantwell, Carper, Snowe

Amendment 533, Bunning F4, as modified
Amendment to prevent tax increases from increasing the cost of medical care to Veterans or reducing Veteran access to treatment.
Agreed to without objection

Amendment 407, Ensign/Carper C8, as modified
Building efforts for wellness and encouraging longer lives amendment
Agreed to by roll call vote, 19 ayes, 4 nays
Ayes: Baucus, Conrad, Bingaman, Kerry, Lincoln, Wyden, Stabenow, Cantwell, Carper, Grassley, Hatch, Snowe, Kyl, Bunning, Crapo, Roberts, Ensign, Enzi, Cornyn
Nays: Rockefeller (proxy), Schumer (proxy), Nelson, Menendez (proxy)

Amendment 71, Stabenow D6, as modified
To recommend guidelines to ensure access for our nations emergency rooms
Accepted without objection

Amendment 451, Cornyn C22, as modified
Encouraging personal responsibility for all Americans
Failed by roll call vote, 9 ayes, 14 nays
Ayes: Carper, Grassley (proxy), Hatch, Snowe, Kyl, Roberts (proxy), Ensign, Enzi, Cornyn
Nays: Baucus, Rockefeller, Conrad (proxy), Bingaman, Kerry (proxy), Lincoln (proxy), Wyden, Schumer (proxy), Stabenow, Cantwell, Nelson (proxy), Menendez (proxy), Bunning, Crapo

Amendment 459, Cornyn C30, as modified
Reducing waste, fraud and abuse in the Medicaid program
Failed by roll call vote, 10 ayes, 13 nays
Ayes: Grassley, Hatch, Snowe, Kyl, Bunning, Crapo, Roberts (proxy), Ensign, Enzi, Cornyn
Nays: Baucus, Rockefeller, Conrad, Bingaman, Kerry (proxy), Lincoln (proxy), Wyden, Schumer (proxy), Stabenow, Cantwell (proxy), Nelson (proxy), Menendez (proxy), Carper (proxy)

Amendment 158, Enzi D1
Strike Mark's amendment of public health service act on grounds of non-germaneness
Withdrawn

Amendment 125, Kyl D2
Ensuring seniors care will not be rationed through the physician feedback program
Failed by roll call vote, 10 ayes, 13 nays
Ayes: Grassley, Hatch (proxy), Snowe, Kyl, Bunning, Crapo, Roberts (proxy), Ensign, Enzi (proxy), Cornyn (proxy)
Nays: Baucus, Rockefeller (proxy), Conrad, Bingaman (proxy), Kerry (proxy) Lincoln, Wyden, Schumer, Stabenow, Cantwell, Nelson (proxy), Menendez (proxy), Carper (proxy)

The Committee on Finance met on Thursday, October 1, 2009 to resume consideration of an original bill entitled, "Americas Healthy Future Act of 2009" and considered the following amendments:

Amendment 534, Crapo/Roberts/Ensign/Hatch F1, as modified
Preventing tax increases in the middle class
Failed by roll call vote, 11 ayes, 12 nays
Ayes: Lincoln, Grassley (proxy), Hatch, Snowe, Kyl (proxy), Bunning, Crapo, Roberts (proxy), Ensign, Enzi (proxy), Cornyn
Ayes: Baucus, Rockefeller, Conrad (proxy), Bingaman, Kerry (proxy), Wyden, Schumer (proxy), Stabenow, Cantwell, Nelson (proxy), Menendez (proxy), Carper (proxy)

Amendment 541, Ensign F2
Exempt individuals making less than $200,000 per year and families making less than $250,000 per year from individual's penalty for failure to have health insurance
Failed by roll call vote, 11 ayes, 12 nays
Ayes: Lincoln, Grassley, Hatch, Snowe, Kyl (proxy), Bunning, Crapo, Roberts (proxy), Ensign, Enzi (proxy), Cornyn
Nays: Baucus, Rockefeller, Conrad, Bingaman, Kerry (proxy), Wyden (proxy), Schumer (proxy), Stabenow, Cantwell, Nelson (proxy), Menendez (proxy), Carper (proxy)

Amendment 521, Snowe/Bingaman/Lincoln F9, as modified
This amendment makes various changes to the modified mark
Approved by unanimous voice vote

Amendment 496, Hatch F6, as modified
To allow an expedited judicial review about the
Constitutionality of the transition relief for the excise tax on high cost of health insurance and the personal responsibility requirement
Chairman ruled the amendment non-germane. Senator Hatch moved to appeal the ruling of the Chair. The ruling of the Chair was sustained by roll call vote: 7 ayes, 9 nays
Ayes: Grassley, Hatch, Snowe, Bunning, Crapo, Ensign, Cornyn
Nays: Baucus, Rockefeller, Bingaman, Kerry (proxy), Lincoln, Wyden, Schumer (proxy), Stabenow, Cantwell, Nelson, Menendez (proxy), Carper, Snowe

Amendment 531, Bunning F2, as modified
Sunset tax increases related to increased costs
Failed by roll call vote, 9 ayes, 14 nays
Ayes: Grassley, Hatch, Kyl (proxy), Bunning, Crapo, Roberts (proxy), Ensign, Enzi (proxy), Cornyn

Nays: Baucus, Rockefeller, Conrad, Bingaman, Kerry (proxy), Lincoln, Wyden, Schumer (proxy), Stabenow, Cantwell, Nelson, Menendez (proxy), Carper, Snowe

Amendment 532, Bunning F3, as modified
Protecting certain vulnerable Americans from the tax increase on catastrophic medical costs
Failed by roll call vote, 9 ayes, 14 nays
Ayes: Grassley, Hatch, Kyl (proxy), Bunning, Crapo, Roberts (proxy), Ensign, Enzi (proxy), Cornyn
Nays: Baucus, Rockefeller (proxy), Conrad (proxy), Bingaman, Kerry (proxy), Lincoln, Wyden (proxy), Schumer (proxy), Stabenow, Cantwell, Nelson, Menendez (proxy), Carper, Snowe

Amendment 555, Cornyn F5
Protecting small business from higher costs; certify no provision will impose additional costs on small business
Failed by roll call vote, 10 ayes, 13 nays
Ayes: Grassley, Hatch, Snowe, Kyl (proxy), Bunning (proxy), Crapo, Roberts (proxy), Ensign, Enzi (proxy), Cornyn
Ayes: Baucus, Rockefeller (proxy), Conrad (proxy), Bingaman (proxy), Kerry (proxy), Lincoln, Wyden, Schumer (proxy), Stabenow, Cantwell, Nelson (proxy), Menendez (proxy), Carper

Amendment 545, Ensign F6
Change the index of the high cost insurance in the Chairman's mark to CPI-Medical.
Failed by roll call vote, 11 ayes, 12 nays
Ayes: Grassley (proxy), Hatch, Snowe, Kyl (proxy), Bunning, Crapo, Roberts (proxy), Ensign, Enzi (proxy), Cornyn (proxy)
Nays: Baucus, Rockefeller (proxy), Conrad (proxy), Bingaman (proxy), Kerry (proxy), Lincoln, Wyden (proxy), Schumer (proxy), Stabenow, Cantwell, Nelson, Menendez (proxy), Carper (proxy)

Amendment 296, Cantwell/Rockefeller C15, as modified
The Basic Health Plan
Approved by roll call vote, 12 ayes, 11 nays
Ayes: Baucus, Rockefeller, Conrad (proxy), Bingaman, Kerry (proxy), Wyden (proxy), Schumer, Stabenow, Cantwell, Nelson (proxy), Menendez (proxy), Carper (proxy)
Nays: Lincoln (proxy), Grassley, Hatch, Snowe, Kyl, Bunning, Crapo (proxy), Roberts (proxy), Ensign, Enzi (proxy), Cornyn (proxy)

Amendment 525, Kyl F4, as modified
Eliminate Health Insurance Providers Tax
Failed by roll call vote, 9 ayes, 14 nays
Ayes: Grassley, Hatch (proxy), Kyl, Bunning, Crapo, Roberts, Ensign, Enzi (proxy), Cornyn
Nays: Baucus, Rockefeller, Conrad (proxy), Bingaman (proxy), Kerry (proxy), Lincoln, Wyden, Schumer (proxy), Stabenow, Cantwell, Nelson, Menendez (proxy), Carper (proxy), Snowe

Amendment 336, Grassley/Snowe C11, as modified
Protect state budgets from maintenance of state mandate
Accepted by voice vote

Amendment 189, Rockefeller C9, as modified

Amendment to require health insurers who offer coverage in the exchange to report a medical loss ratio of at least 85% for those plans
Withdrawn

Amendment 527, Kyl F6
Eliminate cap on flexible spending accounts
Failed by roll call vote, 10 ayes, 13 nays
Ayes: Grassley (proxy), Hatch, Snowe, Kyl, Bunning, Crapo (proxy), Roberts, Ensign (proxy), Enzi (proxy) Cornyn
Nays: Baucus, Rockefeller, Conrad (proxy), Bingaman, Kerry (proxy), Lincoln (proxy), Wyden (proxy), Schumer, Stabenow (proxy), Cantwell, Nelson, Menendez (proxy), Carper

Amendment 530, Bunning F1, as modified
Amendment to sunset tax increases
Failed by roll call vote, 9 ayes, 13 nays, 1 pass
Ayes: Grassley (proxy), Hatch, Kyl, Bunning, Crapo (proxy), Roberts, Ensign (proxy), Enzi (proxy), Cornyn (proxy)
Nays: Baucus, Rockefeller, Conrad (proxy), Bingaman (proxy), Kerry (proxy), Lincoln, Wyden (proxy), Schumer Stabenow (proxy), Nelson, Menendez (proxy), Carper (proxy), Snowe
Pass: Cantwell

Amendment 384, Kyl C17, as modified
Increase current limits on Health Savings Accounts contributions
Failed by roll call vote, 10 ayes, 12 nays, 1 pass
Ayes: Grassley (proxy), Hatch, Snowe, Kyl, Bunning, Crapo, Roberts (proxy), Ensign (proxy), Enzi (proxy), Cornyn (proxy)
Nays: Baucus, Rockefeller, Conrad (proxy) Bingaman (proxy), Kerry (proxy), Lincoln, Wyden (proxy), Schumer (proxy), Stabenow, Nelson, Menendez (proxy), Carper
Pass: Cantwell

Amendment 43, Lincoln D11
To overturn Centers for Medicare and Medicaid Services CY 2010 Physician Fee Schedule Proposed Rule's application of equipment utilization policy to radiation therapy. The amount would exempt from budget neutrality requirements within the statute.
Withdrawn

Amendment 381, Kyl D4
Clarification that legal immigrants must reside in the U.S. for at least 5 years in order to be eligible for the tax credit available through state exchanges
Failed by roll call vote, 10 ayes, 13 nays
Ayes: Grassley, Hatch, Snowe, Kyl, Bunning, Crapo, Roberts (proxy), Ensign (proxy), Enzi (proxy), Cornyn (proxy)
Nays: Baucus, Rockefeller, Conrad, Bingaman, Kerry (proxy), Lincoln, Wyden (proxy), Schumer, Stabenow, Cantwell, Nelson, Menendez, Carper (proxy)

Amendment 472, Lincoln/Menendez/Conrad F1, as modified

This amendment makes various changes to the Chairman's Mark
Accepted by roll call vote, 14 ayes, 8 nays, 1 pass
Ayes: Baucus, Rockefeller, Conrad, Bingaman (proxy), Kerry, Lincoln, Wyden, Schumer, Stabenow, Cantwell, Nelson, Menendez, Carper, Snowe
Nays: Grassley, Hatch, Kyl, Bunning, Crapo, Roberts (proxy), Enzi (proxy), Cornyn (proxy)
Pass: Ensign

Amendment 487, Grassley F5, as modified
Fail-safe mechanism to ensure health care reform does not increase the budget deficit
Accepted without objection

Amendment 60, Wyden/Nelson/Schumer D17, as modified
Medicare Advantage transition to competitive bidding and increased quality bonus
Accepted by unanimous voice vote

Amendment 235, Kerry C10
Ensuring the premium tax credits continue to make health insurance affordable
Withdrawn

Amendment 233, Kerry C8
Empowering state exchanges to be prudent purchasers
Withdrawn

Amendment 181, Rockefeller C1, as modified
Apply health insurance market reforms
Withdrawn

Amendment 194 & 195
Rockefeller C14 & C15
Medicaid Amendment, merged with
Elimination of state mandates providing a real choice for low income populations to keep current Medicaid coverage
Withdrawn

Amendment 262, Schumer/Snowe C3, as modified
Reduce individual mandate penalty
Accepted by roll call vote, 22 ayes, 1 nay
Ayes: Baucus, Rockefeller, Conrad, Bingaman, Kerry, Lincoln (proxy), Wyden, Schumer, Stabenow, Cantwell, Nelson, Menendez, Carper (Proxy), Grassley, Hatch (proxy), Snowe, Bunning (proxy), Crapo (proxy), Roberts (proxy), Ensign, Enzi (proxy), Cornyn (proxy),
Nays: Kyl

Amendment 53, Wyden/Carper D10, as modified
Personalize medicine and independence at home
Approved by unanimous voice vote
(Note: Grassley requested that record reflect he would have voted no on a roll call vote.)

Amendment 524, Kyl F3, as modified
Strike tax on medical devices
Failed by roll call vote, 10 ayes, 13 nays
Ayes: Grassley, Hatch (proxy), Snowe, Kyl, Bunning (proxy), Crapo, Roberts (proxy), Ensign, Enzi (proxy), Cornyn (proxy)
Nays: Baucus, Rockefeller, Conrad, Bingaman, Kerry, Lincoln (proxy), Wyden (proxy), Schumer (proxy), Stabenow, Cantwell, Nelson, Menendez, Carper

Amendment 201, Rockefeller C21, as modified
Remove the Children's Health Insurance Program (CHIP) from the exchange
Approved by roll call vote, 13 ayes, 9 nays, 1 pass
Ayes: Baucus, Rockefeller, Conrad, Bingaman, Kerry, Lincoln, Schumer (proxy), Stabenow, Cantwell, Nelson, Menendez, Carper, Snowe
Nays: Grassley, Hatch (proxy), Kyl, Bunning (proxy), Crapo, Roberts (proxy), Ensign, Enzi (proxy), Cornyn (proxy)
Pass: Wyden

Amendment 465, Rockefeller/Kerry/Schumer/Menendez/Stabenow F1, as modified
Makes various changes to the modified Chairman's mark
Accepted by roll call vote, 13 ayes, 10 nays
Ayes: Baucus, Rockefeller, Conrad, Bingaman, Kerry, Lincoln, Wyden, Schumer, Stabenow, Cantwell, Nelson, Menendez, Carper
Nays: Grassley, Hatch (proxy), Snowe, Kyl (proxy), Bunning (proxy), Crapo, Roberts (proxy), Ensign (proxy), Enzi (proxy), Cornyn (proxy)

Amendment 248, Wyden C1
Ensure affordable access to health insurance exchange plans for all Americans
Withdrawn

Amendment 540, Ensign F1, as modified
Flexible Spending Accounts Improvement
Failed on roll call vote, 11 ayes, 12 nays
Ayes: Lincoln, Grassley, Hatch (proxy), Snowe, Kyl (proxy), Bunning (proxy), Crapo, Roberts (proxy), Ensign, Enzi (proxy), Cornyn (proxy)
Nays: Baucus, Rockefeller, Conrad, Bingaman, Kerry, Wyden, Schumer, Stabenow, Cantwell, Nelson, Menendez, Carper

The Committee on Finance met on Tuesday, October 13, 2009, to resume consideration of an original bill entitled, "Americas Healthy Future Act of 2009" and considered the following amendment and voted to report the Chairman's Mark, as follows:

Chairman's Motion to adopt the Technical Corrections to Redline of Chairman's Mark, dated October 5, 2009
Approved by roll call vote, 13 ayes, 10 nays
Ayes: Baucus, Rockefeller, Conrad, Bingaman, Kerry, Lincoln, Wyden, Schumer, Stabenow, Cantwell, Nelson, Menendez, Carper

Nays: Grassley, Hatch, Snowe, Kyl, Bunning, Crapo, Roberts, Ensign, Enzi, Cornyn

The Chairman's Mark, as amended, was ordered favorably reported by a roll call vote of 14 ayes and 9 nays. The vote was as follows:
Ayes: Baucus, Rockefeller, Conrad, Bingaman, Kerry, Lincoln, Wyden, Schumer, Stabenow, Cantwell, Nelson, Menendez, Carper, Snowe
Nays: Grassley, Hatch, Kyl, Bunning, Crapo, Roberts, Ensign, Enzi, Cornyn

V. CHANGES IN EXISTING LAW MADE BY THE BILL, AS REPORTED

In the opinion of the Committee, in order to expedite the business of the Senate, it is necessary to dispense with the requirements of paragraph 12 of rule XXVI of the Standing Rules of the Senate (relating to the showing of changes in existing law made by the bill as reported by the Committee).

VI. ADDITIONAL VIEWS

ADDITIONAL VIEWS ON AFFORDABILITY SUBMITTED BY SENATORS STABENOW, ROCKEFELLER, MENENDEZ, KERRY, AND SCHUMER

We commend Chairman Baucus for supporting changes to the America's Healthy Future Act of 2009 to make health insurance more affordable. Most importantly, bringing down the sliding scale for subsidies down to 2% through 12% for working middle-class families is a step in the right direction.

We, however, remain concerned about the overall affordability of health insurance, which is critical because the Mark will require people to purchase insurance. Throughout this important debate, we have asserted that a health plan must be affordable to ensure maximum participation and coverage. As the health care debate moves forward, we must do more to improve the premium subsidies, address cost-sharing, and strengthen the actuarial values of plans offered in the exchange. Since 2000, premiums have increased nearly 5 times greater than families' paychecks. Such increases are unsustainable for families. The plans offered through the exchange must remain in reach of the average middle-class family.

It is important to understand what a family goes through when paying their monthly bills. In "Too Great a Burden: Americans Face Rising Health Care Costs," Families USA looked at the annual costs for a typical family with a household income of $60,000. After taxes, their income shrank to about $49,000. Housing and utilities might take up a third of their income, and food and personal care might take up a fifth. For most, there is little income left to spend on health care. The premiums offered through health reform must fit into a family budget and be affordable.

The Congressional Budget Office estimates that, for those individuals and families who purchase health care coverage in 2016, the changes included in the Chairman's Mark will reduce the financial burden of coverage (including both premiums and out-of-pocket costs) by about one percent, as a percent of income. While families below 133 percent of poverty are protected against unaffordable health care costs, families between 133 and 450 percent of poverty still face substantial total health care spending. Although their premiums may be affordable as defined by the Mark, total out of pocket costs, including premiums, co-payments, and other costs are estimated to consume upwards of ten to almost twenty percent of a family's annual income.

We plan to continue with working Chairman Baucus on affordability so that middle-class Americans do not have to choose between health insurance and other family needs.

ADDITIONAL VIEWS OF SENATOR MARIA CANTWELL

This bill lays the foundation for the comprehensive reform America can no longer wait to achieve. The bill contains many provisions that will help decrease the cost of health care for all Americans. These provisions must be maintained or expanded as the bill moves to the Floor.

The bill begins the critical process of reforming Medicaid's long-term care coverage, providing seniors with the opportunity to receive care in their homes, rather than being forced into institutional nursing homes. Currently, most state Medicaid programs force seniors and the disabled into nursing homes at a cost to America of $100 billion a year. Better and cheaper alternatives can be made available. Offering long-term care in home and community based settings provides patients with an improved quality of life at a savings of nearly 70 percent; this bill includes the necessary incentives for states to transition into a well-balanced system of nursing home and home and community based long-term care.

We also create transparency in the pharmacy benefit manager industry that will help drive down the price of brand name drugs by almost ten percent, according to a study by the Human Resource Policy Association.

In this bill we lay out a clear plan for transitioning Medicare providers away from the current fee-for-service system, which reimburses based only on volume with no regard to the value providers offer their patients. By including a value modifier in the physician payment formula, we could help to save $50 billion or more each year in wasted Medicare expenses that burden seniors and drain Medicare's trust fund.

The basic health plan provides another critical way to reduce costs. By allowing states to negotiate on behalf of those Americans who require the largest federal subsidy – people from 133 to 200 percent of poverty – we can make coverage more affordable without increasing the total cost of subsidies. Washington State has seen a 35 to 40 percent cost savings through this type of Basic Health Plan when compared to comparable benefit packages in the private market. This model provides a clear way to offer low-income Americans high-quality, affordable health coverage.

All of these reforms will help to drive down costs, but it still does not do enough to drive down health care costs. We must continue working to bend the cost curve down to a level that more closely matches the two to three percent general inflation rate; today's nearly eight percent annual inflation in the health care industry is unacceptable and unsustainable. Until we actually get these reforms enacted, such uncontrolled costs will wreak havoc on American lives.

Insurance companies have a right to make a profit, but a 119 percent increase to premiums and a 428 percent increase in profits are unacceptable when it means more and more small businesses

can no longer compete while providing health care for their employees, and when it means 14,000 Americans are losing their health coverage each day.

We must do more to reverse this trend, including adding a public option and building on the Basic Health Plan to increase competition in the health care markets. We must also work to close the anti-trust loop-hole that allows insurance companies to fix prices and manipulate markets.

The excise tax on high-cost insurance plans is too harsh on middle-income workers. We must make sure we do not place any added burden on workers who have, over the years, negotiated away salary increases in order to get or keep better health benefits. Health care reform should help prevent workers from facing this tradeoff in the future. We must be able to reassure the 85 percent of Americans who currently have health coverage that we are focused on making health reform improve their financial situation, not make it worse. I am worried the excise tax will not help us achieve this critical goal.

The health insurance exchanges will do a great deal to help consumers, but they may also be confusing for many Americans. Tools such as user-friendly websites will play a critical role in helping people access coverage through the exchange. However, many of those who will need this access the most may not have experience sorting through complex information online. New technological advancements, such as virtual agents, can help answer questions and walk people through registration processes. We should encourage states to make use of virtual agents that offer interactive self-help and intelligent self-service capabilities, providing feedback using voice, text, and page navigation. This technology can help Americans choose the coverage that fits them best.

The hard work and compromise we have put in so far has established a framework for the reforms our health care system needs. As the legislative process moves forward we must be sure to build on this framework to further drive down health care costs and improve quality, until we have a system that is stable and affordable for all Americans.

VII. MINORITY VIEWS

MINORITY VIEWS SUBMITTED BY SENATORS GRASSLEY, HATCH, KYL, BUNNING, CRAPO, ROBERTS, ENSIGN, ENZI AND CORNYN

While Republicans agree that changes are needed in our health care system, we believe that America's Healthy Future Act of 2009 (AHFA) takes the system in the wrong direction. Unfortunately, the proposals set forth in the AHFA will, if enacted, burden taxpayers with increased taxes to pay for unprecedented government spending. In addition, the changes in the AHFA would make the largest expansion of Medicaid since its creation in 1965. All of these changes would be paid for by Medicare cuts combined with increased premiums on Medicare prescription drug coverage and Medicare Advantage that will devastate access for the nation's Medicare beneficiaries. In addition, this bill will significantly expand the government's role in health care by adding 32 million to government subsidized health care, and neither the Committee deliberations, nor the Chairman's Mark or Modification have provided clear guidance on the cost of increased government administration. The AHFA also hides its true cost by delaying implementation of the new coverage subsidies until July of 2013 by and by delaying the expansion of Medicaid until 2014. In fact, the true fully-implemented ten-year cost of the AHFA totals at least $1.8 trillion.

The challenges facing our health care system affect one-sixth of the economy and touch the lives of every single American. These challenges deserve bipartisan solutions. We have too many people who cannot find affordable insurance because costs are growing too quickly and insurers deny coverage because of pre-existing illnesses. The quality of medical care varies from world-class to inefficient and wasteful because the system pays based on the quantity of care provided instead of rewarding quality.

Unfortunately, throughout the Finance Committee process, Republican efforts to bring effective solutions to these and other problems were defeated. And in addition to offering alternative ideas, Republican efforts to shield seniors and non-elderly consumers from higher prices and reduced benefits also failed.

It is important for the public to be aware that proposals in the AHFA will actually result in drastic cost increases for consumers. At a time when consumers are struggling to keep up with health care costs, this bill will just make the problem worse.

New health insurance benefit mandates, based on federally determined actuarial values, will increase premiums for many consumers by as much as 44 percent. In some states this increase, coupled with other regulatory reforms, could raise premiums will by as much as 73 percent for people purchasing coverage in the individual market. Seniors will also see the cost of

prescription drug plan premiums go up and Medicare Advantage benefits reduced. In addition to the $117 billion in direct cuts to Medicare Advantage, the AHFA gives the newly-created Medicare Commission the specific authority to make further cuts to Medicare Advantage and reduce funding for the Medicare Part D program. These cuts will increase premiums and cut benefits to pay for a brand new national health care program. If people were hoping to pay less for health care after health reform is enacted, this bill is going in the wrong direction.

Republican efforts to include medical malpractice reforms were also rebuffed. These amendments would have provided incentives through Medicaid for states to enact medical malpractice reforms. Despite the fact that the committee has often required states to enact certain legislation or meet other requirements as a condition of funding within the committee's jurisdiction, these amendments were ruled out of order. The AHFA should include medical malpractice reform to reduce abusive lawsuits that drive up costs and limit access to physicians. Health care reform should be working to create an environment where doctors don't have to engage in defensive medicine just to keep their practices open.

The AHFA also has almost half a trillion dollars in Medicare cuts. Payment cuts of this magnitude will threaten access to health care for seniors and the disabled. The Balanced Budget Act of 1997 (BBA) cut Medicare by over $385 billion and threatened the ability of hospitals, nursing homes and home health agencies to keep their doors open. As a result, Congress was forced to undo many of these Medicare payment cuts by passing bills in 1999 and 2000 to return over 20 percent to providers.

The BBA experience provides two important lessons. The first lesson is that these Medicare cuts will be devastating to the program. The second lesson is that in the end, Medicare cuts will not actually be allowed to go into effect. Congress will have to intervene and prevent these cuts as soon as they begin inflicting the damage to health care access that they will cause. That means that the Medicare cuts this bill relies on to be fully offset are a mirage.

Another important area of concern is the impact the AHFA has on Medicaid and the Children's Health Insurance Program (CHIP). Medicaid and CHIP play an important role in the U.S. health care system by providing health care coverage to low income children. According to data from the Centers for Medicare and Medicaid Services, the number of children "ever enrolled" in public health coverage programs in 2008 was 29.8 million in Medicaid and 7.9 million children in CHIP, for a combined total of 37.7 million children.

The Medicaid and CHIP programs aspire to provide coverage to low income children but are hampered by extremely low provider payment rates. A 2009 study in the journal *Health Affairs*[1] found Medicaid payment rates nationally to be 72 percent of Medicare rates with five states (California, District of Columbia, New Jersey, New York, and Rhode Island) reimbursing

[1] Trends in Medicaid Physician Fees, 2003–200. Stephen Zuckerman, Aimee F. Williams and Karen E. Stockley. Health Affairs, 28, no. 3 (2009): w510-w519. (Published online 28 April 2009).

at less than 60 percent of Medicare rates. Low reimbursement rates are cited as a primary cause of why Medicaid patients have difficulty finding doctors to treat them. A 2002 MedPAC report stated that 40 percent of physicians restricted access for Medicaid patients and in a 2009 survey of 15 major metropolitan markets found the Medicaid provider participation rate for five medical specialties to be 55.4 percent.[2]

Expanding the Medicaid program to cover as many as 14 million people without making significant reforms to improve the program seems imprudent. Throughout 2009, the Finance Committee considered numerous provisions to improve the Medicaid program. Ultimately, the AHFA fails to address the many challenges that currently face the Medicaid program.

During the Coverage Roundtable and Walkthrough, the Committee considered a provision to increase reimbursement to providers. Higher reimbursement rates could have provided an incentive for greater provider participation in Medicaid, and therefore greater access for recipients to providers. That provision was not included in the AHFA.

During the Coverage Roundtable and Walkthrough, the Committee considered a provision to require all states to provide Medicaid recipients with 12 months continuous eligibility for Medicaid. This provision would have prevented a significant problem faced by Medicaid recipients who have gaps in their health insurance coverage as their income cycles above Medicaid eligibility levels. This provision was not included in the AHFA.

Millions of children benefit from the Early, Periodic, Screening, Diagnosis, and Treatment (EPSDT) provision in the Medicaid statute. This benefit provides long term habilitation and rehabilitation for children with chronic and serious mental, physical and developmental disabilities. It provides a class of benefit (e.g., personal care, case management, private nursing) more extensive than levels of coverage found in a typical private insurance plan. In 2005, a provision was included in the Deficit Reduction Act (DRA) that allowed states to put Medicaid recipients in private-style coverage on the condition that children received supplemental coverage consisting of EPSDT benefits. Current law requires that benefit be available for children up to age 6 and with family incomes of up to 133 percent of poverty and for children ages 6 to 19 with family incomes of up to 100 percent of poverty. The AHFA provided that all children up to age 19 with family incomes up to 250 percent of poverty would receive the EPSDT benefit through supplemental coverage. The provision to provide additional supplemental benefits to children similar to the provision in the DRA was struck from the AHFA through the Rockefeller Amendment #C21.

The Rockefeller Amendment #C21 to the AHFA is a particularly ill-conceived provision for providing coverage to children. The amendment requires states to maintain their current CHIP eligibility levels from 2014 through 2019. However, while the amendment states that the CHIP program be reauthorized by September 30, 2013, if the program is not reauthorized, states will

[2] 2009 Survey of Physician Appointment Wait Times. Merritt Hawkins & Associates. Irving, Texas.

not have adequate funding from 2014 through 2019 to maintain coverage levels. The Congressional Budget Office assumes that states will reduce the size of their CHIP populations by nearly 60 percent from 2014 through 2019, and the amendment also does not provide states with any specific tools or guidance as to how they should reduce their coverage levels over the six-year period. The Rockefeller Amendment #C21 could reduce benefits available to children, and force states to remove children from the CHIP program. These issues must be addressed before it may be considered to become law.

In addition, the AHFA does not fully consider the impact of significant Medicaid expansion on the budgets of states. The Congressional Budget Office projects states will face increased spending of $33 billion due to the coverage provisions in the AHFA. As most states operate under a balanced budget requirement, any increase in state spending will require states to find offsets through either increased taxes or reduced spending on other programs. Further, by increasing the federal share of Medicaid reimbursement to states for adults and higher income children, the AHFA creates an incentive for states to focus their resources away from lower income children if not an outright disincentive.

Finally on Medicaid, given the emphasis placed on providing greater choices in AHFA, Republican Members of the Senate Finance Committee also believe that Medicaid beneficiaries should have the choice to elect coverage under Medicaid or receive tax subsidies to purchase private coverage in the new exchanges. The Medicaid program has serious and systemic problems that restrict patients' ability to see doctors and often lead to worse health care outcomes. The sole fact that Medicaid costs less than other forms of insurance is not a sufficient reason to deny low income Americans the right to choose the health care program that best meets their needs.

Republican members of the Senate Finance Committee also have concerns over the financing measures included in the AHFA. One of our primary concerns with the AHFA is that it calls for over $400 billion in new taxes. The Congressional Budget Office (CBO) and the Joint Committee on Taxation (JCT) each testified that these new taxes will be borne by all taxpayers, including families with incomes below $250,000 per year (and individuals with incomes below $200,000 per year). These tax increases include a new excise tax on high-cost health insurance plans, fees on health insurance providers, medical device manufacturers, and manufacturers of prescription drugs, a limitation on pre-tax contributions to a flexible spending arrangement (FSA) under a cafeteria plan, the elimination of tax-free reimbursements for over-the-counter medicines, and a proposal to raise the 7.5 percent adjusted gross income (AGI) threshold for the itemized deduction for medical expenses to 10 percent.

Under the AHFA, so-called fees will be imposed on health insurance providers, medical device manufacturers, and manufacturers of brand name prescription drugs. JCT has characterized these so-called fees as excise taxes. CBO and JCT testified that these excise taxes will be passed through to health care consumers. The result will be higher health insurance premiums for

policyholders and higher prices for health care-related products. The Chairman has argued that once the health insurance reforms in the AHFA are in place, premiums will decrease. CBO, however, has not confirmed this argument as fact. Instead, CBO testified – and explained in a September 22, 2009 letter to the Chairman – that health insurance premiums will be lower for some Americans, while health insurance premiums for other Americans will be higher. Under the AHFA, the excise taxes imposed on health insurance providers, medical device manufacturers, and prescription drug manufacturers become effective January 1, 2010. The majority of the health insurance reforms set forth in the AHFA, on the other hand, do not go into effect until January 1, 2013 (in some cases, July 1, 2013). As a result, for three years (in some cases, three years and six months), the effect of these fees will be higher premiums, according to CBO and JCT. We believe that these arbitrary excise taxes on individual segments of the health care industry will increase costs for each and every American and are contrary to efforts to truly reform our nation's health care system.

The AHFA also limits the amount of salary reduction contributions an employee may elect for any taxable year for purposes of coverage under a FSA to $2,500. Under current law, such FSA salary reduction contributions may be made on a pre-tax basis. Thus, the new limitation will impose a higher tax burden on those employees that elect to make FSA salary reduction contributions in excess of the limit. The majority of employees that currently make FSA salary reduction contributions in excess of $2,500 do so to pay for catastrophic medical expenses. Also, statistics show that the average income of an employee electing to make FSA salary reduction contributions is $55,000 per year. As a result, this tax increase imposed by the AHFA will fall most heavily on middle-income employees with serious medical conditions.

Another proposal in the AHFA will adversely affect middle-income individuals who do not purchase health insurance through an employer, but instead, purchase insurance on their own. Specifically, the proposal to restrict the eligibility criteria for the itemized medical expense deduction – by increasing the 7.5 percent AGI threshold to 10 percent – will increase taxes on taxpayers with income between $50,000 and $75,000 and taxpayers 65 or older. While an amendment to exempt taxpayers 65 or older from the new 10 percent AGI threshold was approved, the exemption is only effective from 2013 to 2016. As a result, in 2017, roughly 50 percent of those taxpayers who would be affected by the proposal will be 65 or older. The Chairman justifies the change by arguing that health insurance purchased in the newly created "exchanges" will have out of pocket maximums. The Chairman contends that the new out-of-pocket limits will eliminate – if not mitigate – the need for taxpayers to claim the itemized medical expense deduction. However, the Chairman overlooks the fact that many medical expenses that are deductible will not be covered by exchange insurance. Moreover, individuals between 210 percent and 400 percent of the Federal Poverty Level (FPL), who will be required to pay the premiums for exchange insurance out of their own pocket, will lose a portion of the itemized medical expense deduction that they may currently claim. This is a clear-cut example of how taxes will increase for Americans earning less than $250,000 per year.

Another concern is that the new employer penalties in this bill are a tax on workers and take-home pay. The Congressional Budget Office has repeatedly said that the increased costs of providing new benefits or paying the new employer penalties will simply be shifted to workers in the form of lower wages. Employers may also respond by cutting jobs (particularly for low-income workers), outsourcing more jobs, or relying more on part-time workers.

With regard to abortion, it remains our strong view that the AHFA does not sufficiently address concerns regarding the prohibition of federal taxpayers' dollars being used to subsidize coverage of elective abortions. The AHFA departs from the principles embodied in the laws that govern current federal health programs, which prohibit both direct funding of abortion (with narrow exceptions) and subsidies to plans that cover abortion. For example, all of the private plans that participate in the Federal Employees Health Benefits Program (FEHBP) currently are prohibited by law from covering abortion, because they are federally subsidized. Likewise, the Hyde Amendment that currently covers the Medicaid program prohibits both direct federal funding of abortion and funding of plans that cover abortion, and this prohibition covers even state matching funds. The language contained in the AHFA would sharply depart from the principles of the Hyde Amendment. Therefore, we believe that the AHFA as reported by the Finance Committee must be further modified to codify the Hyde language so that federal dollars are prohibited from being used to pay for abortions, or benefits packages covering abortion, except in cases of rape, incest or when the life of the mother is endangered. This would bring the legislation into compliance with all other major federal health programs on this issue, including the Children's Health Insurance Program and Federal Employees Health Benefits Program.

In addition, broad regulatory authorities included in the AHFA could result in federal mandates that require abortion coverage or abortion access. We believe that the AHFA does not adequately ensure against such regulatory abortion mandates, and that further language is necessary to prevent such mandates and to protect existing state laws. Furthermore, the AHFA is unprecedented in its call for each region in the Exchange to include a health plan covering elective abortions -- that is, a plan that violates the federal government's policy in its own programs.

In addition, we believe the protection of the conscience rights of health care providers, entities and plans is essential in any health reform bill. The AHFA does not adequately protect the conscience rights of health care providers, entities and plans. The conscience protections afforded in the Hyde/Weldon conscience clause (included in the annual appropriations legislation that has funded the Department of Health and Human Services since 2004) should be codified in the AHFA. The Hyde/Weldon conscience clause language prohibits federal agencies and state and local entities that receive federal dollars from forcing health care providers to provide, pay for or refer for abortions. It is vitally important to have specific legislative language in the AHFA that reflects both the Hyde provision that prohibits federal dollars from being used

to fund elective abortion coverage, and the Hyde/Weldon language to protect health care providers' conscience rights instead of relying on a general reference to a provision that is included in annual appropriations language.

It is also unclear whether or not the AHFA preempts constitutional state abortion laws. We believe clarification on this point is critically important. We look forward to working with the Chairman and others in resolving these four important issues so it is absolutely clear that federal funds are not used to pay for elective abortions or plans that cover elective abortion; that the AHFA does not provide any basis for mandating access to elective abortion services and does not preempt state laws regulating abortions; and that conscience protections are ensured for health care providers.

Finally, the AHFA significantly expands the federal government's role in health care. While the Chairman has stated that he does not intend to grow the government, the Committee has no idea how many more Federal employees, particularly employees of the Internal Revenue Service (IRS), will be needed to administer and enforce the provisions set forth in the AHFA. Specifically, the AHFA tasks the IRS with administering several new and very controversial provisions, including the individual mandate, the employer "free-rider" penalty, the premium tax credit for low-income individuals, the small business tax credit, and the AHFA requires the IRS to work with the new "exchanges" or a new Federal entity to verify income information. The costs to implement these provisions are not included in any CBO or JCT estimates. We are concerned that the additional resources needed could significantly increase the unprecedented government spending already called for by the Chairman.

We appreciate the hard work of the Chairman and the Committee staff on the AHFA, and thank the Chairman for the opportunity to offer amendments in the normal course, and in the regular order, of the Committee process.

In order to avoid a damaging outcome to the nation's economy and the health care system that will be difficult to reverse, we urge the Chairman and members of the Senate to consider the concerns outlined above prior to, or contemporaneous with, full Senate consideration of the AHFA, or any related legislation.

Charles E. Grassley
Orrin G. Hatch
Jon Kyl
Jim Bunning
Mike Crapo
Pat Roberts
John Ensign
Michael B. Enzi
John Cornyn

ADDITIONAL VIEWS BY SENATOR JIM BUNNING

The Minority Views filed by most Republicans, including myself, point out that this bill hides the true cost of health care reform by delaying implementation of many of the provisions until 2013 and 2014, and that the fully-implemented, 10-year cost of this bill is actually at least $1.8 trillion.

However, there are two other areas that this bill does not address that could significantly increase the cost of health care over the next 10 years that are not being adequately accounted for.

The first one is the bill's failure to permanently address Medicare's flawed and broken formula for reimbursing physicians and certain non-physician practitioners. For the past eight years, doctors have faced decreases in their reimbursement rates for seeing Medicare patients.

In fact, in 2002 doctors actually received at 5.4% cut in their reimbursement rates when they saw Medicare patients. The reductions doctors face have become quite large and truly unsustainable for many practices to absorb. For example in 2008, doctors faced a 10% cut in their reimbursement rates. In 2009, doctors would have received a 15% cut. For 2010, the doctors are facing a 21% cut.

However, each year since 2002, Congress has stepped in to override the reimbursement reduction, by either freezing the reimbursement level or giving physicians a slight increase in their reimbursement rates, such as a 0.5% increase or a 1.5% increase.

The way Congress has dealt with this flawed formula over the years is unfair to providers. Without knowing how much they are going to be paid, it is hard for doctors to plan their budgets and determine how many Medicare patients they can see.

The Chairman's mark overrides the 21% payment cut for just 2010 with a 0.5% increase. The cost is $10.9 billion.

While a one-year fix that is paid for is better than nothing, I suppose, the Chairman's mark misses the real opportunity to deal with this broken formula once and for all. This bill is supposed to provide comprehensive health care reform, yet it leaves this flawed formula is place.

It makes no sense, is short-sighted, and is unfair to doctors.

Not permanently fixing this formula also hides the true cost of health care reform. It is estimated that a permanent fix for the flawed formula is between $285 billion and $344 billion under current law.

However, this cost isn't included in the Chairman's cost estimate for the bill. I believe this cost will likely be added onto the bill at some point, but it isn't clear if it will be paid for. That means this bill will likely cost another $300 billion, which is not reflected in the cost estimate.

My second area of concern deals with illegal immigrants and whether or not they will be covered under this bill.

The Chairman's mark tries to prevent them from being covered under the new law. However, I am concerned that some recent court rulings and legal precedent may require us to eventually cover all illegal immigrants, especially if a public option is included in the final version of the bill.

While I disagree with that idea, I am concerned that when Congress creates such a large new entitlement program, particularly with a public plan, that eventually activist courts will require that illegal immigrants be covered, which will dramatically increase the costs of this health care reform bill.

The Congressional Budget Office estimates that under the Chairman's mark, 25 million people in this country will be uninsured in 2019, with one-third of these individuals being illegal aliens. That's eight million more people who would be covered under the bill.

If we are forced by the courts to cover these individuals, prices will increase significantly.

We aren't being honest with the American taxpayers about how much we are spending or how much our future costs will be, particularly if we eventually provide a permanent fix for the doctor's payment formula and if we are forced to cover illegal aliens under health care reform.

We need to be upfront about the costs and we need to live within our means. That will mean making some hard decisions, but it is the responsible thing to do.