

MEMORANDUM

To: PPSV Clients
From: Peter Thomas, Bobby Silverstein, Adam Chrisney and Theresa Morgan
Date: December 4, 2009
Re: Summary of Majority Leader Reid's Senate Healthcare Reform Bill (H.R. 3590)

Status of the Health Care Reform Debate

On Saturday, November 21, the Senate voted along party lines to proceed to debate on H.R. 3590, the Senate version of the healthcare reform bill. The chamber began debate on the underlying provisions of the bill on Monday afternoon, November 30. The Senate is expected to continue debating well into December, with the intention of passing a Senate bill before the holiday recess, but it is unclear whether this will occur.

The Senate bill, the *Patient Protection and Affordable Care Act*, contains a number of controversial provisions that politically moderate Senators warn could prevent their support for "cloture" to end debate and bring the bill to a final vote. Cloture requires 60 favorable votes. One of the most controversial issues is whether to include in the bill a "public option," which Majority Leader Harry Reid (D-NV) supports with an accommodation to states to "opt out" if they so choose. A few moderate Democrats oppose the public option, including Democratic Senators Ben Nelson (NE), Blanche Lincoln (AR), Mary Landrieu (LA), as well as Independent Senator Joe Lieberman (CT). The moderates will push for more changes to the final bill in exchange for their support of cloture and passage.

The Congressional Budget Office scored the bill at \$848 billion, which represents the amount spent in subsidies provided through the exchanges, the expansion and outlays for Medicaid and the Children's Health Insurance Program (CHIP), and tax credits for small employers. The CBO estimates that those costs are more than offset by revenue sources, resulting in a net reduction in federal deficits of \$130 billion between 2010 and 2019. CBO also estimates that health care nonsubsidized plan premiums in the individual market under the Senate bill would be 10 to 13 percent higher in 2016 than under current law, but the coverage would be more comprehensive. However, CBO estimates that for plans available through the health insurance exchanges, premiums would be 56 percent to 59 percent lower than under current law, largely due to the prevalence of federal subsidies.

The House passed their bill to overhaul the healthcare system on November 7, 2009. It is rumored that Congressional Democratic leaders have already begun ironing out differences between the House and Senate bills. If the Senate passes its bill, it is possible that the House could amend and vote on HR 3590. That altered legislation would then be sent back to the Senate, avoiding the necessity for a formal conference. In the alternative, Democratic leaders could opt for the formal conference process, resulting in a revised final bill that both chambers would then need to pass before sending legislation to the President's desk.

The remainder of this memorandum summarizes key provisions of the 2,000-page Senate bill. Section references are provided for ease in learning more about particular provisions.

Private Market Reforms

Consumer Protections and Nondiscrimination Provisions

- **Sec. 1101:** Enacts a **temporary insurance program** for those who have been uninsured and have a **pre-existing condition**; allows premium rating based on age subject to a 4 to 1 ratio; requires sanctions for plans that “dump” onto the program; terminates when the Exchanges are operational in 2014
- **Sec. 2711:** Prohibits all plans from establishing **lifetime** limits or “**unreasonable**” annual limits on the dollar value of benefits within the exchange; allows group health plans or other plans doing business outside of the exchange to place annual or lifetime limits on specific covered benefits (Effective the plan year six months after enactment)
- **Sec. 2712:** Prohibits all plans from **rescinding coverage** except to a covered individual who has performed an act or practice that constitutes fraud or makes an intentional misrepresentation of material fact as prohibited by the terms of the plan or coverage (Effective the plan year six months after enactment)
- **Sec. 2702:** Requires each health insurance issuer to accept every employer and individual in the State that applies for coverage, restricted to annual and special enrollment periods
- **Sec. 2701:** Allows **premium rating** in the **individual and small group markets** only for family structure, geography, the actuarial value of the benefit, age (limited to a ratio of 3 to 1), and tobacco use (limited to a ratio of 1.5 to 1)
- **Sec. 2703:** Requires **guaranteed renewability** of coverage in the individual and group markets
- **Sec. 2704:** Prohibits insurers in individual and group markets from imposing **pre-existing condition exclusions**
- **Sec. 2705:** Expands to the individual insurance market HIPAA non-discrimination protections that prohibit discrimination against participants based on health status, claims experience and disability; codifies an exception for **premium rating** up to 30 percent generally and 50 percent when HHS permits in the **large group market** based on **employer wellness program** participants' achievement of health outcomes; implements a 10-state demo to test wellness premium rating in the **individual market**
- **Sec. 2713:** Requires all plans to cover certain **preventive services and immunizations** without any cost-sharing
- **Sec. 4203:** Requires the Access Board to establish **standards for accessibility** of medical diagnostic equipment (e.g., exam tables, weight scales) to individuals with disabilities

- **Sec. 1554:** Prevents the HHS Secretary from promulgating regulations **limiting access to therapies** and healthcare services based on a variety of factors
- **Sec. 2706:** Prohibits plans from discriminating against **health care providers** by denying them participation in a plan if the providers act within the scope of their professional license and applicable State laws; but this provision does *not* require a group health plan or health insurance issuer to contract with “**any willing provider**,” even if the provider agrees to abide by the terms and conditions for participation established by the plan or issuer
- **Sec. 1557:** Protects individuals against **discrimination** under the Civil Rights Act, the Education Amendments Act, the **Age Discrimination Act**, and the **Rehabilitation Act**, through exclusion from participation in or denial of benefits under any health program or activities

Essential Benefits Package and State Exchanges

- **Sec. 2707:** Requires insurers in small group and individual markets to offer coverage that includes the **essential health benefits package**; if a state permits large employers to enter an exchange, then plans must offer the benefits to those employers
- **Sec. 1302:** Defines **essential health benefits package** for exchanges to:
 - include key categories of essential health services, including rehabilitative and habilitative services and devices, vision and oral pediatric services, mental health services and chronic disease management services;
 - allow states to add on benefits at their own cost;
 - require the Secretary to define the package so that benefits are not unduly weighted towards one category; benefits are not designed in ways that discriminate against individuals because of age, disability or expected length of life; and the health care needs of diverse segments of the population are accounted for and that essential benefits are not denied due to an individual’s health status;
 - prohibit **out-of-pocket limits** in all markets that are greater than the limits for Health Savings Accounts; prohibits **deductibles** that are greater than \$2,000 for individuals and \$4,000 for families
- **Sec. 1311:** Requires states to:
 - establish **exchanges by 2014** for the individual and small group markets;
 - offer plans in the exchange with the **essential benefits package** (states must cover the cost of any additional benefits they require);
 - require exchanges to **certify and rate plans** that meet established criteria (taking into account whether a network includes a **sufficient number of providers** and the amount of premium variation among plans); and
 - ensure plans establish the same **cost sharing requirements** for essential services inside and outside of plan networks.

This section also allows voluntary and HHS approved **interstate and regional exchanges**, as well as **subsidiary exchanges**; requires HHS to issue guidelines on developing **plan payment structures** that use **payment incentives** to reward improved health outcomes, decreased hospital readmissions, the reduction of medical errors and the implementation of health and wellness promotion activities; and requires HHS to report to exchanges on the payment incentive activities of qualified health plans.

Public Plan

- **Sec. 1323:** Requires the Secretary to offer a **public plan through state exchanges**, while allowing states to **opt out** of offering the option (by passage of a state law); requires the Secretary to **negotiate provider reimbursement rates**, but they must not be higher than average rates paid by private qualified health plans; allows providers to reject the plan without penalty; allows for **national pooling** of all enrollees; creates **state advisory councils** to develop recommendations on **alternative payment policies** that promote quality and reduce costs; HHS may apply the payment recommendations from one state advisory council to the public plan in one, some or all states
- **Sec. 1324:** States may opt to offer certain **standard health plans** to eligible individuals in lieu of offering those individuals insurance through an exchange; eligible individuals would have income between 133 and 200 percent of the federal poverty level and would be ineligible for Medicaid, Medicare or an affordable employer sponsored plan

Medicaid

Eligibility and Services Updates

- **Sec 2001:** Establishes **133 percent of the federal poverty** as the new mandatory minimum Medicaid income eligibility level for all non-elderly, non-pregnant individuals not eligible for Medicare beginning in 2014; the federal government would provide significant financial assistance to states to help defray the costs of covering newly-eligible beneficiaries; **prescription drugs** and **mental health services** must be covered at actuarial equivalence
- **Sec. 2003:** Requires states in 2013 to offer premium assistance and **wrap-around benefits** to Medicaid beneficiaries who are offered insurance through an employer
- **Sec. 2302:** Allows children enrolled in Medicaid or CHIP to receive **hospice services** without foregoing curative treatment related to a terminal illness
- **Sec. 2401:** Establishes an optional Medicaid benefit for **community-based attendant services and supports** to Medicaid beneficiaries with disabilities who would otherwise require the level of care offered in a facility such as a nursing home
- **Sec. 2402:** Allows states to provide more types of **home and community based services** (HCBS) to individuals with higher levels of need, rather than through a waiver, and to extend full Medicaid benefits to individuals receiving HCBS under a State plan amendment
- **Sec. 2406:** Expresses the **Sense of the Senate** that Congress address **long-term services and supports**, guaranteeing seniors and individuals with disabilities the care they need
- **Sec. 2502:** Removes smoking cessation drugs, barbiturates, and benzodiazepines from **Medicaid's excludable drug** list in 2014
- **Sec. 2002:** Requires states to use **modified gross income** to determine **Medicaid eligibility**; income disregards and asset tests would no longer apply in Medicaid, except for long-term services and supports, and except for exempted groups including seniors or Social Security Disability Insurance (SSDI) beneficiaries, and those with disabilities

- **Sec. 4106:** Expands current Medicaid option to provide **diagnostic, screening, preventive, and rehabilitation services**; states that cover this option would receive increased Federal funding for these services

Payment Adjustments

- **Sec. 2551:** Reduces States' **disproportionate share hospital (DSH)** allotments by 50 percent once the rate of the uninsured in a State decreases by 45 percent (low DSH States would receive a 25 percent reduction); a State's DSH allotment cannot be reduced to less than 35 percent of its FY2012 allotment, adjusted for inflation
- **Sec. 2702:** Expands upon Medicare policy to prohibit Federal payments to states for Medicaid services to treat **healthcare acquired conditions**
- **Sec. 2501:** Increases the **flat rebate percentage** for outpatient brand name prescription drugs from 15.1 percent to 23.1 percent, except for certain clotting factors and outpatient drugs, for which the basic rebate would increase to 17.1 percent; total rebate liability would be limited to 100 percent of the average manufacturer price

Delivery Reform and Demonstration Programs

- **Sec. 2703:** Gives states the option of enrolling Medicaid beneficiaries with **chronic conditions** into a **health home**, which would be composed of a team of health professionals to provide a comprehensive set of medical services, including **care coordination**; during the first eight years of implementation, Federal assistance would equal 90 percent of the cost of the program; HHS would partner with an independent entity **to evaluate and assess** reductions in hospital admissions, emergency room visits and admissions to skilled nursing facilities
- **Sec. 2403:** Extends the **Money Follows the Person Rebalancing Demonstration** through 2016 and changes the eligibility rules by requiring that participating individuals reside in an inpatient facility for at least 90 consecutive days
- **Sec. 2704:** Establishes a Medicaid **bundled payment demonstration** in up to eight states that would give hospitals a single payment from Medicaid for acute care and post-acute care provided in hospitals and nonhospital settings
- **Sec. 2705:** Establishes a demonstration project that would allow participating States to change their payment structure for **safety net hospitals** from a fee-for-service model to a global capitated payment structure
- **Sec. 2706:** Establishes a demonstration allowing **pediatric providers** to be recognized and receive payments as **Accountable Care Organizations** under Medicaid
- **Sec. 2707:** Establishes a demonstration requiring participating states to reimburse **institutions for mental disease** for services provided to stabilize an **emergency psychiatric condition**
- **Sec. 2602:** Establishes a new CMS office, the Office of Coordination for **Dual Eligible Beneficiaries** (OCDEB)

Nursing Home Transparency

- **Sec. 6101:** Requires **nursing facilities** make available information on ownership

- **Sec. 6112:** Directs the Secretary to establish a demonstration project to test a national independent monitor program of interstate and intrastate chains of **nursing facilities**
- **Sec. 6114:** Requires the Secretary to conduct two facility-based demonstration projects to test best practice models in facilities that are involved in the “culture change” movement and best practices in IT that facilities are using to improve resident care
- **Sec. 6121:** Requires facilities to include **dementia management and abuse prevention** training as part of pre-employment initial training

Medicare

Payment Adjustments and Benefits Updates

- **Sec. 3101:** Replaces the scheduled 21 percent payment reduction to the **Medicare physician fee schedule** for 2010 with a 0.5 percent positive update (a permanent repeal of the Sustainable Growth Rate formula for the fee schedule is not included)
- **Sec. 3007:** Directs HHS to **adjust Medicare physician payments** based on the quality and cost of the care they deliver, to be phased in over a 2-year period beginning in 2015
- **Sec. 5501:** **Provides primary care practitioners** with a **10 percent payment bonus** for five years; **Half of the cost of the bonuses** would be offset through an across-the-board reduction in all other services
- **Sec. 3008:** Requires Medicare to **adjust hospital payments** so that hospitals in the top 25th percentile of rates for certain **hospital acquired conditions** would be subject to a payment penalty; requires HHS to submit a report to Congress in 2012 on establishing a similar policy for other Medicare providers
- **Sec. 3025:** Requires the **adjustment of hospital payments** based on the dollar value of each hospital’s percentage of potentially **preventable Medicare readmissions**
- **Sec. 3131:** Directs the Secretary to rebase **home health payments** based on an analysis of the current mix of services and intensity of care provided to home health patients; Establishes a 10 percent cap on the amount of reimbursement a home health provider can receive from outlier payments
- **Sec. 3132:** Requires the Secretary to update **Medicare hospice claims forms and cost reports** by 2011 and implement **changes to the hospice payment system** in 2013
- **Sec. 3133:** Effective in 2015, reduces base **Disproportionate Share Hospital** payments to 25% of the amount that would otherwise be paid; the other 75% would be reduced by the percentage decrease in the uninsured, and allocated based on each hospital’s uncompensated care costs compared to the uncompensated care costs for all other DSH hospitals
- **Sec. 3134:** Directs the Secretary to regularly review **fee schedule rates** for physician services; strengthens the Secretary’s authority to adjust fees schedule rates that are found to be “mis-valued” or inaccurate
- **Sec. 3135:** Increases the practice expense units for **imaging services** to 65 percent for 2010 through 2012, 70 percent in 2013, and 75 percent thereafter; excludes low-tech imaging such as ultrasound, x-rays and EKGs from this adjustment; adjusts the technical component discount on single session imaging studies on contiguous body parts from 25 percent to 50 percent

- **Sec. 3136:** Eliminates the option for Medicare beneficiaries to purchase **power-driven wheelchairs** with a lump-sum payment at the time the chair is supplied; **complex rehabilitative power wheelchairs** would be exempt from this new policy
- **Sec. 3401:** Incorporates a **productivity adjustment** into the market basket update for **inpatient hospitals, home health providers, nursing homes, hospice providers, inpatient psychiatric facilities, skilled nursing facilities, long-term care hospitals and inpatient rehabilitation facilities, durable medical equipment, prosthetics, orthotics and supplies providers, laboratory services, ambulance and ambulatory surgical center services**; implements additional market basket reductions for certain providers:
 - Home Health: 1% off market basket in 2011 and 2012;
 - Laboratory Services: 1.75% from 2011-2015
 - Hospice: 0.5% in 2013 – 2019*
 - Hospitals (in/out patient, IPF, IRF, LTCH): 2010 & 2011 – 0.25%; 2012 – 2019 – 0.2%*

* = Out-year gains in productivity would lead to further market-basket adjustments

- **Sec. 3137:** Extends **section 508 reclassifications** to September 30, 2010; requires the Secretary to provide recommendations to Congress on ways to comprehensively reform the **Medicare wage index system**; directs the Secretary to restore the reclassification thresholds used to determine **hospital reclassifications** to the percentages used in FY2009
- **Sec. 3141:** Requires application of budget neutrality associated with the effect of the imputed rural and rural floor to be applied on a national basis, rather than a state-wide basis, to the area **hospital wage index**, starting in October 2010
- **Sec. 3103:** Extends by one year the **exceptions process** to limitations on **medically necessary rehabilitation therapy services (i.e., the therapy caps)**
- **Sec. 3107:** Increases the **payment rate for psychiatric services** by 5 percent for two years
- **Sec. 3139:** Sets the add-on payment rate for **biosimilar products** reimbursement under Medicare Part B at 6 percent of the average sales price of the brand biological product
- **Sec. 3315:** Increases the initial coverage limit in the standard **Part D benefit** by \$500 for 2010
- **Sec. 6410:** Expands the number of areas to be included in round two of the durable medical equipment **competitive bidding program** from 79 to 100 of the largest metropolitan statistical areas, and to use competitively bid prices in all areas by 2016
- **Sec. 5503:** Redistributes 65% of unused **residency slots** to primary care and general surgery programs; gives preference for the redistributed slots to hospitals located in states with a low resident-to-population ratio, states with a high percent of the population living in health professional shortage areas, and rural states
- **Sec. 5504:** Allows time spent by the resident in non-provider settings to be counted toward **DGME and IME** if the hospital incurs the costs of the stipends and fringe benefits; if more than one hospital incurs these costs, such hospitals shall count a proportional share of the time, as determined by a written agreement between the hospitals, that a resident spends training in that setting
- **Sec. 5505:** Allows hospitals to count **resident time** spent in non-patient care activities, such as didactic conferences (except for research unassociated with the treatment or diagnosis of a particular patient), in provider settings in calculating the IME adjustment

(effective for cost periods on or after 10/1/01) and in non-provider settings in calculating the DGME payment (effective for cost periods on or after 7/1/09); clarifies that sick leave and vacation can be counted for **IME and GME**

- **Sec. 5506:** Allows for the **redistribution of resident slots** from closed hospitals, with preference for the redistribution given to hospitals in proximity to the closed hospital

Advisory Boards, Delivery Reform, Quality Reporting and Demonstrations

- **Sec. 3403:** Creates the **Medicare Advisory Board** (“Super MedPAC”) to recommend cost cutting proposals to Congress; in years when Medicare costs are projected to be unsustainable, the Board’s proposals would take effect unless Congress passed an alternative measure that achieves the same level of savings
- **Sec. 3023:** Directs the Secretary to develop a **national, voluntary bundled payment pilot** for hospitals, doctors, and post-acute care providers; requires the Secretary to submit a plan by 2016 on expansion of the program
- **Sec. 3026:** Provides funding to hospitals and community-based entities that furnish evidence-based **care transition services** to Medicare beneficiaries at high risk for readmission
- **Sec. 3001:** Establishes a **hospital value-based purchasing program** starting in 2012 and ties incentive payments to outcomes on common high-cost conditions
- **Sec. 3006:** Directs the Secretary to submit a plan to Congress in 2012 on **value-based purchasing** payment systems for **skilled nursing facilities** and **home health agencies**
- **Sec. 3002:** Extends through 2014 incentive payments under the **Physician Quality Reporting System**; in subsequent years, physicians who do not submit measures will have their Medicare payments reduced; creates informal appeals and feedback processes; requires integration of **PQRI and electronic health record (EHR) reporting** by 2012
- **Sec. 3004:** Requires participation in **new quality measure reporting program** for **long-term care hospitals, inpatient rehabilitation facilities, and hospice providers**, or providers face a reduction in their annual market basket update
- **Sec. 3011:** Establishes a **national strategy** to improve the delivery of health care services, patient health outcomes, and population health
- **Sec. 3013:** Authorizes \$75 million over 5 years for the **development of quality measures** at AHRQ and CMS for conditions without same
- **Sec. 3015:** Allows HHS to **award grants** for the collection of **quality and resource use data** to implement the public reporting of performance information
- **Sec. 3021:** Establishes the **Center for Medicare & Medicaid Innovation** to test and develop payment and delivery arrangements to improve the quality and reduce the cost of care; identifies for testing a model designed to improve post-acute care through **continuing care hospitals** that offer inpatient rehabilitation, long-term care hospitals, and home health or skilled nursing care during an inpatient stay and the 30 days immediately following discharge
- **Sec. 3022:** Rewards **Accountable Care Organizations** that meet **quality-of-care targets and reduce costs** with a share of the savings they achieve for the Medicare program
- **Sec. 3024:** Creates a new demonstration program for beneficiaries with **multiple chronic conditions** to test a **payment and delivery system** that rewards “**independence at home**”

medical practices” for improving health outcomes and meeting spending targets; requires minimum savings of 5% annually and provides for sharing of savings with providers beyond 5%.

- **Sec. 3140:** Directs the Secretary to establish a demonstration program allowing patients eligible for **hospice care** to simultaneously receive all other Medicare covered services
- **Sec. 3027:** Extends the DRA authorized **gain-sharing demonstration** through mid-2011
- **Sec. 3113:** Creates a demonstration program to test the impact of direct payments for certain complex **laboratory tests** on Medicare quality and costs.

Medicare Advantage

- **Sec. 3201:** Sets **Medicare Advantage** payment based on the average of the bids from Medicare Advantage plans in each market
- **Sec. 3202:** Prohibits **Medicare Advantage** plans from charging beneficiaries more than what is charged under the traditional fee-for-service program
- **Sec. 3209:** Authorizes HHS Secretary to deny bids submitted by **Medicare Advantage** and prescription plans, beginning in 2011, that propose to significantly increase beneficiary cost sharing or decrease benefits offered under the plan

Wellness and Prevention under Medicare

- **Sec. 4103:** Provides coverage with no co-payment or deductible for an **annual wellness visit** and personalized **prevention plan services**
- **Sec. 4104:** Waives **beneficiary coinsurance requirements** for most **preventive services**, including preventive services recommended with a grade of A or B by the U.S. Preventive Services Task Force
- **Sec. 4105:** Authorizes the Secretary to modify the coverage of any currently covered **preventive service** if the modification is consistent with U.S. Preventive Services Task Force recommendations and the services are not used for diagnosis or treatment

Transparency under Medicare

- **Sec. 6001:** Prohibits **physician-owned hospitals** that do not have a provider agreement prior to February 1, 2010, to participate in Medicare
- **Sec. 6003:** Requires physicians under the **in-office ancillary exception** to inform the patient in writing that the individual may obtain the specified service outside the practice
- **Sec. 6404:** Reduces the maximum period for submission of **Medicare claims** to not more than 12 months
- **Sec. 6405:** Requires **durable medical equipment or home health services** to be ordered by a Medicare eligible professional or physician enrolled in the Medicare program
- **Sec. 6411:** Requires states to establish contracts with one or more **Recovery Audit Contractors**

Individual Mandate

- **Sec. 5000A:** Requires individuals to maintain minimum essential health care coverage beginning in 2014 or face a penalty; exceptions to the mandate include religious objectors, illegal immigrants and the incarcerated; exemptions from the penalty are available based on financial hardship

Subsidies and Credits

- **Sec. 36B** Offers a **premium credit** calculated on a sliding scale starting at two percent of income for those at or above 100 percent of poverty and phasing out to 9.8 percent of income for those at 400 percent of poverty; employees offered coverage where the employer's share of the total costs is less than 60 percent or where the premium exceeds 9.8 percent of the employee's income are eligible for the premium assistance credit
- **Sec 45R:** Provides credits to small and tax exempt employers with fewer than 25 full time equivalent employees and average annual wages of less than \$40,000; requires HHS Secretary to issue regulations on employees' hours of service, including employees who work salary and not hourly

Employer Sponsored Plans

- **Sec. 1513:** Requires an **employer to pay a fee** if the employer has more than **50 full-time employees** and fails to offer coverage, and has at least one full-time employee receiving the premium credit through an exchange; Employers with more than 50 full time employees that require a **waiting period** will be charged fees based on the length of the wait (This policy is in contrast to the House bill's employer mandate)
- **Sec. 125(f)(3):** Allows large employers in 2017 in electing states to offer plans provided through the exchange as an eligible benefit under an employer-sponsored cafeteria plan
- **Sec. 2716:** Employers that provide health coverage will be prohibited from limiting eligibility for coverage based on the wages or salaries of full-time employees
- **Sec 45R:** Provides credits to small employers with fewer than 25 full time employees and average annual wages of less than \$40,000; requires HHS Secretary to issue regulations on employees' hours of service, including employees who work on salary and not hourly

Insurer fees and reporting responsibilities

- **Sec. 2718:** Requires insurers to **refund each enrollee for non-claims costs** that exceed 20 percent in the group market and 25 percent in the individual market
- **Sec. 2719:** Requires insurers to implement an **appeals process for coverage and claims determinations**
- **Sec. 2717:** Requires Secretary to promulgate regulations for health insurer reporting requirements on coverage benefits and reimbursement structures that improve health outcomes, prevent hospital readmissions, emphasize best practices and implement wellness activities
- **Sec. 2718:** Health insurance companies will be required to report the percentage of premiums spent on clinical services, quality and all other non-claims costs

Public Health and Prevention

- **Sec. 5605:** Establishes a Commission to conduct a comprehensive oversight of a newly established **key national indicators system**, with a required annual report to Congress
- **Sec. 4001:** Creates an interagency council to establish a **national prevention and health promotion strategy** and develop interagency relationships to implement the strategy
- **Sec. 4002:** Establishes a **Prevention and Public Health Investment Fund**
- **Sec. 4004:** Directs the Secretary to convene a national public/private partnership to conduct a national prevention and health promotion **outreach and education campaign**
- **Sec. 4302:** Ensures that any ongoing or new Federal health program collect data on **health disparities**, including by race, ethnicity, sex, primary language, and **disability status**
- **Sec. 4303:** Requires the CDC to study **employer-based wellness practices** and provide an educational campaign and technical assistance to worksite health promotion to employers
- **Sec. 4305:** Authorizes an IOM Conference on Pain Care to evaluate the adequacy of **pain assessment, treatment, and management**; authorizes the Pain Consortium at NIH to enhance and coordinate clinical research on pain causes and treatments; establishes a grant program to improve the assessment and treatment of pain
- **Sec. 4401:** Expresses the sense of the Senate that Congress and the CBO should develop better methodologies for **scoring prevention and wellness programs** given that results may occur outside the 5 and 10 year budget windows

Workforce and Education

*Primary Care Workforce and Education**

- **Sec. 5103:** Codifies National Center for Health Care Workforce Analysis and establishes several regional centers to report data on the **primary care workforce**
- **Sec. 5405:** Creates a **Primary Care Extension Program** to educate primary care providers about evidence-based therapies, preventive medicine, health promotion, chronic disease management, and mental health
- **Sec. 5508:** Directs the Secretary to establish a grant program, and provides additional funding under the PHSA, to support new or expanded **primary care residency programs**
- **Sec. 5201:** Eases current criteria to make the **primary care student loan program** more attractive to medical students
- **Sec. 5101:** Establishes a **national commission** tasked with reviewing health care workforce and projected workforce needs

** Also see IME and GME provisions under Medicare payment adjustments*

Nurse Education

- **Sec. 5208:** Creates a \$50 million grant program administered by HRSA to support **nurse-managed health clinics**
- **Sec. 5202:** Increases loan amounts and updates the years for **nursing schools** to establish and maintain student loan funds
- **Sec. 5309:** Awards grants to **nursing schools** for nurse education and training programs
- **Sec. 5310:** Allows **faculty at nursing schools** to be eligible for loan repayment and scholarship programs
- **Sec. 5203:** Establishes a loan repayment program for certain **pediatric subspecialists** and providers of **mental and behavioral health services** to children and adolescents
- **Sec. 5509:** Directs the Secretary to establish a demonstration program to increase graduate **nurse education training** under Medicare

Direct Care and Geriatric Workforce and Education

- **Sec. 5302:** Authorizes funding to establish **new training opportunities** for **direct care workers** providing **long-term care services and supports**
- **Sec. 5305:** Authorizes funding to **geriatric education centers** for training in **geriatrics, chronic care management, and long-term care** for **faculty in health professions schools and family caregivers**; develop **curricula and best practices in geriatrics**; establishes traineeships for individuals preparing for advanced education degrees in **geriatric nursing**

Mental Health

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

Fraud and Abuse

- **Sec. 6002:** Requires drug, device, biological and medical supply manufacturers to **report transfers of value** made to a physician, physician medical practice, a physician group practice, and/or a teaching hospital
- **Sec. 6201:** Requires the Secretary to establish a **nationwide program** for national and state background checks on **direct patient access employees** of certain long-term supports and services facilities or providers
- **Sec. 6401:** Requires that the Secretary and OIG establish procedures for **screening providers and suppliers** participating in Medicare, Medicaid, and CHIP; new providers and suppliers 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; certain providers and suppliers would be required to establish **compliance programs**

- **Sec. 6402:** Requires CMS to include in the integrated data repository **claims and payment data** from Medicare, Medicaid, CHIP, health-related programs administered by the Departments of Veterans Affairs and Defense, and the Social Security Administration; requires that **overpayments** be reported and returned within 60 days from the date the overpayment was identified; requires the Secretary to issue a regulation mandating that all Medicare, Medicaid, and CHIP providers include their **National Provider Identifier** on enrollment applications; expands the use of **Civil Monetary Penalties** to certain excluded individuals; authorizes the Secretary to **suspend payments** to a provider or supplier pending a fraud investigation
- **Sec. 6703:** Requires HHS to **award grants** for the provision of greater protection to those individuals seeking care in facilities that provide **long-term services and supports**

Health Information Technology

- **Sec. 1104:** Accelerates HHS adoption of uniform standards and operating rules for the **electronic transactions** that occur between providers and health plans, such as benefit eligibility verification, prior authorization and electronic funds transfer payments, with most new operating rules becoming effective in 2013 and 2014
- **Sec. 1561:** Requires the development of standards and **protocols on interoperability** of systems for enrollment of individuals in health and human services programs; allows for electronic data matching, and electronic documentation; Secretary may require states or other entities to incorporate standards as a condition of receiving Federal HIT funds

Comparative Effectiveness and Research

- **Sec. 6301:** Establishes a private, nonprofit entity to identify priorities for and provide for the conduct of **comparative outcomes research**; requires the Institute to ensure that subpopulations are appropriately accounted for in research designs; prohibits any findings to be construed as mandates on practice guidelines or coverage decisions and contains **patient safeguards** to protect against discriminatory coverage decisions by HHS based on age, **disability**, terminal illness, or an individual's quality of life preference
- **Sec. 933:** Builds on the Center for Quality Improvement and Patient Safety ability to provide grants to identify, develop, evaluate, disseminate, and provide training in innovative methodologies and strategies for **quality improvement practices** in the delivery of health care services

Medical Malpractice

- **Sec. 6801:** Expresses the Sense of the Senate that health reform presents an opportunity to address **medical malpractice** and medical liability insurance

SCHIP

- **Sec. 2101:** Requires states to **maintain income eligibility levels** for CHIP through September 30, 2019; between 2014 and 2019, states would receive a 23 percentage point increase in the CHIP match rate, subject to a cap of 100 percent

Revenue to Help Pay for Reform

- **Sec. 9001:** Levies an **excise tax of 40 percent** on the “excess amount” of high cost insurance plans above the threshold of \$8,500 for single coverage and \$23,000 for family coverage
- **Sec. 9008:** Imposes an annual fee of \$2.3 billion on the pharmaceutical manufacturing sector
- **Sec. 9009:** Imposes an annual fee of \$2 billion on the medical device manufacturing sector
- **Sec. 9010:** Imposes an annual fee of \$6.7 billion on the health insurance sector
- **Sec. 9015:** Increases the hospital insurance (Medicare) tax rate by 0.5 percentage points on an individual earning over \$200,000 (\$250,000 for married couples filing jointly)

Other

- **Sec. 7101:** Extends the **340B discounts** to inpatient drugs and also extends participation to certain children’s hospitals, cancer hospitals, critical access and sole community hospitals, and rural referral centers
- **Sec. 7103:** Requires the GAO to make recommendations to Congress on the **340B program**
- **Sec. 8002:** Establishes a new, voluntary, self-funded public **long-term care insurance program** (known as the “CLASS Act”) for the purchase of community living assistance services and supports by individuals with functional limitations
- **Sec. 9023:** Creates a two-year temporary tax credit to encourage investments in **new therapies to prevent, diagnose, and treat acute and chronic diseases**