



Detailed Summary

The *Patient Protection and Affordable Care Act* and the *Health Care and Education Reconciliation Act*, together referred to as the *Affordable Care Act*, ensure that all Americans have access to quality, affordable health care and create the transformation within the health care system necessary to contain costs. The Congressional Budget Office (CBO) has determined that the two bills are fully paid for, ensure that more than 94 percent of Americans have access to quality, affordable health insurance, bend the health care cost curve, and reduce the deficit by \$143 billion over the next ten years and even more in the following decade.

The *Affordable Care Act* addresses essential components of reform:

- Quality, affordable health care for all Americans
- The role of public programs
- Improving the quality and efficiency of health care
- Preventing chronic disease and improving public health
- Health care workforce
- Transparency and program integrity
- Improving access to innovative medical therapies
- Community living assistance services and supports
- Revenue provisions

Title I. Quality, Affordable Health Care for All Americans

The *Affordable Care Act* accomplishes a fundamental transformation of health insurance in the United States through shared responsibility. Systemic insurance market reform will eliminate discriminatory practices by health insurers such as pre-existing condition exclusions. Achieving these reforms without increasing health insurance premiums will mean that all Americans must have coverage. Tax credits for individuals, families, and small businesses will ensure that insurance is affordable for everyone. These three elements are the essential links to achieving meaningful reform.

Immediate Improvements. Implementing health insurance reform will take some time. However, many immediate reforms will take effect in the first year following enactment. The *Affordable Care Act*:

- Eliminates lifetime and unreasonable annual limits on benefits, with annual limits prohibited in 2014
- Prohibits rescissions of health insurance policies
- Provides assistance for those who are uninsured because of a pre-existing condition
- Prohibits pre-existing condition exclusions for children
- Requires coverage of preventive services and immunizations
- Extends dependant coverage up to age 26
- Develops uniform coverage documents so consumers can make apples-to-apples comparisons when shopping for health insurance

- Caps insurance company non-medical, administrative expenditures
- Ensures consumers have access to an effective appeals process and provide consumers a place to turn for assistance navigating the appeals process and accessing their coverage
- Creates a temporary re-insurance program to support coverage for early retirees
- Establishes an internet portal to assist Americans in identifying coverage options
- Facilitates administrative simplification to lower health system costs

Health Insurance Market Reforms. Beginning in 2014, additional insurance reforms will be implemented. Across individual and small group health insurance markets in all states, new rules will end medical underwriting and pre-existing condition exclusions. Insurers will be prohibited from denying coverage or setting rates based on gender, health status, medical condition, claims experience, genetic information, evidence of domestic violence, or other health-related factors. Premiums will vary only by family structure, geography, actuarial value, tobacco use, participation in a health promotion program, and age (by a ratio of not more than three to one).

Available Coverage. A qualified health plan, to be offered through the new American Health Benefit Exchange, must provide essential health benefits which include cost sharing limits. Out-of-pocket requirements may not exceed those in Health Savings Accounts, and deductibles in the small group market cannot exceed \$2,000 for an individual and \$4,000 for a family. Coverage will be offered at four levels with actuarial values defining how much the insurer pays: Platinum – 90 percent; Gold – 80 percent; Silver – 70 percent; and Bronze – 60 percent. A less costly catastrophic-only plan will be offered to individuals under age 30 and to others who are exempt from the individual responsibility requirement.

American Health Benefit Exchanges. By 2014, each state will establish an Exchange to help individuals and small employers obtain coverage. Plans participating in the Exchanges will be accredited for quality, will present their benefit options in a standardized manner for easy comparison, and will use one, simple enrollment form. Individuals qualified to receive tax credits for Exchange coverage must be ineligible for affordable, employer-sponsored insurance or any form of public insurance coverage. Undocumented immigrants are ineligible for premium tax credits. Federal support will be available for new non-profit, member run insurance cooperatives, and the Office of Personnel Management will supervise the offering by private insurers of multi-State plans, available nationwide. States will have flexibility to establish basic health plans for non-Medicaid eligible, lower-income individuals; states may also seek waivers to explore other reform options; and states may form compacts with other states to permit cross-state sale of health insurance. No federal dollars may be used to pay for abortion services.

Making Coverage Affordable. New, refundable tax credits will be available for Americans with incomes up to 400 percent of the federal poverty line (FPL) (about \$88,000 for a family of four this year). The credit amount is equal to the cost of the health insurance plan that exceeds a specified percentage of income, based on poverty level. The income percentage is two percent for those with income up to 133 percent FPL and calculated on a sliding scale starting at three percent of income for those at or above 133 percent of FPL and phasing out at 9.5 percent of income at 300-400 percent FPL. If an employer offer of coverage exceeds 9.5 percent of a worker's family income, or the employer pays less than 60 percent of the premium, the worker may enroll in the Exchange and receive credits. Out-of-pocket maximums (\$5,950 for individuals and \$11,900 for families) are reduced to one-third for those with income between 100-200 percent FPL, one-half for those with

incomes between 200-300 percent FPL, and two-thirds for those with income between 300-400 percent FPL. Credits are available for eligible citizens and legally-residing aliens. A new credit will assist small businesses with fewer than 25 workers for up to 50 percent of the total premium cost.

Shared Responsibility. Beginning in 2014, most individuals will be responsible for maintaining minimum essential coverage or paying a penalty of \$95 or one percent of income in 2014, \$325 or two percent of income in 2015 and \$695 or 2.5 percent of income in 2016, with a cap at the national average bronze plan premium. Families will pay half the amount for children up to a cap of \$2,250 for the entire family. After 2016, dollar amounts will increase by the annual cost of living adjustment. Exceptions to this requirement are made for religious objectors, individuals not lawfully present, and incarcerated individuals. Exemptions from the penalty are made for those who cannot afford coverage, taxpayers with income below the filing threshold, Indian tribe members, those who receive a hardship waiver, and those not covered for less than three months.

Any individual or family who currently has coverage and would like to retain that coverage can do so under a ‘grandfather’ provision. This coverage is deemed to meet the individual responsibility to have health coverage. Similarly, employers that currently offer coverage are permitted to continue offering such coverage under the ‘grandfather’ policy.

Employers with more than 200 employees must automatically enroll new full-time employees in coverage. Any employer with 50 or more full-time employees that does not offer coverage and has at least one full-time employee receiving the premium assistance tax credit will make a payment of \$2,000 per full-time employee (not including the first 30 workers). An employer with 50 or more employees that offers coverage that is deemed unaffordable or does not meet the standard for minimum essential coverage and but has at least one full-time employee receiving the premium assistance tax credit because the coverage is either unaffordable or does not cover 60 percent of total costs, will pay the lesser of \$3,000 for each of those employees receiving a credit up to a cap of \$2,000 for each of their full-time employees total (not including the first 30 workers).

Title II. The Role of Public Programs

The *Affordable Care Act* expands eligibility for Medicaid to lower income persons and assumes federal responsibility for much of the cost of this expansion. The law provides enhanced federal support for the Children’s Health Insurance Program, simplifies Medicaid and CHIP enrollment, improves Medicaid services, provides new options for long-term services and supports, improves coordination for dual-eligibles, and improves Medicaid quality for patients and providers.

Medicaid Expansion. States may expand Medicaid eligibility as early as April 1, 2010. Beginning on January 1, 2014, all children, parents and childless adults who are not entitled to Medicare and who have family incomes up to 133 percent FPL will become eligible for Medicaid. Between 2014 and 2016, the federal government will pay 100 percent of the cost of covering newly-eligible individuals. After that, Federal assistance will continue at the following rates: 95 percent in 2017, 94 percent in 2018, 93 percent in 2019, and 90 percent thereafter. In the case of expansion states, additional federal support for covering nonpregnant, childless adults is phased-in so that in 2019 and thereafter, expansion states would receive the same Federal medical assistance percentage (FMAP) as other states for newly-eligible and previously-eligible nonpregnant, childless adults. States will be required to maintain the same income eligibility levels through December 31, 2013

for all adults, and this requirement is extended through September 30, 2019 for children currently in Medicaid.

Children’s Health Insurance Program. States will be required to maintain income eligibility levels for CHIP through September 30, 2019. The current reauthorization period of CHIP is extended for two years, to September 30, 2015. Between fiscal years 2016 and 2019, states will receive a 23 percentage point increase in the CHIP federal match rate, subject to a 100 percent cap.

Simplifying Enrollment. Individuals will be able to apply for and enroll in Medicaid, CHIP, and the Exchange through state-run websites. Medicaid and CHIP programs and the Exchange will coordinate enrollment procedures to provide seamless enrollment for all programs. Hospitals will be permitted to provide Medicaid services during a period of presumptive eligibility to members of all Medicaid eligibility categories.

Community First Choice Option. A new optional Medicaid benefit is created through which states may offer community-based attendant services and supports to Medicaid beneficiaries with disabilities who would otherwise require care in a hospital, nursing facility, or intermediate care facility for the mentally retarded.

Disproportionate Share Hospital Allotments. The Secretary of HHS will establish a procedure to reduce states’ disproportionate share hospital (DSH) allotments by \$14.1 billion, beginning in 2014. The Secretary will take into account states that have diverted all or portions of their DSH allotments to coverage and low-DSH states in such procedure.

Dual Eligible Coverage and Payment Coordination. The Secretary of HHS will establish a Federal Coordinated Health Care Office by March 1, 2010 to integrate care under Medicare and Medicaid, and improve coordination among the federal and state governments for individuals enrolled in both programs (dual-eligibles).

Title III. Improving the Quality and Efficiency of Health Care

The *Affordable Care Act* will improve the quality and efficiency of U.S. medical care services for everyone, and especially for those enrolled in Medicare and Medicaid. Payment for services will be linked to better quality outcomes and substantial investments will improve the quality and delivery of care and support research to inform consumers about patient outcomes resulting from different approaches to treatment and care delivery. New patient care models will be created and disseminated, rural patients and providers will see meaningful improvements, and payment accuracy will improve. The Medicare Part D prescription drug benefit will be enhanced and the coverage gap, or donut hole, will be eliminated. An Independent Payment Advisory Board will develop recommendations to ensure long-term fiscal stability.

Linking Payment to Quality Outcomes in Medicare. A value-based purchasing program for hospitals will launch in Fiscal Year (FY) 2013 to link Medicare payments to quality performance on common, high-cost conditions. The Physician Quality Reporting Initiative (PQRI) is extended through 2014, with incentives for physicians to report Medicare quality data – physicians will receive feedback reports beginning in 2012. Long-term care hospitals, inpatient rehabilitation facilities, certain cancer hospitals, and hospice providers will participate quality measure reporting starting in FY2014, with penalties for non-participating providers.

Strengthening the Quality Infrastructure. The Secretary of HHS will establish a national strategy to improve health care service delivery, patient outcomes, and population health. The President will convene an Interagency Working Group on Health Care Quality to collaborate on the development and dissemination of quality initiatives consistent with the national strategy.

Encouraging Development of New Patient Care Models. A new Center for Medicare & Medicaid Innovation will research, develop, test, and expand innovative payment and delivery arrangements. Accountable Care Organizations (ACOs) that take responsibility for cost and quality of care will receive a share of savings they achieve for Medicare. The Secretary of HHS will develop a national, voluntary pilot program encouraging hospitals, doctors, and post-acute providers to improve patient care and achieve savings through bundled payments. A new demonstration program for chronically ill Medicare beneficiaries will test payment incentives and service delivery using physician and nurse practitioner-directed home-based primary care teams. Beginning in 2012, hospital payments will be adjusted based on the dollar value of each hospital's percentage of potentially preventable Medicare readmissions.

Ensuring Beneficiary Access to Physician Care and Other Services. The Act extends a floor on geographic adjustments to the Medicare fee schedule to increase provider fees in rural areas and gives immediate relief to areas affected by geographic adjustment for practice expenses. The Act extends Medicare bonus payments for ground and air ambulance services in rural and other areas. The Act creates a 12 month enrollment period for military retirees, spouses (and widows/widowers) and dependent children, who are eligible for TRICARE and entitled to Medicare Part A based on disability or ESRD, who have declined Part B.

Rural Protections. The Act extends the outpatient hold harmless provision, allowing small rural hospitals and Sole Community Hospitals to receive this adjustment through FY2010 and reinstates cost reimbursement for lab services provided by small rural hospitals from July 1, 2010 to July 1, 2011. The Act extends the Rural Community Hospital Demonstration Program for five years and expands eligible sites to additional states and hospitals.

Improving Payment Accuracy. The Secretary of HHS will rebase home health payments starting in 2014 to better reflect the mix of services and intensity of care provided to patients. The Secretary will update Medicare hospice claims forms and cost reports to improve payment accuracy and revise the underlying payment system to better reflect the cost of providing care to hospice patients. The Secretary will revise Disproportionate Share Hospital (DSH) payments to better account for hospitals' costs of treating the uninsured and underinsured, including adjustments to DSH payments to reflect lower uncompensated care costs resulting from increases in the number of insured patients. The Act also makes changes to improve payment accuracy for imaging services and power-driven wheelchairs. The Secretary will study and report to Congress on reforming the Medicare hospital wage index system and will establish a demonstration program to allow hospice-eligible patients to receive all other Medicare covered services during the same period.

Medicare Advantage (Part C). Medicare Advantage (MA) benchmark payments for 2011 will be frozen at 2010 levels. Beginning in 2012, benchmarks will vary from 95 percent of Medicare spending in high-cost areas to 115 percent of Medicare spending in low-cost areas, with benchmarks increased by five percentage points in all areas for high-quality plans. Changes will be

phased in over three, five, or seven years, dependent on the level of payment reductions. Medicare Advantage plans will be prohibited from charging beneficiaries cost sharing for covered services greater than what is charged under fee-for-service. Plans providing extra benefits must give priority to cost sharing reductions, wellness and preventive care prior to covering benefits not currently covered by Medicare. The Act also extends CMS authority to adjust risk scored in Medicare Advantage for observed differences in coding patterns relative to fee-for-service and phases up that adjustment beginning in 2014. Beginning in 2014, Medicare Advantage plans will be required to spend at least 85 percent of revenue on medical costs or activities that improve quality of care, rather than profit and overhead.

Medicare Prescription Drug Plan Improvements (Part D). Medicare Part D enrollees who do not receive Medicare Extra Help, also called the Low-Income Subsidy (LIS), will receive a \$250 rebate when they enter the donut hole in 2010. Beginning in 2011, pharmaceutical manufacturers will provide beneficiaries a 50 percent discount on brand-name drugs and biologics purchased in the donut hole. In addition, beneficiary cost-sharing for all drugs purchased in the coverage gap will gradually decrease until 2020, when the donut hole will be completely filled.

Ensuring Medicare Sustainability. A productivity adjustment will be added to the market basket update for inpatient hospitals, home health providers, nursing homes, hospice providers, inpatient psychiatric facilities, long-term care hospitals and inpatient rehabilitation facilities. The Act creates a 15-member Independent Payment Advisory Board to present Congress with proposals to reduce costs and improve quality for beneficiaries. When Medicare costs are projected to exceed certain targets, the Board's proposals will take effect unless Congress passes an alternative measure to achieve the same level of savings. The Board will not make proposals that ration care, raise taxes or beneficiary premiums, or change Medicare benefit, eligibility, or cost-sharing standards.

Health Care Quality Improvements. The Act will create a new program to develop community health teams supporting medical homes to increase access to community-based, coordinated care. It supports a health delivery system research center to conduct research on health delivery system improvement and best practices that improve the quality, safety, and efficiency of health care delivery. It also encourages the use of medication management services by local health providers to help patients better manage chronic disease.

Title IV. Prevention of Chronic Disease and Improving Public Health

To better orient the nation's health care system toward health promotion and disease prevention, a set of initiatives will provide the impetus and the infrastructure. A new interagency prevention council will be supported by a new Prevention and Public Health Investment Fund. Barriers to accessing clinical preventive services will be removed. Developing healthy communities will be a priority, and a 21st century public health infrastructure will support this goal.

Modernizing Disease Prevention and Public Health Systems. A new interagency council is created to promote healthy policies and to establish a national prevention and health promotion strategy. A Prevention and Public Health Investment Fund is established to provide an expanded and sustained national investment in prevention and public health. The Secretary of HHS will convene a national public/private partnership to conduct a national prevention and health promotion outreach and education campaign to raise awareness of activities to promote health and prevent disease across the lifespan.

Increasing Access to Clinical Preventive Services. The Act authorizes important new programs and benefits related to preventive care and services:

- For the operation and development of School-Based Health Clinics.
- For an oral healthcare prevention education campaign.
- To provide Medicare coverage – with no co-payments or deductibles – for an annual wellness visit and development of a personalized prevention plan.
- To waive coinsurance requirements and deductibles for most preventive services, so that Medicare will cover 100 percent of the costs.
- To provide States with an enhanced match if the State Medicaid program covers: (1) any clinical preventive service recommended with a grade of A or B by the U.S. Preventive Services Task Force and (2) adult immunizations recommended by the Advisory Committee on Immunization Practices without cost sharing.
- To require Medicaid coverage for counseling and pharmacotherapy to pregnant women for cessation of tobacco use.
- To award grants to states to provide incentives for Medicaid beneficiaries to participate in programs providing incentives for healthy lifestyles.

Creating Healthier Communities. The Secretary will award grants to eligible entities to promote individual and community health and to prevent chronic disease. The CDC will provide grants to states and large local health departments to conduct pilot programs in the 55-to-64 year old population to evaluate chronic disease risk factors, conduct evidence-based public health interventions, and ensure that individuals identified with chronic disease or at-risk for chronic disease receive clinical treatment to reduce risk. The Act authorizes all states to purchase adult vaccines under CDC contracts. Restaurants which are part of a chain with 20 or more locations doing business under the same name must disclose calories on the menu board and in written form.

Support for Prevention and Public Health Innovation. The Secretary of HHS will provide funding for research in public health services and systems to examine best prevention practices. Federal health programs will collect and report data by race, ethnicity, primary language and any other indicator of disparity. The CDC will evaluate best employer wellness practices and provide an educational campaign and technical assistance to promote the benefits of worksite health promotion. A new CDC program will help state, local, and tribal public health agencies to improve surveillance for and responses to infectious diseases and other important conditions. An Institute of Medicine Conference on Pain Care will evaluate the adequacy of pain assessment, treatment, and management; identify and address barriers to appropriate pain care; increase awareness; and report to Congress on findings and recommendations.

Title V. Health Care Workforce

To ensure a vibrant, diverse and competent workforce, the *Affordable Care Act* will encourage innovations in health care workforce training, recruitment, and retention, and will establish a new workforce commission. Provisions will help to increase the supply of health care workers. These workers will be supported by a new workforce training and education infrastructure.

Innovations in the Health Care Workforce. The Act establishes a National Health Workforce commission to review current and projected workforce needs and to provide comprehensive information to Congress and the Administration to align federal policies with national needs. It also

establishes competitive grants to enable state partnerships to complete comprehensive workforce planning and to create health care workforce development strategies.

Increasing the Supply of Health Care Workers. The federal student loan program will be modified to ease criteria for schools and students, shorten payback periods, and to make the primary care student loan program more attractive. The Nursing Student Loan Program will be expanded and updated. A loan repayment program is established for pediatric subspecialists and providers of mental and behavioral health services to children and adolescents who work in a Health Professional Shortage Area, a Medically Underserved Area, or with a Medically Underserved Population. Loan repayment will be offered to public health students and workers in exchange for working at least three years at a federal, state, local, or tribal public health agency. Loan repayment will be offered to allied health professionals employed at public health agencies or in health care settings located in Health Professional Shortage Areas, Medically Underserved Areas, or with Medically Underserved Populations. A mandatory fund for the National Health Service Corps scholarship and loan repayment program is created. A \$50 million grant program will support nurse-managed health clinics. A Ready Reserve Corps within the Commissioned Corps is established for service in times of national emergency. Ready Reserve Corps members may be called to active duty to respond to national emergencies and public health crises and to fill critical public health positions left vacant by members of the Regular Corps who have been called to duty elsewhere.

Enhancing Health Care Workforce Education and Training. New support for workforce training programs is established in these areas:

- Family medicine, general internal medicine, general pediatrics, and physician assistantship.
- Rural physicians.
- Direct care workers providing long-term care services and supports.
- General, pediatric, and public health dentistry.
- Alternative dental health care provider.
- Geriatric education and training for faculty in health professions schools and family caregivers.
- Mental and behavioral health education and training grants to schools for the development, expansion, or enhancement of training programs in social work, graduate psychology, professional training in child and adolescent mental health, and pre-service or in-service training to paraprofessionals in child and adolescent mental health.
- Cultural competency, prevention and public health and individuals with disabilities training.
- Advanced nursing education grants for accredited Nurse Midwifery programs.
- Nurse education, practice, and retention grants to nursing schools to strengthen nurse education and training programs and to improve nurse retention.
- Nurse practitioner training program in community health centers and nurse-managed health centers.
- Nurse faculty loan program for nurses who pursue careers in nurse education.
- Community health workforce grants to promote positive health behaviors and outcomes in medically underserved areas through use of community health workers.
- Fellowship training in public health to address workforce shortages in state and local health departments in applied public health epidemiology and public health laboratory science and informatics.

- A U.S. Public Health Sciences Track to train physicians, dentists, nurses, physician assistants, mental and behavior health specialists, and public health professionals emphasizing team-based service, public health, epidemiology, and emergency preparedness and response in affiliated institutions.

Supporting the Existing Health Care Workforce. The Act reauthorizes the Centers of Excellence program for minority applicants for health professions, expands scholarships for disadvantaged students who commit to work in medically underserved areas, and authorizes funding for Area Health Education Centers (AHECs) and Programs. A Primary Care Extension Program is established to educate and provide technical assistance to primary care providers about evidence-based therapies, preventive medicine, health promotion, chronic disease management, and mental health.

Strengthening Primary Care and Other Workforce Improvements. Beginning in 2011, the Secretary of HHS may redistribute unfilled residency positions, redirecting those slots for training of primary care physicians. A demonstration grant program is established to serve low-income persons including recipients of assistance under Temporary Assistance for Needy Families (TANF) programs to develop core training competencies and certification programs for personal and home care aides. Also, a grant program is established to provide grant funding and payments to teaching health centers that are focused on training primary care providers in the community. Medicare is also directed to test new models for improving the training of advance practice nurses.

Improving Access to Health Care Services. The Act authorizes new and expanded funding for federally qualified health centers and reauthorizes a program to award grants to states and medical schools to support the improvement and expansion of emergency medical services for children needing trauma or critical care treatment. Also supported are grants for coordinated and integrated services through the co-location of primary and specialty care in community-based mental and behavioral health settings. A Commission on Key National Indicators is established.

Title VI. Transparency and Program Integrity

To ensure the integrity of federally financed and sponsored health programs, this Title creates new requirements to provide information to the public on the health system and promotes a newly invigorated set of requirements to combat fraud and abuse in public and private programs.

Physician Ownership and Other Transparency. Physician-owned hospitals that do not have a provider agreement prior to December 31, 2010 will not be able to participate in Medicare. Drug, device, biological and medical supply manufacturers must report gifts and other transfers of value made to a physician, physician medical practice, a physician group practice, and/or a teaching hospital. Referring physicians for imaging services must inform patients in writing that the individual may obtain such service from a person other than the referring physician, a physician who is a member of the same group practice, or an individual who is supervised by the physician or by another physician in the group. Prescription drug makers and distributors must report to the Secretary of HHS information pertaining to drug samples currently being collected internally. Pharmacy benefit managers (PBM) or health benefits plans that provide pharmacy benefit management services that contract with health plans under Medicare or the Exchange must report information regarding the generic dispensing rate; rebates, discounts, or price concessions negotiated by the PBM.

Nursing Home Transparency and Improvement. The Act requires that skilled nursing facilities (SNFs) under Medicare and nursing facilities (NFs) under Medicaid make available information on ownership. SNFs and NFs will be required to implement a compliance and ethics program. The Secretary of HHS will publish new information on the Nursing Home Compare Medicare website such as standardized staffing data, links to state internet websites regarding state survey and certification programs, a model standardized complaint form, a summary of complaints, and the number of instances of criminal violations by a facility or its employee. The Secretary also will develop a standardized complaint form for use by residents in filing complaints with a state survey and certification agency or a state long-term care ombudsman.

Targeting Enforcement. The Secretary may reduce civil monetary penalties for facilities that self-report and correct deficiencies. The Secretary will establish a demonstration project to test and implement a national independent monitoring program to oversee interstate and large intrastate chains. The administrator of a facility preparing to close must provide written notice to residents, legal representatives of residents, the state, the Secretary and the long-term care ombudsman program in advance of the closure.

Improving Staff Training. Facilities must include dementia management and abuse prevention training as part of pre-employment training for staff.

Nationwide Program for Background Checks on Direct Patient Access Employees of Long Term Care Facilities and Providers. The Secretary will establish a nationwide program for national and state background checks of direct patient access employees of certain long-term supports and services facilities or providers.

Patient-Centered Outcomes Research. The Act establishes a private, nonprofit entity (the Patient-Centered Outcomes Research Institute) governed by a public-private board appointed by the Comptroller General to provide for the conduct of comparative clinical outcomes research. No findings may be construed as mandates on practice guidelines or coverage decisions and important patient safeguards will protect against discriminatory coverage decisions by HHS based on age, disability, terminal illness, or an individual's quality of life preference.

Medicare, Medicaid, and CHIP Enrollment. The Secretary will establish procedures to screen providers and suppliers participating in Medicare, Medicaid, and CHIP. Providers and suppliers enrolling or re-enrolling will be subject to new requirements including a fee, disclosure of 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 is authorized to deny enrollment in these programs if these affiliations pose an undue risk.

Enhanced Medicare and Medicaid Program Integrity Provisions. CMS will include in the integrated data repository (IDR) claims and payment data from 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). New penalties will exclude individuals who order or prescribe an item or service, make false statements on applications or contracts to participate in a Federal health care program, or who know

of an overpayment and do not return the overpayment. Each violation would be subject to a fine of up to \$50,000. The Secretary may suspend payments to a provider or supplier pending a fraud investigation. Health Care Fraud and Abuse Control (HCFA) funding will be increased by \$350 million over the period of fiscal years 2011 through 2020. The requirements to meet the definition of community mental health center will be tightened to prevent deceitful providers from billing as such. The Secretary will establish a national health care fraud and abuse data collection program for reporting adverse actions taken against health care providers, suppliers, and practitioners, and submit information on the actions to the National Practitioner Data Bank (NPDB). The Secretary will have the authority to disenroll a Medicare-enrolled physician or supplier who fails to maintain and provide access to written orders or requests for payment for durable medical equipment (DME), certification for home health services, or referrals for other items and services. The Secretary will also have the authority to withhold payment from new providers and suppliers of DME during their first 90 days in the program if fraudulent activity is suspected. The Secretary will also have expanded authority to use Medicare prepayment medical review. The Secretary of HHS will expand the number of areas to be included in round two of the DME competitive bidding program from 79 of the largest metropolitan statistical areas (MSAs) to 100 of the largest MSAs, and to use competitively bid prices in all areas by 2016.

Additional Medicaid Program Integrity Provisions. States must terminate individuals or entities from their Medicaid programs if the individuals or entities were terminated from Medicare or another state's Medicaid program. Medicaid agencies must 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; (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. Agents, clearinghouses, or other payees that submit claims on behalf of health care providers must register with the state and the Secretary. States and Medicaid managed care entities must submit data elements for program integrity, oversight, and administration. States must not make any payments for items or services to any financial institution or entity located outside of the United States.

Additional Program Integrity Provisions. Employees and agents of multiple employer welfare arrangements (MEWAs) will be subject to criminal penalties if they provide false statements in marketing materials regarding a plan's financial solvency, benefits, or regulatory status. A model uniform reporting form will be developed by the National Association of Insurance Commissioners, under the direction of the Secretary of HHS. The Department of Labor will adopt regulatory standards and/or issue orders to prevent fraudulent MEWAs from escaping liability for their actions under state law by claiming that state law enforcement is preempted by federal law. The Department of Labor is authorized to issue "cease and desist" orders to temporarily shut down operations of plans conducting fraudulent activities or posing a serious threat to the public, until hearings can be completed. MEWAs will be required to file their federal registration forms, and thereby be subject to government verification of their legitimacy, before enrolling anyone.

Elder Justice Act. The Elder Justice Act will help prevent and eliminate elder abuse, neglect, and exploitation. The Secretary of HHS will award grants and carry out activities to protect individuals seeking care in facilities that provide long-term services and supports and provide greater incentives for individuals to train and seek employment at such facilities. Owners, operators, and employees will be required to report suspected crimes committed at a facility. Owners or operators of such

facilities will be required to submit to the Secretary and to the state written notification of an impending closure of a facility within 60 days prior to the closure.

Sense of the Senate Regarding Medical Malpractice. The Act expresses the sense of the Senate that health reform presents an opportunity to address issues related to medical malpractice and medical liability insurance, states should be encouraged to develop and test alternative models to the existing civil litigation system, and Congress should consider state demonstration projects to evaluate such alternatives.

Title VII. Improving Access to Innovative Medical Therapies

Biologics Price Competition and Innovation. The *Affordable Care Act* establishes a process under which FDA will license a biological product that is shown to be biosimilar or interchangeable with a licensed biological product, commonly referred to as a reference product. No approval of an application as either biosimilar or interchangeable is allowed until 12 years from the date on which the reference product is first approved. If FDA approves a biological product on the grounds that it is interchangeable to a reference product, HHS cannot make a determination that a second or subsequent biological product is interchangeable to that same reference product until one year after the first commercial marketing of the first interchangeable product.

More Affordable Medicines for Children and Underserved Communities. Drug discounts through the 340B program are extended to inpatient drugs and also to certain children's hospitals, cancer hospitals, critical access and sole community hospitals, and rural referral centers.

Title VIII. Community Living Assistance Services and Supports

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

TITLE IX. REVENUE PROVISIONS

Excise tax on high cost employer-sponsored health coverage. Beginning in 2018, levies an excise tax of 40 percent on insurance companies and plan administrators for any health coverage plan that is above the threshold of \$10,200 for single coverage and \$27,500 for family coverage. The tax applies to self-insured plans and plans sold in the group market, but not to plans sold in the individual market (except for coverage eligible for the deduction for self-employed individuals). The tax does not apply to stand-alone dental and vision coverage. The tax applies to the amount of the premium in excess of the threshold. The threshold is indexed at CPI-U plus one percentage point in year 2019 and CPI-U in years thereafter. An increase in the threshold amount of \$1,650 for singles and \$3,450 for families is available for retired individuals age 55 and older and for plans

that cover employees engaged in high risk professions. This provision also includes an adjustment for firms whose health costs are higher due to the age or gender of their workers and adjusts the initial threshold if there is unexpected high growth in premiums before 2018.

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

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

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

Limitation on health flexible spending arrangements under cafeteria plans. Limits the amount of contributions to health FSAs to \$2,500 per year beginning in 2013. The cap is indexed at CPI-U in subsequent years.

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

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

Imposition of annual fee on branded prescription pharmaceutical manufacturers and importers. Imposes an annual fee on the pharmaceutical manufacturing sector. The amount of the fee is \$2.5 billion in 2011, \$2.8 billion in years 2012-2013, \$3.0 billion in 2014-2016, \$4.0 billion in 2017, \$4.1 billion in 2018 and \$2.8 billion in 2019 and years thereafter. This non-deductible fee is allocated across the industry according to market share with a reduction in share for companies with annual sales of branded pharmaceuticals of less than \$400 million.

Excise Tax on Medical Devices. Imposes an excise tax on the sale of medical devices by the manufacturer or importer equal to 2.3 percent of the sales price. The tax is deductible for federal income tax purposes. The excise tax does not apply to any sale of eyeglasses, contact lenses, hearing aids, or any medical device of a type generally purchased by the public at retail. In addition, sales for export and sales of devices for use in further manufacturing are exempt from the excise tax.

Imposition of annual fee on health insurance providers. Imposes an annual fee on the health insurance sector. The amount of the fee is \$8.0 billion in 2014, \$11.3 billion in years 2015-2016,

\$13.9 billion in 2017, and \$14.3 billion in 2018. For years after 2018, the amount of the annual fee is the amount for the preceding year increased by the rate of premium growth for the preceding calendar year. This non-deductible fee is allocated across the industry according to market share and does not apply to companies whose net premiums written are \$25 million or less. The fee also does not apply to any employer or governmental entity. Cooperatives and the national plan are subject to the insurance provider fee. This provision exempts from the fee non-profits which receive more than 80 percent of their gross revenues from government programs that target low-income, elderly, or disabled populations. In addition, only 50 percent of net premiums written by entities who are tax exempt under Internal Revenue Code sections 501(c)(3), (4), (26), and (29) are included for purposes of determining an entity's market share.

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

Eliminate deduction for expenses allocable to Medicare Part D. Eliminates the deduction for the subsidy paid by the federal government to employers who maintain prescription drug plans for their Medicare Part D eligible retirees beginning in 2013.

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

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

Additional hospital insurance tax on high-income taxpayers. Beginning in 2013, increases the hospital insurance tax rate by 0.9 percentage points on an individual taxpayer earning over \$200,000 (\$250,000 for married couples filing jointly). The revenues from this tax will be credited to the HI trust fund. This provision also expands the hospital insurance tax to include a 3.8 percent tax on income from interest, dividends, annuities, royalties and rents which are not derived in the ordinary course of trade or business, excluding active S corporation or partnership income, on taxpayers with income above \$200,000 for singles (\$250,000 for married filing jointly).

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

Excise tax on indoor tanning services. Imposes a ten percent tax on amounts paid for indoor tanning services. Indoor tanning services are services that use an electronic product with one or more ultraviolet lamps to induce skin tanning. The tax is effective for services on or after July 1, 2010.

Cellulosic biofuels loophole. Modifies the \$1.01 per gallon cellulosic biofuel producer credit to exclude fuels with significant water, sediment, or ash content, such as black liquor. The provision excludes from the definition of cellulosic biofuel any fuels that (1) are more than four percent (according to weight) water and sediment in any combination, or (2) have an ash content of more than one percent (according to weight).

Clarification of the economic substance doctrine; penalties. Clarifies the application of the economic substance doctrine which has been used by courts to deny tax benefits for transactions lacking economic substance. The provision also imposes a 40 percent strict liability penalty on underpayments attributable to a transaction lacking economic substance (unless the transaction was disclosed, in which case the penalty is 20 percent). This provision is effective for transactions entered into after the date of enactment.

Exclusion of health benefits provided by Indian tribal governments. Provides an exclusion from gross income for the value of specified Indian tribal health benefits.

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

Qualifying therapeutic discovery project credit. Creates a two-year temporary tax credit subject to an overall cap of \$1 billion to encourage investments in new therapies to prevent, diagnose, and treat acute and chronic diseases.

Health professionals State loan repayment tax relief. Excludes from gross income payments made under any State loan repayment or loan forgiveness program that is intended to provide for the increased availability of health care services in underserved or health professional shortage areas. This provision is effective for amounts received by an individual in taxable years beginning after December 31, 2008.

Expansion of adoption tax credit and adoption assistance programs. Increases the adoption tax credit and adoption assistance exclusion (\$12,170 for 2009) by \$1,000, and makes the credit refundable. The credit is extended through 2011.

TITLE X. STRENGTHENING QUALITY, AFFORDABLE CARE

Title X made many improvements to the preceding nine titles, and descriptions of those changes are included above. Changes included in Title X that do not amend previous titles are described below.

Coverage Improvements. Requires employers that offer and make a contribution towards employee coverage to provide free choice vouchers to qualified employees for the purchase of qualified health plans through Exchanges. Requires the Secretary of HHS to consult stakeholders and the National Committee on Vital and Health Statistics and the Health Information Technology Standards and Policy Committees to identify opportunities to create uniform standards for financial and administrative health care transactions, not already named under HIPAA, that would improve the operation of the health system and reduce costs.

Improvements in the Role of Public Programs. Creates financial incentives, including Federal Medical Assistance Percentage (FMAP) increases, for States to shift Medicaid beneficiaries out of nursing homes and into home and community based services (HCBS). Establishes a Pregnancy Assistance Fund for the purpose of awarding competitive grants to States to assist pregnant and parenting teens and women, with a matching requirement.

Indian Health Care Improvement. Authorizes appropriations for the Indian Health Care Improvement Act, including programs to increase the Indian health care workforce, new programs for innovative care delivery models, behavioral health care services, new services for health promotion and disease prevention, efforts to improve access to health care services, construction of Indian health facilities, and an Indian youth suicide prevention grant program.

Medicare Improvements. Makes improvements to Medicare beneficiary services, including coverage for individuals exposed to environment health hazards, prescription drug review through medication therapy management programs, development of a “Physician Compare” website to help beneficiaries learn more about their doctors, and a study on beneficiary access to dialysis services. Medicare payment changes include financial protections for states in which at least 50 percent of counties are frontier, an additional 0.5 percent bonus for physicians who report quality measures, delay of certain skilled nursing facility “RUGs-IV” payment changes, authority for the Secretary of HHS to test value-based purchasing programs for certain providers, and authorization for release and use of certain Medicare claims data to measure provider and supplier performance in a way that protects patient privacy. Other changes in this section include grants to develop networks of providers to deliver coordinated care to low-income populations, a requirement for the Secretary of HHS to develop a methodology to measure health plan value and to develop a plan to modernize computer and data systems at the Centers for Medicare & Medicaid Services, codification of the Office of Minority Health and elevation of the National Center on Minority Health and Health Disparities at NIH to the Institute level.

Public Health Program Improvements. Directs the Secretary of HHS to develop a national report card on diabetes to be updated every two years, and to work with States to improve data collection related to diabetes and other chronic diseases. Authorizes grants for small businesses to provide comprehensive workplace wellness programs. Authorizes the Cures Acceleration Network, within the National Institutes of Health (NIH), to award grants and contracts to develop cures and treatments of diseases. Directs the Administrator of the Substance Abuse and Mental Health Services Administration to award grants to centers of excellence in the treatment of depressive disorders. Allows the Secretary of HHS to enhance and expand existing infrastructure to track the epidemiology of congenital heart disease. Amends and reauthorizes the Automated Defibrillation in Adam’s Memory Act. Directs the Secretary of HHS to develop a national education campaign for young women and health care professionals about breast health and risk factors for breast cancer.

Workforce Improvements. Authorizes grants for medical schools to establish programs that recruit students from underserved rural areas who have a desire to practice in their hometowns. Amends and reauthorizes the preventive medicine and public health residency program. Improves the National Health Service Corps program by increasing the loan repayment amount, allowing for half-time service, and allowing for teaching to count for up to 20 percent of the Corps service commitment. Provides funding to HHS for construction or debt service on hospital construction costs for a new health facility meeting certain criteria. Establishes a Community Health Centers and National Health Service Corps Fund. Directs the Secretary of HHS to establish a 3-year demonstration project in States to provide comprehensive health care services to the uninsured at reduced fees.

Transparency and Program Integrity Improvements. Enhances the fraud sentencing guidelines, changes the intent requirement for fraud under the anti-kickback statute, and increases subpoena authority relating to health care fraud. Authorizes grants to States to test alternatives to civil tort litigation that emphasize patient safety, the disclosure of health care errors, and the early resolution of disputes, and allow patients to opt-out of these alternatives at any time. The Secretary of HHS would be required to conduct an evaluation to determine the effectiveness of the alternatives. Extends the protections from liability contained in the Federal Tort Claims Act to free clinics. Modifies requirements applicable to the labeling of generic drugs.