RESPONSIBLE REFORM
FOR THE MIDDLE CLASS
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The Patient Protection and Affordable Care Act

Detailed Summary

The Patient Protection and Affordable Care Act will ensure that all Americans have access to quality, affordable health care and will create the transformation within the health care system necessary to contain costs. The Congressional Budget Office (CBO) has determined that the Patient Protection and Affordable Care Act is fully paid for, will provide coverage to more than 94% of Americans while staying under the $900 billion limit that President Obama established, bending the health care cost curve, and reducing the deficit over the next ten years and beyond.

The Patient Protection and Affordable Care Act contains nine titles, each addressing an essential component of reform:

- Quality, affordable health care for all Americans
- The role of public programs
- Improving the quality and efficiency of health care
- Prevention of 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 Patient Protection and Affordable Care Act will accomplish a fundamental transformation of health insurance in the United States through shared responsibility. Systemic insurance market reform will eliminate discriminatory practices such as pre-existing condition exclusions. Achieving these reforms without increasing health insurance premiums will mean that all Americans must be part of the system and must have coverage. Tax credits for individuals and families will ensure that insurance is affordable for everyone. These three elements are the essential links to achieve reform.

Immediate Improvements: Achieving health insurance reform will take some time to implement. In the immediate reforms will be implemented in 2010. The Patient Protection and Affordable Care Act will:

- Eliminate lifetime and unreasonable annual limits on benefits
- Prohibit rescissions of health insurance policies
- Provide assistance for those who are uninsured because of a pre-existing condition
- Require coverage of preventive services and immunizations
- Extend dependant coverage up to age 26
- Develop uniform coverage documents so consumers can make apples-to-apples comparisons when shopping for health insurance
- Cap insurance company non-medical, administrative expenditures

- Ensure consumers have access to an effective appeals process and provide consumer a place to turn for assistance navigating the appeals process and accessing their coverage
- Create a temporary re-insurance program to support coverage for early retirees
- Establish an internet portal to assist Americans in identifying coverage options
- Facilitate administrative simplification to lower health system costs

Health Insurance Market Reform: Beginning in 2014, more significant 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 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 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. No out-of-pocket requirements can 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 lower-benefit catastrophic 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 any form of public insurance coverage. Undocumented immigrants are ineligible for premium tax credits. The Secretary of Health and Human Services (HHS) will establish a national public option – the Community Health Insurance Option – and permit states to opt-out. Federal support will also be available for new non-profit, member run insurance cooperatives. States will have flexibility to establish basic health plans for non-Medicaid, 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 between 100 and 400 percent of the federal poverty line (FPL) (about $88,000 for a family of four). The credit is calculated on a sliding scale beginning at two percent of income for those at 100 percent FPL and phasing out at 9.8 percent of income at 300-400 percent FPL. If an employer offer of coverage exceeds 9.8 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 required to maintain minimum essential coverage or pay a penalty of $95 in 2014, $350 in 2015, $750 in 2016 and indexed thereafter; for those under 18, the penalty will be one-half the amount for adults. Exceptions to this requirement are made for religious objectors, those who cannot afford coverage, taxpayers with incomes less than 100 percent FPL, Indian tribe members, those who receive a hardship waiver, individuals not lawfully present, incarcerated individuals, 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 requirement 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 more than 50 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 $750 per full-time employee. An employer with more than 50 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 or $750 for each of their full-time employees total.

Title II. The Role of Public Programs

The Patient Protection and Affordable Care Act expands eligibility for Medicaid to lower income persons and assumes federal responsibility for much of the cost of this expansion. It 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 January 1, 2011. 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. In 2017 and 2018, states that initially covered less of the newly-eligible population ("Other States") will receive more assistance than states that covered at least some non-elderly, non-pregnant adults ("Expansion States"). States will be required to maintain the same income eligibility levels through December 31, 2013 for all adults, and this requirement would be 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. Between fiscal years 2014 and 2019, states would 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: States' disproportionate share hospital (DSH) allotments are reduced by 45 percent once a state's uninsurance rate decreases by 50 percent (low DSH states would receive a 25 percent reduction). As the rate continues to decline, states' DSH allotments would be reduced by a corresponding amount. At no time could a state's allotment be reduced by more than 65 percent compared to its FY2012 allotment.

Dual Eligible Coverage and Payment Coordination: The Secretary of Health and Human Services (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 Patient Protection and 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. The Patient Protection and Affordable Care Act will make substantial investments to 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. Payment accuracy will improve. The Medicare Part D prescription drug benefit will be enhanced and the coverage gap, or donut hole, will be reduced. An Independent Medicare 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 FY2013 will link Medicare payments to quality performance on common, high-cost conditions such as cardiac, surgical and pneumonia care. 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 and hospice providers will participate in value-based purchasing with quality measure reporting starting in FY2014, with penalties for non-participating providers.

Strengthening the Quality Infrastructure: The HHS Secretary 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 be established within the Centers for Medicare and Medicaid Services to research, develop, test, and expand innovative payment and delivery arrangements. Accountable Care Organizations (ACOs) that take responsibility for cost and quality received by patients will receive a share of savings they achieve for Medicare. The HHS Secretary 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 harmed by geographic adjustment for practice expenses. The Act extends bonus payments by Medicare 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 Patient Protection and Affordable Care Act extends the Rural Community Hospital Demonstration Program for two years and expands eligible sites to additional states and hospitals.

Improving Payment Accuracy: The HHS Secretary will rebase home health payments starting in 2013 based on the current 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. The Secretary will update Disproportionate Share (DSH) payments to better account for hospital uncompensated care costs; Medicare DSH payments will reflect lower uncompensated care costs tied to decreases in the number of uninsured. The bill 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 payments will be based on the average of the bids submitted by insurance plans in each market. Bonus payments will be available to improve the quality of care and will be based on an insurer's level of care coordination and care management, as well as achievement on quality rankings. New payments will be implemented over a four-year transition period. MA 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.

Medicare Prescription Drug Plan Improvements (Part D): In order to have their drugs covered under the Medicare Part D program, drug manufacturers will provide a 50 percent discount to Part D beneficiaries for brand-name drugs and biologics purchased during the coverage gap beginning July 1, 2010. The initial coverage limit in the standard Part D benefit will be expanded by $500 for 2010.

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 an independent, 15-member Medicare 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 Patient Protection and Affordable Care 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. And, it support 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 HHS Secretary 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 authorize the HHS Secretary to modify coverage of any Medicare-covered preventive service to be consistent with U.S. Preventive Services Task Force recommendations.
- 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 HHS Secretary 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 Patient Protection and Affordable Care Act will encourage innovations in health 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 Patient Protection and Affordable Care Act establishes a national commission to review health care workforce and projected workforce needs and to provide comprehensive information to Congress and the Administration to align workforce resources with national needs. It will also establish competitive grants to enable state partnerships to complete comprehensive workforce planning and to create health care workforce development strategies.

Increasing the Supply of the 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 increased and the years for nursing schools to establish and maintain student loan funds are 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 settings providing health care to patients, including acute care facilities, ambulatory care facilities, residences, and other settings located in Health Professional Shortage Areas, Medically Underserved Areas, or with Medically Underserved Populations. Authorization of appropriations for the National Health Service Corps scholarship and loan repayment program will be extended 2010-2015. 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.
- 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 faculty loan program for nurses who pursue careers in nurse education.
- Grants to promote the community health workforce 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 Patient Protection and Affordable Care 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 HHS Secretary 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.

Improving Access to Health Care Services: The Patient Protection and Affordable Care 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 pubic and private programs.

Physician Ownership and Other Transparency: Physician-owned hospitals that do not have a provider agreement prior to February 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 HHS Secretary 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 Health and Human Services will publish new information on the Nursing Home Compare

Medicare website: 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 Patient Protection and Affordable Care 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 Program Integrity Provisions: 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 will take into account the volume of billing for a DME supplier or home health agency when determining the size of a surety bond. The Secretary may suspend payments to a

provider or supplier pending a fraud investigation. Health Care Fraud and Abuse Control (HCFAC) funding will be increased by $10 million each year for fiscal years 2011 through 2020. 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 HHS Secretary 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 HHS Secretary. 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 HHS Secretary 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 would be required to report suspected crimes committed at a facility. Owners or operators of such facilities would 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 Patient Protection and 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 Patient Protection and 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 HHS Secretary 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: The Patient Protection and Affordable Care Act levies a new excise tax of 40 percent on insurance companies and plan administrators for any health coverage plan with an annual premium that is above the threshold of $8,500 for single coverage and $23,000 for family coverage. The tax applies to self-insured plans and plans sold in the group market, and not to plans sold in the individual market (except for coverage eligible for the deduction for self-employed individuals). The tax applies to the amount of the premium in excess of the threshold. A transition rule increases the threshold for the 17 highest cost states for the first three years. An additional threshold amount of $1,350 for singles and $3,000 for families is available for retired individuals age 55 and older and for plans that cover employees engaged in high risk professions.

Increasing Transparency in Employer W-2 Reporting of Value of Health Benefits: This provision 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 qualified medical expenses.

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 and increases the additional tax for Archer MSA withdrawals from 15 percent to 20 percent.

Limiting Health FSA Contributions: This provision limits the amount of contributions to health FSAs to $2,500 per year.

Corporate Information Reporting: This provision requires businesses that pay any amount greater than $600 during the year to corporate providers of property and services to file an information report with each provider and with the IRS.

Pharmaceutical Manufacturers Fee: This provision imposes an annual flat fee of $2.3 billion on the pharmaceutical manufacturing sector beginning in 2010 allocated across the industry according to market share. The fee does not apply to companies with sales of branded pharmaceuticals of $5 million or less.

Medical Device Manufacturers Fee: This provision imposes an annual flat fee of $2 billion on the medical device manufacturing sector beginning in 2010 allocated across the industry according to market share. The fee does not apply to companies with sales of medical devices in the U.S. of $5 million or less. The fee also does not apply to any sale of a Class I product or any sale of a Class II product that is primarily sold to consumers at retail for not more than $100 per unit (under the FDA product classification system).

Health Insurance Provider Fee: This provision imposes an annual flat fee of $6.7 billion on the health insurance sector beginning in 2010 allocated across the industry according to market share. The fee does not apply to companies whose net premiums written are $25 million or less and whose fees from administration of employer self-insured plans are $5 million or less.

Eliminating the Deduction for Employer Part D Subsidy: This provision eliminates the deduction for the subsidy for employers who maintain prescription drug plans for their Medicare Part D eligible retirees.

Modification of the Threshold for Claiming the Itemized Deduction for Medical Expenses: This provision 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.

Tax on Elective Cosmetic Surgery. This provision imposes a five percent excise tax on voluntary cosmetic surgical and medical procedures performed by a licensed medical professional. The tax would be collected by the medical professional at the point of service. The definition of voluntary cosmetic procedures generally would be the same as the definition of cosmetic surgery or similar procedures that are not treated as included in medical care under the current Section 213(d)(9) definition. The excise tax would be effective for procedures performed on or after January 1, 2010.

Executive Compensation Limitations. This provision limits the deductibility of executive compensation for insurance providers if at least 25 percent of the insurance provider's gross premium income 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 for High Wage Workers. The provision increases the hospital insurance tax rate by 0.5 percentage points on an individual taxpayer earning over $200,000 ($250,000 for married couples filing jointly).

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, including the deduction for 25 percent of claims and expenses and the 100 percent deduction for unearned premium reserves.

Simple Cafeteria Plans for Small Businesses. This provision would establish a new employee benefit cafeteria plan to be known as a Simple Cafeteria Plan. This eases the participation restrictions so that small businesses can provide tax-free benefits to their employees and it includes self-employed individuals as qualified employees.