



H.R. 3590

Patient Protection and Affordable Care Act

Public Law 111-148¹

Enacted March 23, 2010

Summary of Major Provisions

Health Insurance Market Reforms

State High-Risk Pools. Creates a temporary state-based high-risk pool program, within 6 months of enactment, to provide health coverage to individuals with pre-existing medical conditions. U.S. citizens and legal immigrants who have a pre-existing medical condition and who have been uninsured for at least six months will be eligible to enroll in the high-risk pool and receive subsidized premiums. Appropriates \$5 billion to finance the program beginning July 1, 2010 until January 1, 2014. Supersedes state laws or regulations on standards for high-risk pools (except for state laws on licensing and solvency). Sec. 1101

Medical Loss Ratios. Effective beginning plan year 2010, requires health plans (including grandfathered plans) to report to the Secretary of Health and Human Services (HHS) the proportion of premium dollars spent on clinical services, quality, and other costs, and, effective January 1, 2011, requires health plans to provide rebates to consumers if medical loss ratio is less than 85 percent for plans in the large group market and 80 percent for plans in the individual and small group markets. The reports are to be made publicly available on the HHS website. Sec. 1001, 10101

Premium Rate Reviews. Effective beginning plan year 2010, establishes a process for reviewing increases in health plan premiums and requires plans to justify increases. Requires states to report to the Secretary on trends in premium increases and recommend whether certain plans should be excluded from the Exchange based on unjustified premium increases. Provides grants to states to support efforts to review and approve premium increases. Beginning with plan years beginning in 2014, requires the Secretary to monitor premium increases for insurance offered in and outside of exchanges. Sec. 1003

Dependent Coverage. Requires all health plans to allow young adults to remain on their parents' insurance policy up to their 26th birthday (effective within 6 months of enactment). For coverage of young adults prior to 2014, the requirement on group health plans is limited to those adult children without an employer offer of coverage. Sec. 1001; Sec. 2301/H.R. 4872

Pre-existing Conditions. Bans coverage exclusions of pre-existing health conditions for children (under age of 19) (effective six months from enactment). Applicable to adults in 2014. Sec. 1201, 10103

Individual and Small Group Market Requirements.

- Bans rating or coverage restrictions or discrimination based on health status, medical condition, medical history, genetic information, evidence of insurability (including acts of domestic violence or disability), claims experience, receipt of health care; requires guaranteed issue and guaranteed renewability and modified community rating, with limited premium variation allowed based only on age (3:1), geographic area, tobacco use, and family size, effective January 1, 2014; rating requirements apply only to fully-insured plans in the large group market, not self-insured plans. Sec. 1201
- Rating reforms must apply uniformly to all health insurance plans in each state insurance market, effective January 1, 2014. Sec. 1252
- Prohibits all insurance plans from placing lifetime limits on the dollar value of benefits, effective six months from enactment, and prohibits annual limits beginning in 2014; prior to January 2014, plans may only impose restricted annual limits on coverage, as defined by the Secretary. Sec. 1001, 10101; Sec. 2301/H.R. 4872
- Prohibits insurers from rescinding coverage except in cases of fraud, effective 6 months after enactment. Sec. 1001; Sec. 2301/H.R. 4872
- Limits waiting periods for coverage under group health plans to 90 days, effective January 1, 2014. Secs. 1201, 10103; Sec. 2301/H.R. 4872
- Requires health plans in the small group and individual markets to include coverage of defined essential benefits, with a specified actuarial value, and with limits on cost-sharing. Sec. 1201
- Requires the Secretary of the Department of Health and Human Services (HHS) to develop standards for uniform explanation of coverage documents for enrollees, and requires plans to provide a summary of coverage to applicants and policyholders, as well as to enrollees (such standards will preempt any related state standards that require a summary of benefits and coverage that provides less information to consumers); requires all plans to disclose information, such as claims payment policies and rating practices, to the Exchange, Secretary, state insurance commissioners, and public. Secs. 1001, 10101
- Establishes an Internet portal for beneficiaries and small businesses to access coverage options, effectively immediately. Sec. 1103; Sec. 10102/H.R. 4872
- Requires plan enrollees be allowed to select a primary care provider (or pediatrician for a child) from any available participating primary care provider; no prior authorization or increased cost-sharing for emergency services, whether provided by in-network or out-of-network providers; direct access to obstetrical or gynecological care. Sec. 1001
- Prohibits insurers from dropping coverage because an individual participates in an approved clinical trial that treats cancer or other life-threatening diseases, and from denying coverage for routine patient costs. Sec. 1201
- Requires first-dollar coverage (i.e., no cost-sharing) of certain preventive health services. Sec. 1001
- Prohibits employers that provide health coverage from limiting eligibility for coverage based on wages or salaries of full-time employees. Sec. 1001

- Requires the Secretary of HHS to develop guidelines for use by health insurers to report information on initiatives and programs that improve health outcomes through the use of care coordination and chronic disease management, prevent hospital readmissions and improve patient safety, and promote wellness and health. Sec. 1001
- Requires qualified health plans to implement activities to reduce health disparities, including the use of language services, community outreach, and cultural competency trainings. Sec. 10104

Reinsurance for Early Retirees. Creates a temporary reinsurance program to provide reimbursement to participating employment-based plans for part of the cost of providing health benefits to retirees (age 55-64) and their families. Sec. 1102

Internal and External Appeals. Health insurers are required to implement an internal appeals process for appeals of coverage determinations and claims and comply with external appeals requirements. Secs. 1001, 10101

Insurance Exchanges

By 2014, states must create exchanges (marketplaces) for the individual market and small business health options program (SHOP) exchanges for the small-group market. States may be granted a waiver from HHS to opt-out from the exchange requirement if they provide coverage at least as comprehensive as that required under the Act. States may form regional exchanges or allow more than one exchange to operate in a state, with approval from the Secretary of HHS. Only qualified health benefit plans (QHBP) meeting specific criteria could be sold in exchanges. Insurers may sell policies outside exchanges. Large employers would be allowed to participate in the exchanges beginning in 2017. Federal funding will be available to states for the planning and establishment of exchanges within one year of enactment and until January 1, 2015. Secs. 1311, 1312, 1332

Health plans may not discriminate against any health care provider, acting within their state scope of practice law, that wants to participate in the plan, but plans are not required to contract with any willing provider. Sec. 1201

The Secretary of HHS will establish a minimum benefits package with limits on cost sharing levels and four plan benefit categories. A separate catastrophic-only policy will be offered to those 30 years old or younger, or to those without affordable coverage. Provides for child-only plans and stand-alone pediatric dental plans. Allows qualified health plans to provide coverage through a qualified direct primary care medical home plan that meets requirements established by the Secretary. Secs. 1302, 10104

Interstate Sale of Insurance

Beginning in 2016, health insurance may be sold across state lines through interstate health care choice compacts. Under such compacts, qualified health plans could be offered in all participating states, but insurers would still be subject to the consumer protection laws of the purchaser's state. Insurers must be licensed in all participating states. States must enact a law to enter into compacts. By July 1, 2013, the Secretary of HHS will issue regulations in consultation with the National Association of Insurance Commissioners (NAIC). Sec. 1333

Reinsurance and Risk Adjustment

Requires states, for 2014, 2015, and 2016, to establish a nonprofit reinsurance entity to collect payments from insurers and make payments to insurers in the individual market that cover high-risk individuals. Requires the Secretary to establish risk corridors for qualified health plans in 2014, 2015, and 2016 to make adjustments in payment to plans to account for higher than average costs.

Requires states to assess a charge on health plans with enrollees of lower-than-average risk, and to make payments to health plans with enrollees of higher-than-average risk. Secs. 1341, 1342, 1343

Patient Safety

By January 1, 2015, plans participating in the exchanges are required to contract with hospitals that meet certain requirements, including the requirement that the hospital utilize a patient safety evaluation system as specified in the Patient Safety Quality Improvement Act. Sec. 1311

Public Health Insurance Option

No public health insurance option. Sec. 10104

Multi State Plans

Requires the Office of Personnel Management (OPM) to contract with health insurers to offer at least two multi-state qualified health plans (at least one non-profit) to provide individual or small group coverage through exchanges in each state. Requires OPM to negotiate contracts in a similar manner as it negotiates for the Federal Employees Health Benefit Program (FEHBP), and allows OPM to prohibit multi-state plans that do not meet standards for medical loss ratios, profit margins, and premiums. Requires multi-state plans to cover essential health benefits and meet all of the requirements of a qualified health plan; states may require multi-state plans to offer additional benefits, but must pay for the additional cost. Multi-state plans must comply with 3:1 age rating, except states may require more protective age rating. Multi-state plans must comply with the minimum standards and requirements of FEHBP and state law, unless they conflict with H.R. 3590. Guarantees that FEHBP will maintain a separate risk pool and remain a separate program. Sec. 10104

State Basic Health Plan

States have the option to establish a federally-funded, non-Medicaid state plan for people with incomes above Medicaid eligibility (133 percent of the federal poverty level (FPL)) but below 200 percent of FPL instead of providing such individuals with tax credits to purchase coverage through health insurance exchanges. States will negotiate contracts with health care systems (licensed HMOs, licensed insurers, or a network of health care providers) to provide services under the basic health plan. State Basic Health Plan administrators will negotiate payment rates and benefit packages and seek to contract with managed care systems. Legal immigrants whose income is less than 133 percent of FPL, and who are not eligible for Medicaid by virtue of the five-year waiting period, will be eligible for the basic health program. Sec. 1331; Sec.10104/H.R. 4872

Consumer Operated and Oriented Plan (CO-OP) Program

Creates the CO-OP program to foster the creation of non-profit, member-run health insurance companies in all 50 states and District of Columbia to compete on a level playing field with the private market. To be eligible to receive funds, an organization must not be an existing organization, substantially all of its activities must consist of the issuance of qualified health benefit plans in each state in which it is licensed, governance of the organization must be subject to a majority vote of its members, it must operate with a strong consumer focus, and any profits must be used to lower premiums, improve benefits, or improve the quality of health care delivered to its members. Grants will be provided to meet state solvency requirements. Ban on insurer or insurance industry involvement. No CO-OP can operate until state has implemented the individual and small group insurance market reforms required under the Act. Authorizes \$6 billion to finance the program and award loans and grants to establish CO-OPs by July 1, 2013. Sec. 1322

Individual Mandate

Requires most U.S. citizens and legal residents to have qualifying health coverage or pay a tax penalty. Those without coverage will pay a tax penalty of the greater of \$695 per year up to a maximum of three times that amount (\$2,085) per family, or 2.5 percent of household income. The

penalty will be phased-in according to the following schedule: \$95 in 2014, \$325 in 2015, and \$695 in 2016 for the flat fee or 1.0 percent of taxable income in 2014, 2.0 percent of taxable income in 2015, and 2.5 percent of taxable income in 2016. Beginning after 2016, the penalty will be increased annually by the cost-of-living adjustment. Exemptions will be granted for financial hardship, religious objections, American Indians, those without coverage for less than three months, undocumented immigrants, incarcerated individuals, those for whom the lowest cost plan option exceeds 8 percent of an individual's income, and those with incomes below the tax filing threshold (in 2009 the threshold for taxpayers under age 65 was \$9,350 for singles and \$18,700 for couples). Secs. 1501, 10106; Sec. 1002/H.R. 4872

Employer Requirements

Effective January 1, 2014, assesses employers with more than 50 employees that do not offer coverage and have at least one full-time employee who receives a premium subsidy a "free rider" penalty of \$2,000 a month per full-time employee, excluding the first 30 employees from the assessment. The penalty is not tax-deductible. Employers with more than 50 employees that offer coverage but have at least one full-time employee receiving a premium tax credit will pay the lesser of \$3,000 for each employee receiving a premium credit or \$2,000 for each full-time employee. The Secretary of Labor shall conduct a study to determine whether employees' wages are reduced by reason of the application of the assessable payments. Secs. 1513, 10106; Sec. 1003/H.R. 4872

Requires employers that offer coverage and make a premium contribution to provide free choice vouchers to employees with incomes of less than 400 percent of FPL for the purchase of qualified health plans through exchanges. The free choice voucher must be equal to the contribution that the employer would have made to its own plan. Employees qualify if their required contribution under the employer's plan would be between 8 and 9.8 percent of their income. Excludes free choice vouchers from taxation and voucher recipients are not eligible for tax credits. Employers providing free choice vouchers will not be subject to penalties for employees that receive premium credits in the Exchange. Effective January 1, 2014. Sec. 10108

Requires employers with more than 200 employees to automatically enroll employees into health insurance plans offered by the employer. Must include notice to employees, and employees may opt out of coverage. This section does not supersede any state law standards or requirements regarding employer payroll, except to the extent any such state law prevents an employer from using automatic enrollment. Sec. 1511

Prohibits employers from discharging or discriminating against any employee because the employee has received a premium tax credit. Sec. 1558

Premium/Cost-Sharing Subsidies to Individuals

Effective January 1, 2014, provides refundable, advanceable, and sliding-scale premium credits to individuals and families with incomes between 133-400% FPL to purchase insurance through the exchanges. Only U.S. citizens and legal immigrants who meet income limits are eligible for premium credits (and cost-sharing subsidies). Legal immigrants who are barred from enrolling in Medicaid during their first five years in the U.S. will be eligible for premium credits. Secs. 1401, 1412; Sec. 1001/H.R. 4872

The premium credits will be tied to the second lowest cost silver plan in the area and will be set on a sliding scale such that the premium contributions are limited to the following percentages of income for specified income levels: up to 133% FPL: 2% of income; 133-150% FPL: 3 – 4% of income; 150-200% FPL: 4 – 6.3% of income; 200-250% FPL: 6.3 – 8.05% of income; 250-300% FPL: 8.05 – 9.5% of income; 300-400% FPL: 9.5% of income. Employees who are offered coverage by an employer are not eligible for premium credits unless the employer plan does not have an actuarial

value of at least 60% or if the employee share of the premium is 9.5% or more of income. Secs. 1401-1402; Sec. 1001/H.R. 4872

Increases the premium contributions for those receiving subsidies annually to reflect the excess of the premium growth over the rate of income growth for 2014-2018. Beginning in 2019, further adjusts the premium contributions to reflect the excess of premium growth over CPI if aggregate premiums and cost sharing subsidies exceed .504 percent of GDP. Sec. 1401; Sec. 1001/H.R. 4872

Provides cost-sharing subsidies to eligible individuals and families. The cost-sharing credits reduce the cost-sharing amounts and annual cost-sharing limits and have the effect of increasing the actuarial value of the basic benefit plan to the following percentages of the full value of the plan for the specified income level: 100-150% FPL: 94%; 150-200% FPL: 85%; 200-250% FPL: 73%; 250-400% FPL: 70%. Sec. 1402; Sec. 1001/H.R. 4872

Premium Subsidies to Employers

Provides tax credits to small employers with no more than 25 employees and average annual wages of less than \$50,000 that purchase health insurance for employees. For tax years 2010 through 2013, provides a tax credit of up to 35 percent of the employer's contribution toward the employee's health insurance premium if the employer contributes at least 50 percent of the total premium cost or 50 percent of a benchmark premium. The full credit will be available to employers with 10 or fewer employees and average annual wages of less than \$25,000. The credit phases-out as firm size and average wage increases. For tax years 2014 and later, for eligible small businesses that purchase coverage through the state exchanges, provides a tax credit of up to 50 percent of the employer's contribution toward the employee's health insurance premium if the employer contributes at least 50 percent of the total premium cost. The credit will be available for two years. The full credit will be available to employers with 10 or fewer employees and average annual wages of less than \$25,000. The credit phases-out as firm size and average wage increases. Sec. 1421; Sec. 10105/H.R. 4872

Expansion of Public Programs

Beginning January 1, 2014, expands Medicaid to all individuals under age 65 (including for the first time, adults without dependent children) with incomes up to 133% FPL. Income eligibility will be based on modified gross income and income disregards and asset tests would no longer apply in most cases. Newly eligible adults will be guaranteed a benchmark benefit package that at least provides the essential health benefits. Secs. 2001, 2002, 10201; Sec. 1201/H.R. 4872

States will receive 100% federal funding for costs of newly eligible individuals for 2014-2016, 95% federal financing in 2017, 94% federal financing in 2018, 93% federal financing in 2019, and 90% federal financing for 2020 and subsequent years. States that have already expanded Medicaid eligibility to adults with incomes up to 100% FPL will receive a phased-in increase in their FMAP for non-pregnant childless adults so that by 2019 they receive the same federal financing as other states (93% in 2019 and 90% in 2020). States have the option to expand Medicaid eligibility to childless adults beginning on April 1, 2010, but will receive their regular FMAP until 2014. Secs. 2001, 10201; Sec. 1201/H.R. 4872

Increases payments for primary care services provided by primary care physicians (family medicine, general internal medicine or pediatric medicine) to 100% of the Medicare payment rates for 2013 and 2014; states will receive 100% federal funding for the increased payment rates. Sec. 1202/H.R. 4872

Increases funding and the spending caps for the territories. Sec. 2005; Sec. 1204/H.R. 4872

Maintenance of income eligibility required for all adults through 12/31/2013. For calendar years 2011 through 2013, state exemption available for MOE for optional non-pregnant non-disabled adult populations above 133% FPL if state has budget deficit or is projected to have deficit in next fiscal

year. Requires states to maintain current income eligibility levels for children in Medicaid and the Children's Health Insurance Program (CHIP) until 2019. Sec. 2001

Extends the current reauthorization period of CHIP for two years, through September 30, 2015. Clarifies that children who cannot enroll in CHIP because allotments are capped are deemed ineligible for CHIP and, therefore, are eligible for tax credits in the exchanges. However, such children must first be screened for Medicaid eligibility, and enrolled if eligible. Requires the HHS Secretary to review and certify which plans in the exchanges provide CHIP-comparable benefits and cost sharing. CHIP benefit package and cost-sharing rules will continue as under current law. Provides states with the option to provide CHIP coverage to children of state employees who are eligible for health benefits if certain conditions are met. Beginning in 2015, states will receive a 23 percentage point increase in the CHIP match rate up to a cap of 100 percent. Extends and increases funding provided in CHIPRA by \$40 million for Medicaid and CHIP enrollment and renewal activities. Secs. 2101, 10201, 10203

Allows states the option of covering family planning services for certain low-income women and requires states to cover services provided by free-standing birth centers. Secs. 2301, 2303

Creates a new Medicaid state plan option to permit Medicaid enrollees with at least two chronic conditions, one condition and risk of developing another, or serious and persistent mental health condition to designate a provider as a health home. Sec. 2703

Makes the state option to cover former foster children in Medicaid mandatory, moves the effective date up to 2014, and limits it to only those children who have aged out of the foster care system as of the date of enactment. Sec. 2004

Increases the transparency of the Medicaid waiver development and approval processes, including requirement of public notice and public input. Requires the Secretary to issue regulations. Sec. 10201

Long Term Care

Creates a national, voluntary long-term care insurance program to help purchase non-medical services and supports for people who have functional limitations, in order to help such individuals maintain personal and financial independence (CLASS program). Financed through voluntary payroll deductions; all working adults will be automatically enrolled, unless they choose to opt-out. Will supplement, not supplant, Medicaid and/or private long-term care insurance. Effective January 1, 2011. Sec. 8002

Provides states with new options for offering home and community-based services (HCBS) through a Medicaid state plan rather than through a waiver for individuals with incomes up to 300 percent of the maximum SSI payment and who have a higher level of need, and permits states to extend full Medicaid benefits to individuals receiving HCBS under a state plan. Effective October 1, 2010. Sec. 2402

Creates the Community First Choice Option in Medicaid to provide community-based attendant supports and services to disabled individuals who require an institutional level of care. Provides states that undertake reforms to increase nursing home diversions and access to home and community-based services in their Medicaid programs with a 6 percent increase in their FMAP for 5 years. Sunsets after 5 years. Effective October 1, 2011. Sec. 2401

Extends the Medicaid Money Follows the Person Rebalancing Demonstration program through September 2106 and allocates \$10 million per year for five years to continue the Aging and Disability Resource Center initiatives. Secs. 2403, 2405

Creates the State Balancing Incentive Program to provide enhanced FMAP to eligible states to increase the proportion of non-institutionally-based long-term care services. Effective October 1, 2011 through September 30, 2015. Sec. 10202

Prevention/Wellness

Develops a national prevention and health promotion strategy that sets specific goals for improving health. Creates a prevention and public health investment fund, providing \$7 billion in funding from 2010 through 2015, and \$2 billion for each fiscal year after 2015, to expand and sustain funding for prevention and public health programs. Secs. 4001-4002

Permits insurers to create incentives for health promotion and disease prevention practices through significant premium discounts and encourages employers to provide wellness programs and provide premium discounts for employees who participate in these programs. Authorizes grants from 2011 through 2015 to small employers that offer comprehensive workplace wellness programs. Secs. 1001, 4303, 10408

Covers only proven preventive services and provides incentives to Medicaid beneficiaries to complete behavior modification programs. Requires Medicaid coverage for tobacco cessation services for pregnant women, and for states that provide coverage for and remove cost-sharing for preventive services recommended by the U.S. Preventive Services Task Force and recommended immunizations, provides a one percentage point increase in the FMAP. Effective January 1, 2013. Secs. 4106, 4107, 4108

Requires chain restaurants and food sold from vending machines to disclose the nutritional content of each item (proposed regulations are to be issued within one year of enactment). Sec. 4205

Appropriates \$25 million for the childhood obesity demonstration project authorized under CHIPRA, and modifies the demonstration time period to fiscal years 2010 through 2014. Sec. 4306

Advance Care Planning

No provision on advance care planning. Prohibits discrimination against any individual or institutional health care entity receiving federal, state, or local government funding on the basis that the entity does not provide assisted suicide, euthanasia, or mercy killing. Sec. 1553.

Comparative Effectiveness Research

An independent, nonprofit institute, the Patient-Centered Outcomes Research Institute, is established to identify national priorities and provide for comparative clinical effectiveness research (CER) on health treatments and strategies. The U.S. Comptroller General will appoint members to the Institute's Board of Governors including four individuals representing practicing clinicians; the Comptroller will also appoint the Institute's Methodology Committee. The Institute is not allowed to issue practice guidelines, coverage recommendations payment or policy recommendations. The Institute will be funded through a Trust Fund initially comprised of federal appropriations and subsequently through annual contributions from the Medicare Trust Funds and assessments on private health insurers. Funding will terminate in 2019.

The Agency for Healthcare Research and Quality (AHRQ) is required to expand CER capacity through training grants for researchers, coordination of access to federal health care program data in order to build data capacity including support for clinical registries and health outcomes research data networks; AHRQ is required to consult with medical and clinical associations and obtain regular, structured feedback to promote uptake of CER findings in clinical practice and to determine the value of information disseminated and assistance provided by AHRQ. Twenty percent of amounts

appropriated or credited to the Institute's Trust Fund each fiscal year will be transferred to HHS to support CER related activities.

Medicare would be authorized to use CER findings in national coverage determinations (NCD), but would be prohibited from solely relying upon CER findings for such determinations and clarifies that the "reasonable and necessary" standard used to make NCDs is not modified. Also, establishes additional limitations on the methodologies and evidence when CER is used for NCD.

The Federal Coordinating Council for CER established by the American Recovery and Reinvestment Act of 2009 (ARRA) is terminated. Secs. 6301, 6302, 10302

Physician Sunshine/Gift Registry

Manufacturers of drugs, devices, biologicals, and medical supplies participating in federal health care program are required to begin reporting to HHS transfers of value to physicians and teaching hospitals. There are a number of exceptions to the reporting requirement. The reports, with some information withheld (such as the national provider identifier (NPI) number), will be publicly posted. Covered manufacturers and group purchasing organization are also required to report any ownership or investment interest (other than in a publicly traded security and mutual fund) held by a physician (or an immediate family member). Prior to posting individuals (and manufacturers and group purchasing organizations) will have 45 days to review and submit corrections to the information. Prohibits states from regulating in areas covered by new law. Requires drug manufacturers and distributors to submit records to HHS on drug samples distributed, destroyed, or returned to manufacturer. These would not be subject to public disclosure. Sec. 6002

Fraud and Abuse

The Health Care Fraud and Abuse Control (HCFAC) program funding will be increased by \$10 million each year for 10 years, and will remain available until expended. Additional funding is appropriate for fiscal years 2011 (\$95 million), 2012 (\$55 million), 2013/2014 (\$30 million), and 2015/2016 (\$20 million). Permanently applies the CPI adjustment to HCFAC funding. Sec. 6402; Sec. 1303/H.R. 4872

HHS in consultation with the HHS Inspector General is required to establish procedures under which screening is conducted with respect to providers of medical or other items or services and suppliers seeking to participate in federal health programs. The Secretary of HHS has the discretion, based on the risk of fraud, waste, and abuse, to include a criminal background check, fingerprinting, site visits, database checks, and any other appropriate screening. There is an enrollment fee of \$500 for institutional providers. Secs. 6401, 10603

As a condition of enrollment in Medicare, Medicaid, or CHIP, physicians are required to establish an anti-fraud and abuse compliance program. HHS in consultation with Office of Inspector General (OIG) will establish the core elements of such a program. Applicants for enrollment or revalidation within one year of the laws enactment are required to disclose affiliations with individual or entity that has an uncollected debt, has been or is subject to payment suspension under a federal health care program, excluded, or had billing privileges revoked or denied. HHS is authorized to impose additional requirements if such affiliations are believed to pose undue risk of fraud waste and abuse or if there are multiple affiliations, deny application. Sec. 6401

The new statute increases penalties for fraud and abuse and establishes new conduct constituting violations. Violations now include: (1) excluded individuals ordering or prescribing an item or service, (2) making false statements on applications or contracts to participate in a Federal health care program, or (c) knowing of an overpayment and not reporting and returning it. Civil monetary penalties could be imposed upward of \$50,000 and individual faces potential exclusion. Sec. 6402

The Centers for Medicare and Medicaid Services (CMS) is required to include in the Integrated Data Repository, at a minimum, 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 (SSA), and the Indian Health Service (IHS). Sec. 6402

HHS is required to enter into data-sharing agreements with Social Security, the VA and DOD, and IHS to help identify fraud, waste, and abuse. The HHS OIG and the DOJ are authorized to access Medicare, Medicaid, and CHIP claims and payment data in order to conduct law enforcement and oversight activities. Privacy, security, and disclosure laws remain applicable. The HHS OIG is also given broad authority to obtain information, including medical records, from “any individual (including a beneficiary provided all applicable privacy protections are followed) or entity” to validate Medicare and Medicaid claims. Sec. 6402

HHS is required to impose an “appropriate administrative penalty commensurate with the offense or conspiracy” if an individual Medicare, Medicaid, or CHIP beneficiary knowingly participates in the offense or conspiracy. Sec. 6402

Amends the intent requirement for violations of the federal health care program Anti-Kickback Statute (AKS). The AKS provides for criminal sanctions against anyone who “knowingly and willfully” offers, pays, solicits, or receives remuneration in connection with inducements for referrals of program-related business. The standard now includes “a person [who does] not have actual knowledge of this section or specific intent to commit a violation.” Sec. 6402

Changes the existing intent standard for violations of the health care provisions of the mail fraud statute from “knowingly and willfully” to “[w]ith respect to violations of this section, a person need not have actual knowledge of this section or specific intent to commit a violation of this section.” Also, includes language concerning more stringent sentencing guidelines and expanded subpoena powers. Sec. 10606

Confers authority on HHS to suspend Medicare and Medicaid payments to a provider or supplier if there is a “credible allegation of fraud” on the part of the supplier or provider. HHS has the discretion to determine if there is “good cause” not to suspend payments. Medicare, Medicaid, CHIP overpayments must be reported and returned within 60 days from the date the overpayment was identified or by the date a corresponding cost report was due, whichever is later. Mandates all Medicare, Medicaid, and CHIP providers include their NPI on enrollment applications. The statute adds new authority for permissive exclusions, testimonial subpoena authority, and for the imposition of surety bonds on providers and suppliers considered to be at risk by the Secretary. Sec. 6402

Entities contracting with the Medicare and Medicaid Integrity Programs must now submit annual performance information to HHS. The information must include “the number and amount of overpayments recovered, the number of fraud referrals, and the return on investment of such activities by the entity.” HHS is required to conduct performance evaluations on each contracted entity no less than every three years and provide an annual report to Congress on the amount and effectiveness of the funds expended on these integrity programs. Sec. 6402

HHS is required to maintain a national health care fraud and abuse data collection program for reporting certain final adverse actions (not including settlements in which no findings of liability have been made) against health care providers, suppliers, or practitioners in the National Practitioner Data Bank (“NPDB”). The Secretary is required to transition information from the Healthcare Integrity and Protection Data Bank (“HIPDB”) to the NPDB. The Secretary must ensure there are appropriate procedures to ensure that data collection and access to the HIPDB and NPDB are not disrupted. Physicians are entitled to request any information that has been reported to the NPDB and HHS is

required to establish a process whereby physicians may dispute the accuracy of the information reported. State licensure boards and Federal and state law enforcement agencies are able to access the data. Also allows access to the NPDB by the Veterans Administration. Sec. 6403

The maximum period for submission of Medicare claims is not to exceed more than 12 months from date of service. (Sec. 6404) Only those physicians “or other eligible professionals” enrolled in the Medicare program may, as of July 1, 2010, order DME or home health services. HHS has the discretion to extend this requirement to other items or services, including Part D drugs. Clarifying language provides that only physicians enrolled in the Medicare program may order home health services under Medicare Part A and B. Secs. 6405, 10604

As of January 1, 2010, physicians and other suppliers and providers who order items of DME, home health services, or other items and services, to “provide access to documentation” relating to such orders. Failure to do so could result in disenrollment from the Medicare program, for up to a year, for the non-complying physician, supplier, or provider. The IG’s permissive exclusion authority now extends to physicians, suppliers and providers who order DME, home health, and other items and services, who fail to provide access to the required documentation. Sec. 6406

Requires face-to-face encounter with patient in any six-month period before physician or other permitted health care professional may certify eligibility for home health services or durable medical equipment. The Secretary is also given the authority to extend this requirement to other items and services if it is determined that to do so would reduce the risk of fraud, waste, or abuse. Face-to-face encounter may be performed by a physician, nurse practitioner, clinical nurse specialist, certified nurse-midwife, or physician assistant. Secs. 6407, 10605

Establishes as well as increases penalties for Medicare Advantage and Part D marketing violations. Specifies conduct that will subject MA plans to penalties including marketing violations, transfers of beneficiaries without their consent or for the purpose solely of earning commission. There are also penalties for all persons who fail to grant HHS OIG access to documents, for the purpose of audits, investigations, evaluations, or other statutory functions, in a timely manner and now provides authority for the imposition of CMPs of \$15,000 per day. Persons who knowingly make false statements in connection with any Federal health care program are now subject to CMPs of \$50,000 for each violation. Sec. 6408

Requires HHS OIG to establish a self-referral disclosure protocol to provide a mechanism for health care providers to disclose actual or potential violations of the physician self-referral law within six months of enactment of the law. Sec. 6409

Expands HHS authority to conduct pre-payment review of Medicare claims and struck statute that established limits. Sec. 1302/HR 4872

Expands the recovery audit contractor program to Medicaid, Medicare Advantage, and the Medicare prescription drug benefit programs. For Medicaid, each State is required to enter into a contracts with a RAC by December 31, 2010, “for the purpose of identifying underpayments and overpayments, and recouping overpayments under the State Plan...”. Under MA and Part D Plans, HHS is required to enter into contracts with RAC contractors that will “ensure that each MA/Part D Plan has an antifraud plan in effect and to review the effectiveness of each such anti-fraud plan.” Sec. 6411

Expands authority for Secretary of HHS and states to collaboratively and independently to undertake heightened scrutiny of Medicaid providers/suppliers during enrollment and expanded program integrity and fraud and abuse authorities in the Medicaid program with most provisions effective January 1, 2011. (Secs. 6411, 6501, 6502, 6503, 6504, 6505, 6506, 6507, 6508)

Biosimilars

Confers the Food and Drug Administration (FDA) with immediate authority to establish an abbreviated pathway to approve biosimilars for market. Provides 12 years of market exclusivity protection. User fees to fund the FDA's activity for approval of the biosimilars. Rigorous regulatory provisions for approval of biosimilars are established including the Risk Evaluation and Mitigation Strategy requirement that it is applied to innovators. Requires the FDA to issue guidance documents for approval of biosimilars; requires immunogenicity studies which may be waived after FDA guidance issued that the current state of scientific evidence allows for a determination of immunogenicity safety. Secs. 7001-7003

Medicare Advantage

Beginning in 2012, HHS will begin transition to fiscal neutrality between regular Medicare fee for service and MA plans. Benchmarks will vary from 95 percent of regular Medicare spending in high cost areas to 115 percent of Medicare in low cost areas. Changes are phased in over a varying number of years, depending on the level of payment reductions. Sec. 3201; Sec. 1102/HR 4872

Authorizes the Secretary of HHS to deny bids submitted by MA and prescription plans. Sec. 3209

In 2011, MA plans prohibited from charging beneficiaries higher cost sharing than they would face in regular fee-for-service. Requires plans that provide extra benefits to give priority to cost sharing reductions, wellness and preventive care, and then benefits not covered under Medicare. Sec. 3202

Provides extra time for CMS, MA plans, and prescription drug plans to process enrollment paperwork during annual enrollment periods and eliminates a duplicative open enrollment period for MA plans. Allows beneficiaries to disenroll from a MA plan and return to the traditional fee-for-service program from January 1 to March 15 of each year. Sec. 3204

Extends the period of time for which cost plans may operate in areas that have other health plan options. Sec. 3206

Allows employer-sponsored MA private fee-for-service plans with current enrollment to use, beginning 2011, a CMS service area waiver available to employer and union group health plans that are coordinated care plans. Sec. 3207

Extends the Special Needs Plan (SNP) program through 2013 and requires SNPs to be NCQA approved. Allows HHS to apply a frailty payment adjustment to fully-integrated, dual-eligible SNPs that enroll frail populations. Requires HHS to transition beneficiaries enrolled in SNPs that do not meet statutory target definitions and requires dual-eligible SNPs to contract with State Medicaid programs beginning 2013. Requires an evaluation of Medicare Advantage risk adjustment for chronically ill populations. Sec. 3205

Allows demonstration plans that serve residents in continuing care retirement communities to operate under the MA program. Sec. 3208

Medicare Part D

Reduces the coverage gap for Medicare prescription drug benefit beneficiaries over time from 2010 to 2020. Beginning July 1, 2010, a \$250 rebate will be given to all Medicare prescription drug plan enrollees who enter the coverage gap. The coverage gap (“donut hole”) falls between \$2,700 and \$6,154 in total drug costs. Beginning in 2011, a decrease in the enrollee coinsurance rate in the donut hole will be phased-in from 100 percent to 25 percent by 2020. Also, beginning in 2011, a 50 percent discount on brand name prescriptions will be mandated for those in the coverage gap. A federal subsidy reaching 75 percent of the drug cost by 2020 for generic drug prescriptions in coverage gap will also begin in 2011. Beginning in 2013, a federal subsidy reaching 25 percent of the drug cost by

2020 for brand-name drug prescriptions filled in the coverage gap will be applied. Between 2014 and 2019, a reduction of the out-of-pocket amount that qualifies an enrollee for catastrophic coverage will be phased-in. Secs. 3301, 3315; Sec. 1101/HR 4872

HHS will develop and maintain a plan complaint system to handle complaints regarding MA and Part D plans or their sponsors. Sec. 3311

Requires Part D plans to use a single, uniform exceptions and appeals process. Sec. 3312

Reduces the Part D premium subsidy for beneficiaries with incomes above the Part B income thresholds in 2011. Sec. 3308

Improves the formulary requirements for prescription drug plans and MA–PD plans with respect to certain categories or classes of drugs. Codifies the current six classes of clinical concern, removes the criteria specified in section 176 of MIPPA that would have been used by HHS to identify protected classes of drugs and gives the Secretary authority to identify classes of clinical concern through rulemaking. Sec. 3307

Eliminates cost sharing for beneficiaries receiving care under a home and community-based waiver program who would otherwise require institutional care. Sec. 3309

Self-Referral Exception for Imaging

Physicians (and other Medicare providers/suppliers) are required to inform patients in writing when they make referrals (permitted by the Medicare in-office exception to the general bar on self-referrals) that the patient may obtain the referred services from a person other than the referring physician and the physician must provide the patient with a list of individuals who furnish the services in an area where the patient resides. Sec. 6003

Medicare Payment/SGR

No provision addressing the Medicare physician payment update. (This will be addressed in separate legislation.) Secs. 3101, 10310

Independent Payment Advisory Board

Establishes a 15-member Independent Payment Advisory Board (IPAB) to expend Medicare solvency and reduce Medicare and national spending growth through use of a Medicare spending target system and fast track legislative approval process. By April 30 of each year, beginning in 2013, the Medicare Actuary's Office would project whether Medicare's per-capita spending growth rate in two years will exceed a targeted rate. The spending target would be the projected 5-year average (ending in such year) percentage increase in the average of the projected percentage increase in Consumer Price Index for all urban consumers (CPI-U) and the Consumer Price Index for all urban consumers for medical care (CPI-M). The target beginning in 2019 would be nominal gross domestic product per capita + 1.0%. If future growth is expected to exceed the targets, IPAB would make recommendations, beginning January 15, 2014, to Congress and the President to reduce the rate of growth in Medicare spending. Spending rate reductions would be established at: 0.5% in 2015; 1.0% in 2016; 1.25% in 2017; 1.5% in 2018 and beyond. If Congress fails to pass legislation by August 15 each year to achieve the required savings through other policy changes, IPAB's recommendations would automatically take effect. The Board is prohibited from submitting proposals that would ration care, increase revenues or change benefits, eligibility or Medicare beneficiary cost sharing (including Parts A and B premiums), or would result in a change in the beneficiary premium percentage or low-income subsidies under Part D. Hospitals and other providers, such as hospices and clinical labs (for one year), will not be subject to cost reductions proposed by the Board from 2015 through 2019. Beginning July 1, 2014, the IPAB must also submit an annual report with information on system-wide health care costs, patient access to care, utilization, and quality of care that allows comparison

by region, types of services, types of providers, and both private payers and Medicare. By January 1, 2015, and at least every other year thereafter, the IPAB would submit recommendations to slow the growth in national health expenditures while preserving or enhancing quality of care. These recommendations could be those that: (i) the Secretary of HHS and other federal agencies could implement administratively; (ii) may require federal legislation to be implemented; (iii) may require state or local government legislation to be implemented; or (iv) private entities can voluntarily implement. Secs. 3403, 10320

Medicare Enrollment

An enrollment application fee of \$500 for institutional providers and suppliers established to cover the costs of screening. Physicians are not subject to the enrollment fee. Secs. 6401, 10603

Geographic Adjustment

Modifies physician payments based on quality/cost index and on budget neutral basis, beginning in 2015 (based on 2014 performance), and all physician payments must be subject to quality/cost payment modifications by 2017. Sec. 3007

Provides new money for 2010/2011 practice expense GPCI adjustments to help payment areas with PE GPCIs less than 1.0. Based on the results of an HHS PE GPCI study, PE GPCIs adjustments would be implemented by 2012 in a budget neutral manner. Sec. 3102

Provides additional funding to establish a practice expense GPCI floor of 1.0 for frontier states (ND, SD, MT, WY, UT) beginning January 1, 2011. Sec. 10324

Physician Resource Use

Expands the Medicare physician feedback program based on episode-grouper methodology that must be developed by January 1, 2012. Secretary must make methodology publicly available and seek endorsement of methodology through NQF. Beginning in 2012, Secretary will provide reports to physicians comparing physicians’ patterns of resource use to other physicians. Public reporting of aggregate reports for MDs and DOs. Sec. 3003

Physician Quality Reporting Initiative

Provides 4 years of PQRI bonuses; 2011 (1%), 2012-2014 (0.5%). Establishes PQRI penalties for unsuccessful participation beginning in 2015 (-1.5%) and thereafter (-2%). Requires timely feedback for PQRI eligible professionals, and a PQRI informal appeals process must be in place by January 1, 2011, for eligible professionals to seek a review of the determination that the eligible professional did not satisfactorily submit data on quality measures. Also, beginning in 2012, Secretary would develop a plan to integrate quality measure reporting with EHR meaningful use reporting requirements. Beginning in 2011, provides an additional 0.5% PQRI bonus for 3 years (2011-2014) if physicians and other eligible professionals report quality data to the PQRI through a maintenance of certification (MOC) process, and after 2014, the Secretary could require participation in an MOC as part of the physician cost/quality index under section 3007. Secs. 3002, 10327

Year	PQRI
2011	1% if no MOC, 1.5% if MOC
2012	0.5% if no MOC, 1% if MOC
2013	0.5% if no MOC, 1% if MOC
2014	0.5%
2015	-1.5%, HHS could begin requiring MOC after 2014
2016	-2%

Quality Improvement Initiatives/CMS Innovation Center

Provides additional resources for development of national strategy and priorities for performance improvement, development and dissemination of quality measures, development and dissemination of best practices, data aggregation, and public reporting of performance information. The public reporting provision does not have an effective date, and therefore the Secretary has the discretion to determine the timeline for public reporting. Provides additional resources for grants for shared decision making programs in federal programs. Secs. 3011-3015, 3501, 10302, 10304, 10305

Requires the Secretary to develop and update outcomes measures for physicians, hospitals and other providers. Measures must address acute and chronic diseases within 2 years of enactment and primary and preventative care within 3 years of enactment, with at least 10 measures for each of these categories. Sec. 10303

Establishes CMS Innovation Center by January 1, 2011, to test care models that improve quality and slow Medicare cost growth rate. The Secretary can expand the duration and scope of a model, including nationwide. Secretary to make public evaluation of each model, including quality of care furnished under the model. Allows the Secretary to limit testing of a model to certain geographic areas. Secs. 3021, 10306

Requires public reporting of physician Medicare and private payer (if available) performance information regarding such matters as PQRI measures and other factors, such as health outcomes, care coordination, resource use, efficiency and patient experience. Data would have to meet certain safeguards (valid, reliable, risk-adjusted) and physicians would have prior opportunity to review data. There would also be appropriate attribution, timely feedback, and CMS computer systems that support valid, reliable and accurate public reporting. Public reporting would begin January 1, 2013 regarding reporting periods that begin no earlier than January 1, 2012. Sec. 10331

Directs the Secretary of HHS to contract with the Institute of Medicine regarding best methods for identifying existing and new clinical practice guidelines that were developed using best practices and methods. Will highlight best practices for developing guidelines as well as the guidelines. HHS Secretary is required to consult with professional societies, voluntary health care organizations, and expert panels. Sec. 10303

Medicare Claims Data

Effective January 1, 2012, the Secretary of HHS will provide Medicare claims data to qualified entities for purposes of public provider performance reports subject to certain conditions. Entities must meet certain safeguards regarding ensuring validity and reliability of the data. Physicians and other providers will have prior review of the data before publicly reported with an opportunity to appeal and correct errors. Data cannot be subject to discovery or admitted as evidence in legal proceedings without consent of provider/supplier. Sec. 10332

Primary Care Bonus

Primary care/general surgery Medicare bonus (10 percent over 5 years): Effective January 1, 2011 through December 31, 2015. Primary care bonus applies to primary care physicians (family medicine, internal medicine, geriatric medicine or pediatric medicine) and practitioners (NP, CNS, or PA) for whom primary care services (HCPCS codes 99201-99215; 99304-99340; and 99341-99350) account for at least 60 percent of Medicare allowed charges over a designated time period. Secs. 5501, 10501(h)

Payment for Imaging Services

In determining Medicare practice expense relative values, sets a 75 percent assumed utilization rate beginning January 1, 2011, for expensive diagnostic imaging equipment priced at more than \$1

million (MRI/CT). This replaces the 90 percent assumed utilization rate that CMS put into effect for 2010 (CMS previously used a 50 percent utilization rate assumption). Beginning July 1, 2010, increases technical multiple imaging procedure payment reduction from 25 percent to 50 percent. Sec. 3135; Sec. 1107/H.R. 4872

Accountable Care Organization

By January 1, 2012, the Secretary will establish Medicare shared savings programs (ACOs) for various providers, including groups of physicians, to share in savings. ACOs will have to be formed for at least 3 years and shall have at least 5,000 beneficiaries assigned to it. Secs. 3022, 10307

Medical Home Pilot Program

Establishes an independence at home demonstration program by January 1, 2012, to bring primary care services to the highest cost Medicare beneficiaries with multiple chronic conditions in their home. Health teams could be eligible for shared savings if they achieve quality outcomes, patient satisfaction, and cost savings. Nurse practitioners and physicians assistants could also lead the home-based primary care team as part of an independence at home medical practice. Sec. 3024

Misvalued Codes Under Physician Fee Schedule

Requires Secretary to identify/adjust RVUs for potentially misvalued CPT codes, and the Secretary may use existing processes for recommendations on review/adjustment. The Secretary would also establish a process to validate RVUs, and may use exiting processes to do so, and shall make adjustments to work RVUs. Sec. 3134

Practicing Physicians Advisory Council

Repeals PPAC. Sec. 3134

Physician-Owned Hospitals

Ban on new physician-owned hospitals in Medicare. For current hospitals, level of physician ownership and investment in the aggregate could not increase, and there are limits on expansions of beds, operating rooms, procedure rooms, and new disclosure requirements. Current hospitals must have a provider agreement in effect as of December 31, 2010. Secs. 6001, 10601; Sec. 1106/H.R. 4872

Preventive Services

Provides incentives for use of Medicare preventive services; eliminates co-insurance; provides annual Medicare coverage of risk assessment and wellness visit and personalized prevention plan, with incentives for healthy lifestyles; no co-insurance. Effective date is January 1, 2011. Secs. 4103, 4104

Work GPCI

Extends the work GPCI floor through 2010. Sec. 3102

Nurse Midwives

Increases Medicare payment rates for nurse-midwives from 65 percent to 100 percent of the Medicare physician fee schedule as of January 1, 2011. Sec. 3114

Medical Liability Reform

Authorizes the Secretary of HHS to award up to \$50 million starting in 2011 in competitive grants to states to pursue demonstration programs on alternative liability reforms. Also, includes a provision that allows patients to opt-out of these alternatives at any time and pursue their liability claim in court. Secretary will consult with a review panel on grant proposals. The Medicare Payment Advisory Commission (MedPAC) and the Medicaid and CHIP Payment and Access Commission (MACPAC) are required to conduct independent evaluations of the state alternatives. Sec. 10607

Extends medical liability protections under the Federal Tort Claims Act (FTCA) to officers, governing board members, employees, and contractors of free clinics. FTCA coverage applies to any act or omission which occurs on or after March 23, 2010. Sec. 10608

Requires a GAO study and report by March 2012 on whether the development, recognition, or implementation of guidelines, standards, or payment adjustments specified in multiple sections of the Act could result in new causes of actions or claims against health care providers. Sec. 3512

Graduate Medical Education (GME)

Authorizes the re-distribution of 65 percent of current unused GME residency slots to qualifying hospitals to address physician shortages, especially in rural and other underserved areas. A hospital that qualifies for an increase in residency positions would have to maintain its base level of primary care residents and ensure that at least 75 percent of the additional positions are in primary care or general surgery residency. Effective July 1, 2011. Sec. 5503

Provide more flexibility for GME programs to count training in outpatient settings and didactic and scholarly activities towards GME payments for 2010, and previous cost reporting periods. Secs. 5504-5505

Preserves GME positions from closed hospitals based on certain criteria. Directs the Secretary of HHS, through rulemaking, to establish in 2010, a process to redistribute medical residency slots from qualifying closed hospitals. Sec. 5506

Requires the Secretary to establish a Medicare graduate nurse education demonstration program. Beginning in FY 2012, under the demonstration program, up to five eligible hospitals will receive Medicare reimbursement for clinical training costs attributed to providing advanced practice nurses with qualified training. Sec. 5509

Health Care Workforce

Workforce provisions authorize: the establishment of a National Health Care Workforce Commission to provide recommendations to Congress on health care workforce needs (appointments to the Commission must be made by September 30, 2010); awarding of state workforce development grants, and the creation of national, state, and regional workforce analysis centers; increased funding for the National Health Service Corps (NHSC) scholarship and loan repayment program (up to \$1.15 billion in FY 2015) and expansion of NHSC eligibility requirements; funding for Title VII health professions and diversity programs, and expansion of Title VII programs to support preventive medicine and public health residency programs, and rural physician training; grants to teaching health centers to establish newly accredited or expanded eligible primary care residency programs; funding for Title VIII nurse education and training programs; amendment to primary care student loan forgiveness requirements; the establishment of a loan repayment program for pediatric subspecialists and mental and behavioral health service providers working in underserved areas; the creation of a Ready Reserve Corps for service in times of national emergency; authorization of funding for direct care worker training for providing long-term care services; expansion of the geriatric academic career awards under Title VII to advanced practice nurses and other health care professionals; the creation of a grant program to support nurse-managed health clinics; a training demonstration program for family nurse practitioners for careers as primary care providers in federally qualified health centers and nurse-managed health clinics; authorization for mental and behavioral health education and training grants; addressing of workforce shortages in state and local health departments in applied public health epidemiology and public health science; and the establishment of a primary care extension program to educate and provide technical assistance to primary care providers about evidence-based therapies, preventive medicine, health promotion, chronic disease management, and mental health. Secs. 5101-5405

Also provides funding to support pilot projects in FY 2010, that design, implement, and evaluate models of regionalized emergency care and trauma systems. In addition, would authorize grants to trauma centers in underserved areas. Secs. 3504-3505

Requires the Secretary of HHS to study the appropriateness of the level of diabetes education in medical schools and report on recommendations by March 2012, for what level of diabetes education should be required in medical education. Sec. 10407(d)

Amends the Internal Revenue Code (IRC) to enable student loan repayment tax relief by exempting certain state funded loan repayments that are intended to increase the availability of health care services in shortage or underserved areas, along with the NHSC loan repayment program, from federal income taxation. The tax exclusion applies to taxable years beginning after December 31, 2008. Sec. 10908

Amends the Income-Based Repayment Program to cap student loan payments for new borrowers after July 1, 2014 to 10 percent of adjusted income (rather than 15 percent) and would allow any remaining debt to be forgiven after 20 years of payments (rather than 25 years). Sec. 2213/H.R. 4872

Requires converting all new federal student lending to the federally run Direct Loan Program as of July 1, 2010, and thus would end government subsidies to private, commercial student lenders. The federal government would lend directly to students. Sec. 2201 et seq./H.R. 4872

Requires the Secretary of HHS, through a negotiated rulemaking process, to establish by July 1, 2011, a comprehensive methodology and criteria for designating medically underserved populations and health professional shortage areas (HPSAs). Sec. 5602

Administrative Simplification

Requires the Secretary of HHS to adopt a single set of operating rules, recommended by a qualifying non-profit entity, for electronic transactions like eligibility verification, claims status, claims remittance/payment, claims attachments, as well as a rule to establish an electronic funds transfers (EFT) standard, within specified periods of time. Also requires the Secretary to adopt a unique health plan identifier system by October 1, 2012, and requires the mandated use of EFT under Medicare by January 1, 2014. Health plans are required to certify compliance with standards and operating rules, and would be subject to penalties for noncompliance. Sec. 1104

Requires the Secretary of HHS to consult with stakeholders and the National Committee on Vital and Health Statistics (NCVHS) to identify additional administrative simplification standards by January 1, 2012, and authorizes the Secretary to convene stakeholders to establish and make recommendations on an ICD-9-CM to ICD-10 crosswalk by January 1, 2011, and on subsequent revisions to the crosswalk. Sec. 10109

Revenues/Financing

Imposes an excise tax on insurers and plan administrators of employer-sponsored health plans with aggregate values that exceed \$10,200 for individual coverage and \$27,500 for family coverage (these threshold values will be indexed to the consumer price index for urban consumers (CPI-U) for years beginning in 2020). The threshold amounts will be increased for retired individuals age 55 and older who are not eligible for Medicare and for employees engaged in high-risk professions by \$1,650 for individual coverage and \$3,450 for family coverage. The threshold amounts may be adjusted upwards if health care costs rise more than expected prior to implementation of the tax in 2018. The thresholds will be increased for firms that may have higher health care costs because of the age or gender of their workers. The tax is equal to 40 percent of the value of the plan that exceeds the threshold amounts and is imposed on the issuer of the health insurance policy, which in the case of a self-insured plan is the plan administrator or, in some cases, the employer. The aggregate value of the

health insurance plan includes reimbursements under a flexible spending account for medical expenses (health FSA) or health reimbursement arrangement (HRA), employer contributions to a health savings account (HSA), and coverage for supplementary health insurance coverage, excluding dental and vision coverage. Effective January 1, 2018. Secs. 9001, 10901; Sec. 1401/H.R. 4872

Excludes the costs for over-the-counter drugs not prescribed by a doctor from being reimbursed through an HRA or health FSA and from being reimbursed on a tax-free basis through an HSA or Archer Medical Savings Account. Effective January 1, 2011. Sec. 9003

Increases the tax on distributions from a health savings account or an Archer MSA that are not used for qualified medical expenses to 20% (from 10% for HSAs and from 15% for Archer MSAs) of the disbursed amount. Effective January 1, 2011. Sec. 9004

Limits the amount of contributions to a flexible spending account for medical expenses to \$2,500 per year increased annually by the cost of living adjustment. Effective January 1, 2013. Secs. 9005, 10902

Increases the threshold for the itemized deduction for unreimbursed medical expenses from 7.5% of adjusted gross income to 10% of adjusted gross income for regular tax purposes; waives the increase for individuals age 65 and older for tax years 2013 through 2016. (Effective January 1, 2013) Sec. 9013

Increases the Medicare Part A (hospital insurance) tax rate on wages by 0.9% (from 1.45% to 2.35%) on earnings over \$200,000 for individual taxpayers and \$250,000 for married couples filing jointly and imposes a 3.8% tax on unearned income for such higher-income taxpayers (thresholds are not indexed). Effective January 1, 2013. Secs. 9015, 10906; Sec. 1402/H.R. 4872

Eliminates the tax deduction for employers who receive Medicare Part D retiree drug subsidy payments. Effective January 1, 2013. Sec. 9012; Sec. 1407/H.R. 4872

Imposes new annual fees on the pharmaceutical manufacturing sector, beginning in 2011. Sec. 9008; Sec. 1404/H.R. 4872

Imposes an annual fee on the health insurance sector, beginning in 2014; for non-profit insurers, only 50% of net premiums are taken into account in calculating the fee. Exemptions granted for non-profit plans that receive more than 80 percent of their income from government programs targeting low-income or elderly populations, or people with disabilities, and voluntary employees' beneficiary associations (VEBAs) not established by an employer. Secs. 9010, 10905; Sec. 1406/H.R. 4872

Imposes an excise tax of 2.3 percent on the sale of any taxable medical device. (Effective for sales after December 31, 2012) Exempts Class I medical devices, eyeglasses, contact lenses, hearing aids, and any device of a type generally purchased by the public at retail or for individual use. Secs. 9009, 10904; Sec. 1405/H.R. 4872

Limits the deductibility of executive and employee compensation to \$500,000 per applicable individual for health insurance providers. Effective January 1, 2009. Sec. 9014

Imposes a tax of 10 percent on the amount paid for indoor tanning services (excludes phototherapy services performed by a licensed medical professional) in lieu of cosmetic surgery tax. Effective July 1, 2010. Sec. 10907

Excludes unprocessed fuels from the definition of cellulosic biofuel for purposes of applying the cellulosic biofuel producer credit. Effective January 1, 2010. Sec. 1408/H.R. 4872

Codifies application of the economic substance doctrine and increases penalties for underpayments attributable to a transaction lacking economic substance. Effective upon enactment. Sec. 1409/H.R. 4872

Provides for a one-time adjustment to corporate estimated taxes for payments made during calendar year 2014. Sec. 1410/H.R. 4872

Miscellaneous

Requires the Architectural and Transportation Barriers Compliance Board to establish standards for accessibility of medical diagnostic equipment to individuals with disabilities. Sec. 4203