



## Manager's Amendment to the Patient Protection and Affordable Care Act

### Section-by-Section Analysis

#### TITLE X— STRENGTHENING QUALITY, AFFORDABLE HEALTH CARE FOR ALL AMERICANS

##### Subtitle A – Provisions Relating to Title I

#### Sec. 10101. Amendments to Subtitle A.

- (a) **Sec. 2711. No lifetime or annual limits.** Prohibits all plans from establishing lifetime limits, and annual limits beginning in 2014, on the dollar value of benefits. Prior to 2014, plans may not have lifetime limits and may only establish restricted annual limits, as defined by the Secretary of Health and Human Services (HHS), on the dollar value of benefits with respect to the essential health benefits under section 1302(b). In restricting annual limits, the provision requires the Secretary to ensure access to needed services with minimal impact on premiums.
- (b) Requires plans to provide a summary of coverage to applicants and policyholders or certificate holders, as well as to enrollees.
- (c) **Sec. 2715A. Provision of additional information.** Requires all plans to disclose the information required in section 1311(e), such as claims payment policies and rating practices. Plans that are not offered through an Exchange must submit this information to the Secretary of HHS and the State insurance commissioner and make such information available to the public.
- (d) **Sec. 2716. Prohibition on discrimination in favor of highly compensated individuals.** Includes a cross-reference to the existing requirements in the Internal Revenue Code in order to avoid redundancy.
- (e) Protects Second Amendment gun rights by precluding the collection and disclosure of information related to gun ownership or use for purposes of determining premium rates.
- (f) **Sec. 2718. Bringing down the cost of health care coverage.** Requires plans offering coverage in the group and individual markets (including grandfathered plans but excluding self-insured plans) to report to the Secretary the amount of premium revenues spent on clinical services, activities to improve quality, and all other non-claims costs as defined by the National Association of Insurance Commissioners and certified by the Secretary of HHS. Beginning in 2011, large group plans which spend less than 85

percent of premium revenue and small group and individual market plans which spend less than 80 percent of premium revenue on clinical services and quality must provide a rebate to enrollees. In addition, each hospital operating within the United States shall publish a list of standard charges for items and services provided by the hospital.

- (g) **Sec. 2719. Appeals process.** Requires plans to implement an effective internal appeals process of coverage determinations and claims and comply with any applicable State external review process. If the State has not established an external review process or the plan is self-insured, the plan shall implement an external review process that meets minimum standards established by the Secretary. The Secretary may deem the external review process of a plan in operation as of enactment to be in compliance with this section.
- (h) **Sec. 2719A. Patient protections.** Requires that a plan enrollee be allowed to select their primary care provider, or pediatrician in the case of a child, from any available participating primary care provider. Precludes the need for prior authorization or increased cost-sharing for emergency services, whether provided by in-network or out-of-network providers. Plans are precluded from requiring authorization or referral by the plan for a female patient who seeks coverage for obstetrical or gynecological care by a specialist in these areas.
- (i) Allows for the establishment of medical reimbursement data centers to develop fee schedules and other database tools that reflect market rates for medical services.

#### **Sec. 10102. Amendments to Subtitle B.**

- (a) Clarifies that reinsurance for early retirees applies to plans sponsored by State and local governments for their employees.
- (b) Clarifies that the immediate internet portal to identify affordable health insurance coverage options in the State shall be available to small businesses and shall contain information on coverage options available to small businesses.

#### **Sec. 10103. Amendments to Subtitle C.**

- (a) Clarifies that rating requirements would apply only to insured plans in the large group market, not self-insured plans.
- (b) Clarifies that waiting periods do not apply to the individual market.
- (c) **Sec. 2709. Coverage for individuals participating in approved clinical trials.** Prohibits insurers from dropping coverage because an individual chooses to participate in a clinical trial and from denying coverage for routine care that they would otherwise provide just because an individual is enrolled in a clinical trial. Applies to all clinical trials that treat cancer or other life-threatening diseases.

- (d) Applies requirements for medical loss ratios and uniform coverage documents to grandfathered plans.
- (e) Clarifies that grandfathering takes effect on the date of enactment. Applies the prohibition on pre-existing condition exclusions with respect to children effective six months after enactment.
- (f) **Sec. 1253. Annual report on self-insured plans.** Requires the Secretary of Labor to prepare an annual report on various aspects of self-insured group health plans.

**Sec. 1254. Study of large group market.** Requires the Secretary of HHS to conduct a study of the fully-insured and self-insured group health plan markets to compare characteristics and determine the extent to which new insurance market reforms are likely to cause adverse selection in the large group market.

#### **Sec. 10104. Amendments to Subtitle D.**

- (a) Conforming amendment to strike the community health insurance option and add the multi-state plans. Allows qualified health plans to provide coverage through a qualified direct primary care medical home plan that meets requirements established by the Secretary.
- (b)(1) Requires, rather than permits, the Secretary to issue regulations on whether employer contributions to Health Savings Accounts (HSAs) count in determining actuarial value.
- (b)(2) Ensures that any payments by qualified health plans to Federally Qualified Health Centers (FQHCs) are at least as high as payments to FQHCs under Medicaid.

#### **(c) Sec. 1303. Special Rules**

- Affirms that States may prohibit abortion coverage in qualified health plans offered through an Exchange in such State if such State enacts a law to provide for such prohibition.
- Plans may elect whether or not to cover abortion. Requires a segregation of funds for subsidy-eligible individuals in plans that cover abortions for which the expenditure of Federal funds appropriated for the Department of Health and Human Services is not permitted. Subsidy-eligible individuals would make two payments, with one going to an allocation account to be used exclusively for payment of such services. Requires State insurance commissioners to ensure compliance with the requirement to segregate federal funds in accordance with generally accepted accounting requirements and guidance from the Office of Management and Budget (OMB) and Government Accountability Office (GAO). Plans would be required to include in their benefit descriptions whether or not they cover abortion, as they will do for all other benefits. The allocation of the premium into its components would not be advertised or used in enrollment material. All applicants would see the same premium when they are choosing a plan.

- Replaces provider conscience protections with new conscience language that would prohibit qualified health plans from discriminating against any individual health care provider or health care facility because of its unwillingness to provide, pay for, provide coverage of, or refer for abortions.
- Federal and State laws regarding abortion are not preempted.
- (d) Defines an “educated health care consumer,” and requires Exchanges to consult with enrollees who are educated health care consumers.
- (e) Clarifies that States must make payments to cover the cost of additional benefits directly to individuals or plans, and not to Exchanges.
- (f)(1) Requires, rather than permits, Exchanges to consider the reasonableness of premium rate increases when determining whether to certify and offer plans.
- (f)(2) Requires plans seeking certification by Exchanges to publicly disclose, in plain language, information on claims payment policies, enrollment, denials, rating practices, out-of-network cost-sharing, and enrollee rights. Requires such plans to provide information to enrollees on the amount of cost-sharing for a specific item or service. Requires the Secretary of Labor to update disclosure rules for group health plans to conform to these standards.
- (g) Requires qualified health plans to implement activities to reduce health disparities, including the use of language services, community outreach, and cultural competency trainings.
- (h) Makes resource partners of the Small Business Administration eligible for grants under the Navigator program.
- (i) Requires the Secretary to establish procedures for agents or brokers to enroll employers in qualified health plans. Strikes the authority to establish rate schedules for broker commissions paid by qualified health plans. Conforming amendment to allow individuals to enroll only in qualified health plans for which they are eligible.
- (j) Narrows the application of the False Claims Act’s public disclosure bar to ensure that whistleblowers who play a significant role in exposing fraud can be included in otherwise meritorious litigation.
- (k) Requires GAO to study the cost and affordability of qualified health plans offered through Exchanges.
- (l) Requires CO-OPs to repay loans within five years and grants within 15 years.
- (m) Strikes the community health insurance option.

- (n) Conforming amendment to require a level playing field for multi-state qualified health plans.
- (o) Makes legal immigrants whose income is less than 133 percent of the Federal Poverty Level (FPL), and who are not eligible for Medicaid by virtue of the five year waiting period, eligible for the basic health program.
- (p) Conforming amendment to strike nationwide plans, which are replaced by multi-state plans.
- (q) 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) through Exchanges in each State. Requires OPM to negotiate contracts in a manner similar to the manner in which it negotiates contracts for Federal Employees Health Benefits 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, unless they conflict with the PPACA. Guarantees that FEHBP will maintain a separate risk pool and remain a separate program.
- (r) Technical correction to clarify that reinsurance applies only to the individual market.

**Sec. 10105. Amendments to Subtitle E.**

- (a) Technical correction to change the household income definition to include those at 100 percent of the federal poverty level.
- (b) Technical correction to set the household income definition to include those at 100 percent of the federal poverty level.
- (c) Technical correction to correct the cross reference from (b)(3)(A)(ii) to (b)(3)(A)(iii).
- (d) Technical correction to add a missing cross reference to 36B.
- (e) Starts small business tax credit in 2010, one year earlier, expands the full credit to firms with average wages up to \$25,000 instead of \$20,000, and makes the credit available to firms with average wages up to \$50,000 instead of \$40,000.
- (f) Directs the Secretary of HHS to study adjusting the definition of “federal poverty level” to reflect cost of living variations among different geographic areas within the United States.

## **Sec. 10106. Amendments to Subtitle F.**

- (a) Revises statement of Congressional findings relative to the individual responsibility requirement.
- (b) Revises penalty amounts for the individual responsibility requirement. Individuals who do not purchase coverage will pay the greater of \$95 in 2014, \$495 in 2015 and \$750 in 2016, or up to two percent of income by 2016, up to a cap of the national average bronze plan premium. Families will pay half the amount for children up to a cap of \$2,250 for the entire family. After 2016, dollar amounts will increase by the annual cost of living adjustment.
- (c) Technical correction to the religious conscience exemption from the individual responsibility requirement.
- (d) Technical correction to the affordability exemption from the individual responsibility requirement.
- (e) **Large employers with waiting periods exceeding 60 days.** Amends the employer share responsibility policy such that a large employer requiring a waiting period before an employee may enroll in coverage of longer than 60 days will pay a fine of \$600 per full-time employee.
- (f)(1) Clarifies that the calculation of full-time workers is made on a monthly basis.
- (f)(2) Defines “applicable large employer” with respect to “construction industry employers” as employers with at least five full-time employees and with an annual payroll in excess of \$250,000.
- (g) Provides the Secretary of HHS the authority to review the accuracy of information provided by large employers.

## **Sec. 10107. Amendments to Subtitle G.**

- (a) Technical correction to add a missing cross reference.
- (b) Directs the GAO to study the rate of denial of coverage and enrollment by health insurance issuers and group health plans. Disallows any waiver of small business contracts under the Federal Acquisition Regulation of the Small Business Act.

**Sec. 10108. Free choice vouchers.** Requires employers that offer coverage and make a contribution to provide free choice vouchers to qualified employees 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.

**Sec. 10109. Development of standards for financial and administrative transactions.**

Requires the Secretary to consult stakeholders and the National Committee on Vital and Health Statistics and the Health Information Technology Standards and Policy Committees to identify opportunities to create uniform standards for financial and administrative health care transactions, not already named under HIPAA, that would improve the operation of the health system and reduce costs.

**Subtitle B—Provisions Relating to Title II**

**Part I – Medicaid and CHIP**

**Sec. 10201. Amendments to the Social Security Act and Title II of this Act.**

- (a) Makes the State option to cover former foster kids 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.
- (b) Moves the start date for the Medicaid State option to cover adults at or below 133 percent FPL to April 1, 2010.
- (c) This section includes a number of clarifications and some policy adjustments related to the Medicaid expansion to 133 percent FPL.
  - Clarifies that to qualify as an “expansion State,” the benefit package must include inpatient hospital services.
  - Clarifies that for the definition of “newly eligible,” current coverage levels are pegged to December 1, 2009.
  - Provides a limited matching rate increase to States that have already undertaken a Medicaid expansion that would not have any “newly eligible” beneficiaries.
  - Requires States to share the benefit of increased federal match with political subdivisions (like counties) that contribute to the non-federal share of Medicaid costs.
  - Applies pre-2017 matching rate to subsequent years in Nebraska.
- (d) Clarifies that new mandatory coverage of childless adults in territories is pegged to current eligibility levels for parents in the territories.
- (e) Gives Hawaii a Medicaid Disproportionate Share Hospital (DSH) allotment and scales back the reductions in federal Medicaid allotments for DSH.
- (f) Clarifies the effective date for the DSH policy.
- (g) Clarifies that children who cannot enroll in the Children’s Health Insurance Program (CHIP) because allotments are capped are deemed ineligible for CHIP and, therefore, eligible for tax credits in the Exchanges.

- (h) Modifies the teen pregnancy prevention provision to read “healthy relationships, including marriage and family interactions.”
- (i) Increases the transparency of the Medicaid waiver development and approval processes, at the State and federal levels.
- (j) **Sec. 3512. GAO study and report on causes of action.** Directs the Comptroller General to conduct a study, within two years of enactment, as to whether implementation of provisions in the legislation would result in the establishment of a new cause of action or claim.

**Sec. 10202. Incentives for States to offer home and community based services as a long-term care alternative to nursing homes.** Adds a new policy that creates financial incentives for States to shift Medicaid beneficiaries out of nursing homes and into home and community based services (HCBS). The provision provides Federal Medical Assistance Percentage (FMAP) increases to States to rebalance their spending between nursing homes and HCBS.

**Sec. 10203. Extension of funding for CHIP through fiscal year 2015 and other CHIP-related provisions.** Extends the current reauthorization period of CHIP for two years, through September 30, 2015. States will receive a 23 percentage point increase in their federal match rates beginning fiscal year 2016 through fiscal year 2019. This provision also increases outreach and enrollment grants by \$40 million, makes some children of public employees eligible for CHIP, and precludes transitioning coverage from CHIP to the Exchange without Secretarial certification. It also requires insurers in the Exchange to report to the Secretary on pediatric quality measures.

## **Part II – Support for Pregnant and Parenting Teens and Women**

**Sec. 10211. Definitions.** Defines “eligible institution of higher learning” as having the same meaning as in section 101 of the Higher Education Act of 1965 (20 U.S.C. 1001). The terms “accompaniment”, “community service center”, “high school”, “intervention service”, “Secretary”, “State”, “supportive social service”, and “violence” are also defined.

**Sec. 10212. Fund.** Establishes a Pregnancy Assistance Fund for the purpose of awarding competitive grants to States to assist pregnant and parenting teens and women. The fund will be established by the Secretary of Health and Human Services in coordination and collaboration with the Secretary of Education.

**Sec. 10213. Permissible use of funds.** Requires States to use the funds provided by these grants to provide support to pregnant and parenting teens and young women. States may use the funds provided to make funding available to eligible institutions of higher learning.

**Matching requirement.** An eligible institution of higher learning that receives funding under this provision shall contribute non-federal funds equal to 25 percent.

Permissible uses of funds include for programs such as those that help pregnant or parenting teens stay in or complete high school, assistance to states in providing intervention services, and outreach so that pregnant and parenting teens and women are aware of services available to them.

**Sec. 10214. Appropriations.** Appropriates \$25 million for each of the fiscal years 2010 through 2019.

### **Part III – Indian Health Care Improvement**

**Sec. 10221. Indian health care improvement.** Authorizes appropriations for the Indian Health Care Improvement Act, including programs to increase the Indian health care workforce, new programs for innovative care delivery models, behavioral health care services, new services for health promotion and disease prevention, efforts to improve access to health care services, construction of Indian health facilities, and an Indian youth suicide prevention grant program.

#### **Subtitle C – Provisions Related to Title III**

**Sec. 10301. Plans for a value-based purchasing program for Ambulatory Surgical Centers.** Requires the Secretary of HHS to develop a plan to reimburse Ambulatory Surgery Centers (ASCs) based on the quality and efficiency of care delivered in ASCs.

**Sec. 10302. Revision to national strategy for quality improvement in health care.** Clarifies that the limitations on use of comparative effectiveness data apply to the development of the National Strategy for Quality Improvement.

**Sec. 10303. Development of outcome measures.** Requires the Secretary of HHS to develop and publicly report on patient outcomes measures.

**Sec. 10304. Selection of efficiency measures.** Clarifies that quality measures include measures of efficiency.

**Sec. 10305. Data collection; public reporting.** Requires the Secretary of HHS to develop a plan for the collection and public reporting of quality measures.

**Sec. 10306. Improvements under the Center for Medicare and Medicaid Innovation.** Adds payment reform models to the list of projects for the Center to consider, including rural telehealth expansions and the development of a rapid learning network. Ensures that quality measures used by the Center are consistent with the quality framework within the underlying bill, and requires the Secretary to focus on models that both improve quality and reduce costs.

**Sec. 10307. Improvements to the Medicare Shared Savings Program.** Provides additional flexibility to the Secretary of HHS to implement innovative payment models for participating Accountable Care Organizations, including models currently used in the private sector.

**Sec. 10308. Revisions to national pilot program on payment bundling.** Provides the Secretary of HHS authority to expand the payment bundling pilot if it is found to improve quality and reduce costs. Also, directs the Secretary to test bundled payment arrangements involving continuing care hospitals within the bundling pilot program.

**Sec. 10309. Revisions to hospital readmissions reduction program.** Makes a technical correction to the hospital readmissions reduction program.

**Sec. 10310. Repeal of physician payment update.** Removes the 0.5 percent physician payment update for 2010.

**Sec. 10311. Revisions to extension of ambulance add-ons.** Requires the Secretary of HHS to implement the extension of the ambulance payment bonuses on January 1, 2010.

**Sec. 10312. Certain payment rules for long-term care hospital services and moratorium on the establishment of certain hospitals and facilities.** Extends Sections 114 (c) and (d) of the Medicare, Medicaid and SCHIP Extension Act of 2007 by two years.

**Sec. 10313. Revisions to the extension for the Rural Community Hospital demonstration program.** Extends the program by five years and makes adjustments to payment levels provided within the demonstration program.

**Sec. 10314. Adjustment to low-volume hospital provision.** Increases threshold for eligible hospitals from 1,500 Medicare Part A discharges per year to 1,600 per year.

**Sec. 10315. Revisions to home health care provisions.** Delays provisions to rebase home health payments by one year to 2014. Also, directs the Secretary to study improving access to home health care for certain patients, including those with high-severity levels of illness, low-income and living in underserved areas, and provides the Secretary authority to conduct a demonstration program based on the results of the study.

**Sec. 10316. Medicare DSH.** Revises the Medicare disproportionate share hospital (DSH) formula to make further adjustments starting in 2015.

**Sec. 10317. Revisions to extension of Section 508 hospital provisions.** Clarifies the Secretary may only use wage data of certain eligible hospitals in carrying out this provision if doing so does not result in lower wage index adjustments for affected facilities.

**Sec. 10318. Revisions to the transitional extra benefits under Medicare Advantage.** Clarifies that the data used in implementing this section are from 2009.

**Sec. 10319. Revisions to market basket adjustments.** Modifies market adjustments for inpatient hospitals, inpatient rehabilitation facilities, inpatient psychiatric hospitals and outpatient hospitals in 2012 and 2013 and for long-term care hospitals in 2011, 2012 and 2013. Also, modifies market basket adjustments for home health providers in 2013 and hospice providers in 2013 through 2019.

**Sec. 10320. Expansion of the scope of, and additional improvements to, the Independent Medicare Advisory Board.** Requires the Board to make annual recommendations to the President, Congress, and private entities on actions they can take to improve quality and constrain the rate of cost growth in the private sector. Requires the Board to make non-binding Medicare recommendations to Congress in years in which Medicare growth is below the targeted growth rate. Prohibits the Board from making recommendations that would reduce premium supports for low-income Medicare beneficiaries. Beginning in 2020, requires the Board to make binding biennial recommendations to Congress if the growth in overall health spending exceeds growth in Medicare spending; such recommendations would focus on slowing overall health spending while maintaining or enhancing beneficiary access to quality care under Medicare. Changes the name of the Board to the “Independent Payment Advisory Board.”

**Sec. 10321. Revision to community health teams.** Clarifies that nurse practitioners and other primary care providers can participate in community care teams.

**Sec. 10322. Quality reporting for psychiatric hospitals.** Establishes a quality measure reporting program for psychiatric hospitals beginning in fiscal year 2014.

**Sec. 10323. Medicare coverage for individuals exposed to environment health hazards.** Provides Medicare coverage and medical screening services to individuals exposed to environmental health hazards as a result of a public health determination under the Comprehensive Environmental Response, Compensation, and Liability Act of 1980.

**Sec. 10324. Protections for frontier states.** Starting in fiscal year 2011, establishes hospital wage index and geographic practice expense floors for hospitals and physicians located in states in which at least 50 percent of the counties in the state are frontier.

**Sec. 10325. Revision to skilled nursing facility prospective payment system.** Delays implementation of certain skilled nursing facility “RUGs-IV” payment system changes by one year to October 1, 2011.

**Sec. 10326. Pilot testing pay-for-performance programs for certain Medicare providers.** Provides the Secretary of HHS the authority to test value-based purchasing programs for inpatient rehabilitation facilities, inpatient psychiatric hospitals, long-term care hospitals, certain cancer hospitals and hospice providers by no later than January 1, 2016.

**Sec. 10327. Improvements to the Physician Quality Reporting System.** Provides an additional 0.5 percent Medicare payment bonus to physicians who successfully report quality measures to CMS via a qualified Maintenance of Certification program. Eliminates the MA Regional Plan Stabilization Fund.

**Sec. 10328. Improvement in Part D medication therapy management (MTM) programs.** Requires Part D prescription drug plans to include a comprehensive review of medications (either in person or through telehealth technology) and a written summary of the review as part

of their medication therapy management programs. Plans must also enroll beneficiaries who qualify on a quarterly basis and allow for opt out.

**Sec. 10329. Developing methodology to assess health plan value.** Requires the Secretary of HHS to develop a methodology to measure health plan value.

**Sec. 10330. Modernizing computer and data systems of the Centers for Medicare & Medicaid Services to support improvements in care delivery.** Requires the Secretary of HHS to develop a plan (and a detailed budget for the resources needed to implement such plan) to modernize the computer and data systems of the Centers for Medicare & Medicaid Services to support improvements in care delivery.

**Sec. 10331. Public reporting of performance information.** Requires the Secretary of HHS to develop a “Physician Compare” website where Medicare beneficiaries can compare scientifically-sound measures of physician quality and patient experience measures, provided that such information provides an accurate portrayal of physician performance.

**Sec. 10332. Availability of Medicare data for performance measurement.** Authorizes the release and use of standardized extracts of Medicare claims data to measure the performance of providers and suppliers in ways that protect patient privacy and in accordance with other requirements.

**Sec. 10333. Community-based collaborative care networks.** Provides grants to develop networks of providers to deliver coordinated care to low-income populations.

**Sec. 10334. Minority health.** Codifies the Office of Minority Health at the Department of Health and Human Services (HHS) and a network of minority health offices located within HHS. Elevates the Office of Minority Health at the National Institutes of Health from a Center to an Institute. The Offices of Minority Health will monitor health, health care trends, and quality of care among minority patients and evaluate the success of minority health programs and initiatives.

**Sec. 10335. Technical correction to hospital value-based purchasing (VBP) program.** Clarifies that the hospital VBP program shall not include measures of hospital readmissions.

**Sec. 10336. GAO study and report on Medicare beneficiary access to high-quality dialysis services.** Directs the Comptroller General to submit to Congress, within one year of enactment, a study on the impact on Medicare beneficiary access to high-quality dialysis services of the end stage renal disease prospective payment system.

**Subtitle D—Provisions Relating to Title IV**

**Sec. 10401. Amendments to Subtitle A.** Technical correction.

**Sec. 10402. Amendments to Subtitle B.**

**(a) Vision services referral from school based health centers.** Adds vision services to the list of health services for which a School Based Health Center should provide referrals.

**(b) Personalized preventive services in Medicare.** Clarifies that Medicare beneficiaries are eligible for the initial preventive physical exam in their first year of Medicare coverage and for personalized prevention services annually thereafter.

**Sec. 10403. Amendments to Subtitle C.** Ensures that 20 percent of the Community Transformation Grants are awarded to rural and frontier areas.

**Sec. 10404. Amendments to Subtitle D.** Technical correction.

**Sec. 10405. Amendments to Subtitle E.** Strikes the Sense of the Senate on Congressional Budget Office (CBO) scoring of prevention programs.

**Sec. 10406. Amendment relating to waiving coinsurance for preventive services.** Clarifies that Medicare beneficiaries do not have to pay coinsurance (including co-pays and deductibles) for preventive services delivered in all settings.

**Sec. 10407. Better diabetes care.** Directs the Secretary of HHS to develop a national report card on diabetes to be updated every two years. Directs the Secretary to work with health professionals and States to improve data collection related to diabetes and other chronic diseases. Provides for an Institute of Medicine study on the impact of diabetes on medical care.

**Sec. 10408. Grants for small businesses to provide comprehensive workplace wellness programs.** Authorizes an appropriation of \$200 million to give employees of small businesses access to comprehensive workplace wellness programs.

**Sec. 10409. Cures Acceleration Network.** Authorizes the Cures Acceleration Network, within the National Institutes of Health (NIH), to award grants and contracts to develop cures and treatments of diseases. Grants will be awarded to accelerate the development of medical products and behavioral therapies. The network shall work with the Food and Drug Administration (FDA) to streamline protocols assuring compliance with regulations and standards that meet regulatory requirements at all stages of manufacturing, review, approval, and safety surveillance.

**Sec. 10410. Centers of excellence for depression.** Directs the Administrator of the Substance Abuse and Mental Health Services Administration to award grants to centers of excellence in the treatment of depressive disorders.

**Sec. 10411. Programs relating to congenital heart disease.** Allows the Secretary of HHS to enhance and expand existing infrastructure to track the epidemiology of congenital heart disease and to organize such information into a National Congenital Heart Disease Surveillance System. Expands, intensifies, and coordinates research at the NIH on congenital heart disease.

**Sec. 10412. Automated Defibrillation in Adam's Memory Act.** Amends and reauthorizes through 2014 public access defibrillation programs in Sec. 312 of the Public Health Service Act.

**Sec. 10413. Young women's breast health awareness and support of young women diagnosed with breast cancer.** Directs the Secretary of HHS to develop a national education campaign for young women and health care professionals about breast health and risk factors for breast cancer. Supports prevention research activities at the Centers for Disease Control and Prevention (CDC) on breast cancer in younger women.

**Subtitle E – Provisions Relating to Title V**

**Sec. 10501. Amendments to Title V.**

- (a) **National Health Care Workforce Commission improvements.** Makes three improvements to the Workforce Commission: adds representation from small businesses to the Commission membership; adds an examination of the barriers of entering and remaining in primary care careers as a high-priority area for the Commission; and includes optometrists and ophthalmologists as members of the health care workforce.
- (b) **Interagency task force to assess and improve access to health care in the State of Alaska.** Establishes a temporary Task Force to assess health care access and develop a strategy to improve health care delivery in Alaska.
- (c) **Technical corrections to the grants for the community health care workforce.** Clarifies the definition and activities of community health workers.
- (d) **Loan repayment for faculty at schools that train physician assistants.** Includes faculty at schools for physician assistants as eligible for faculty loan repayment within the workforce diversity program.
- (e) **Demonstration grants for family nurse practitioner training programs.** Establishes a training demonstration program that supports recent Family Nurse Practitioner graduates in primary care for a twelve month period in Federally Qualified Health Centers (FQHCs) and nurse-managed health clinics. The demonstration is authorized from 2011 through 2014.
- (f) **Technical corrections to the primary care extension program.** Clarifies program eligibility and the section number.
- (g) **National diabetes prevention program.** Establishes a national diabetes prevention program at the CDC. State, local, and tribal public health departments and non-profit entities can use funds for community-based prevention activities, training and outreach, and evaluation.

- (h) Budget neutrality for primary care bonuses.** Removes the budget-neutrality adjustment that would have offset half of the cost of the primary care and general surgery bonuses.
- (i) Medicare Federally Qualified Health Center improvements.** The underlying bill establishes a prospective payment system (PPS) for care delivered in Medicare Federally-qualified health centers (FQHCs). Clarifies that the Secretary of HHS shall vary payments to FQHCs based on the type, duration, and intensity of services they deliver and establishes an annual FQHC market basket update.
- (j) Technical corrections to the rules for counting resident time for didactic and scholarly activities and other activities.** Clarifies that the Secretary is not required to reopen certain settled cost reports in applying changes to Medicare graduate medical education payment rules related to didactic training.
- (k) State grants to health care providers who provide services to a high percentage of medically underserved populations or other special populations.** Creates a grant program to support health care providers who treat a high percentage of medically underserved populations.
- (l) Rural physician training grants.** Authorizes grants for medical schools to establish programs that recruit students from underserved rural areas who have a desire to practice in their hometowns. Programs would provide students with specialized training in rural health issues, and assist them in finding residencies that specialize in training doctors for practice in underserved rural communities.
- (m)(1) Preventive medicine and public health training grant program.** Amends and reauthorizes section 768 of the Public Health Service Act, the preventive medicine and public health residency program.
- (n)(1) National Health Service Corps improvements.** Improves the National Health Service Corps program by increasing the loan repayment amount, allowing for half-time service, and allowing for teaching to count for up to 20% of the Corps service commitment.

**Sec. 10502. Infrastructure to expand access to care.** Provides funding to HHS for construction or debt service on hospital construction costs for a new health facility meeting certain criteria.

**Sec. 10503. Community Health Centers and National Health Service Corps Fund.** Establishes a Community Health Centers and National Health Service Corps Fund. The fund will create an expanded and sustained national investment in community health centers under section 330 of the Public Health Service Act and the National Health Service Corps.

**Sec. 10504. Demonstration project to provide access to affordable care.** Directs the Secretary of HHS to establish a 3-year demonstration project in States to provide comprehensive health care services to the uninsured at reduced fees.

**Subtitle F—Provisions Relating to Title VI**

**Sec. 10601. Revisions to limitation on Medicare exception to the prohibition on certain physician referrals for hospitals.** Amends the date by which a physician-owned hospital must have a provider agreement to participate in Medicare to August 1, 2010, rather than February 1, 2010.

**Sec. 10602. Clarifications to patient-centered outcomes research.** Clarifies publication rights of researchers with respect to peer-reviewed journals and clarifies that findings published by the Institute do not include practice guidelines, coverage, payment, or policy recommendations. The provision also increases the number of physicians on the Board of Governors from three to four.

**Sec. 10603. Striking provisions relating to individual provider application fees.** Removes the enrollment fee for physicians.

**Sec. 10604. Technical correction to Section 6405.** Clarifies that only physicians enrolled in the Medicare program may order home health services under Medicare Part A and Part B.

**Sec. 10605. Certain other providers permitted to conduct face-to-face encounter for home health services.** Clarifies that the face-to-face encounter required prior to certification for home health services may be performed by a physician, nurse practitioner, clinical nurse specialist, certified nurse-midwife, or physician assistant.

**Sec. 10606. Health care fraud enforcement.** Enhances the fraud sentencing guidelines, changes the intent requirement for fraud under the anti-kickback statute, and increases subpoena authority relating to health care fraud.

**Sec. 10607. State demonstration programs to evaluate alternatives to current medical tort litigation.** Authorizes grants to States to test alternatives to civil tort litigation. These models would be required to emphasize patient safety, the disclosure of health care errors, and the early resolution of disputes. Patients would be able to opt-out of these alternatives at any time. The Secretary of HHS would be required to conduct an evaluation to determine the effectiveness of the alternatives.

**Sec. 10608. Extension of medical malpractice coverage to free clinics.** Extends the protections from liability contained in the Federal Tort Claims Act to free clinics.

**Sec. 10609. Labeling changes.** Modifies requirements applicable to the labeling of generic drugs.

**Subtitle G – Provisions Relating to Title VIII**

**Sec. 10801.** Technical corrections.

**Subtitle H – Provisions Relating to Title IX**

**Sec.10901. Modifications to excise tax on high cost employer-sponsored health coverage.**

Adds individuals who perform longshore work to the list of high-risk employees qualifying for the higher thresholds for imposing the excise tax. Clarifies that plans providing certain excepted benefits under IRC Section 9832(c) are not subject to the excise tax.

**Sec. 10902. Inflation adjustment of limitation on Flexible Spending Account (FSA)**

**contributions.** Indexes the \$2,500 limit on contributions to a flexible spending arrangement by CPI-U for years after December 31, 2011.

**Sec. 10903. Limitation on charitable hospitals.** Modifies the limitation on the amount that can be charged by a charitable hospital for emergency or medically necessary care from the “lowest amount charged” to individuals who have insurance to “the amount generally billed”.

**Sec. 10904. Medical device manufacturers fee.** Eliminates the fee for 2010. Establishes the annual fee at \$2 billion for the years 2011 through 2017 and \$3 billion for years after 2017.

**Sec. 10905. Health insurance provider fee.** Removes third party administration agreement fees from the allocation of the fee to health insurance providers. Eliminates the fee for 2010. Establishes the annual fee at \$2 billion for 2011, \$4 billion for 2012, \$7 billion for 2013, \$9 billion for years 2014 through 2016 and \$10 billion for years after 2016. Creates a limited exemption from the fee for certain non-profit insurers with a medical loss ratio of 90 percent or more.

**Sec. 10906. Additional Hospital Insurance (HI) tax for high wage workers.** Modifies the increased HI tax rate for single taxpayers with income in excess of \$200,000 and couples filing jointly with incomes in excess of \$250,000 from 0.5 percentage points to 0.9 percentage points.

**Sec. 10907. Excise tax on indoor tanning services.** Imposes a ten percent tax on amounts paid for indoor tanning services in lieu of the tax on cosmetic surgery. Indoor tanning services are services that use an electronic product with one or more ultraviolet lamps to induce skin tanning. The tax would be effective for services on or after July 1, 2010.

**Sec 10908. Health professionals State loan repayment tax relief.** Excludes from gross income payments made under any State loan repayment or loan forgiveness program that is intended to provide for the increased availability of health care services in underserved or health professional shortage areas. This provision is effective for amounts received by an individual in taxable years beginning after December 31, 2008.

**Sec. 10909. Expansion of adoption tax credit and adoption assistance programs.** Increases the adoption tax credit and adoption assistance exclusion (\$12,170 for 2009) by \$1,000, and makes the credit refundable. The credit is extended through 2011.