HELP Health Reform Legislation – Section by Section Narrative with Options

(6-9-09)

Title I. QUALITY, AFFORDABLE HEALTH COVERAGE FOR ALL AMERICANS

Subtitle A. Effective Coverage for All Americans

Synopsis: This subtitle provides the basic structure for a reformed market for health insurance in all 50 states. Health status underwriting and the imposition of any pre-existing condition exclusion are prohibited in all individual and group employer markets. Rates within a geographic region may only vary by family composition, the value of the benefits package, and age by a factor of not more than two to one. Guaranteed issue will be required for all insurers operating in the individual and group health insurance markets. Medical loss ratios will be limited in the group and individual markets. All insurance policies must incorporate incentives for high quality and preventive health care services. Dependents will be permitted to stay on parents' policies until age 26. Lifetime and annual benefit limits will be prohibited in all individual and group policies.

Amendments to HIPAA

Insurance Market Reforms: Subtitle A will reform the individual and group health insurance markets in all 50 states to promote availability of coverage for all individuals and employer groups. Under these new requirements, premium payments for insurance policies within each market will be permitted to vary only by family structure, geographic region, the actuarial value of benefits provided, and age. Rates specifically will not be permitted to vary based on gender, class of business, or claims experience. Insurers will be permitted to incentivize health promotion and disease prevention practices. Guaranteed issue and guaranteed renewability will be required in all states in each individual and group health insurance market. (§ 2701, 2702, 2703)

Option A: Rating by age will be permitted to vary by no more than a factor of two to one.

Option B: Allow a wider range of modified community rating, with a total rate for a single adult not to be below 2:1 or above 7.5:1.

Option C (R): Include guaranteed issue and renewability, along with a prohibition on exclusions of pre-existing conditions, but otherwise leave it to states to determine if they will restrict variation in insurance premiums.

Option D (R): Offer financial incentives to states to implement guaranteed issue and end rating based on health status and implement a federal fallback if states do not implement.

Option E (R): Apply reforms only to individual and small group market.

Medical Loss Ratios: Medical loss ratios refer to the percentage of premium dollars spent on medical care as opposed to dollars spent on administrative and marketing costs as well as profits. Health insurers offering group or individual policies will be required to maintain minimum loss ratios as determined by the Secretary of Health and Human Services. Insurers whose medical loss ratios exceed the allowable limits will be required to provide rebates to enrollees. (§ 2704)

Option A (R): Drop the entire section regarding medical loss ratios.

Option B (R): Drop the rebate requirements.

Prohibiting Discrimination Based on Health Status: In issuing health insurance policies, insurers will not be permitted to establish terms of coverage based on any applicant's health status, medical condition (including physical and mental illness), claims experience, prior receipt of health care, medical history, genetic information, evidence of insurability (such as being a victim of domestic violence), or disability. (§2705)

Option A (R): Modify rate bands so that age cannot exceed 5:1, tobacco use cannot exceed 1.5:1, and allow rating based on adherence to programs of health promotion and disease prevention.

Ensuring the Quality of Care: Health insurance policies will be required to include financial incentives to reward the provision of high quality care that includes case management, care coordination, chronic disease management, wellness and health promotion activities, child health measures, activities to improve patient safety and reduce medical errors, as well as culturally and linguistically appropriate care. (§2706)

Option A (R): Drop new quality and other mandates on insurance plans, and require plans to report whether they cover such items and services.

Option B (R): Allow rating based on tobacco use at 1.5:1, and allow rating based on adherence to programs of health promotion and disease prevention.

Coverage of Preventive Health Services: Health insurance policies will not be allowed to impose more than minimal cost sharing for certain preventive services endorsed by the U. S. Preventive Services Task Force as clinically and cost effective, for immunizations recommended by the CDC, and for certain child preventive services recommended by the Health Resources and Services Administration. (§2707)

Option A (R): Drop new quality and other mandates on insurance plans, and require plans to report whether they cover such items and services.

Extension of Dependent Adults: All individual and group coverage policies will be required to offer dependent coverage for children up to age 26, according to regulations to be established by the Secretary of Health & Human Services. (§2708)

Option A (R): Drop requirement that insurers must provide coverage for children who are not more than 26 years of age.

No Lifetime or Annual Limits. No individual or group health insurance policy will be permitted to establish lifetime or annual limits on benefits for any enrollee or beneficiary. (§ 2709)

Option A (R): Drop annual and lifetime limit restrictions on health plans.

Prohibition of Discrimination Based on Salary: Health insurers will not be permitted to limit eligibility based on the wages or salaries of employees. (§ 2719)

Option A (R): Drop requirement that a group health plan may not limit eligibility based on the annual salary of the employee.

Limitation on Self-Insuring: The Secretary of Labor will issue regulations to establish minimum levels at which employer groups will be permitted to self insure. (§ 2720)

Option A (R): Drop prohibition of group health plan with 250 or fewer members from self-insuring.

Option B (R): Limit prohibition to firms with 50 or fewer workers.

Subtitle B. Available Coverage for All Americans

Synopsis: This subtitle authorizes the establishment of an Affordable Health Benefit Gateway in each state. Planning grants are provided to each state to support the creation of state Gateways. States can establish Gateways as quickly they wish, thus qualifying their residents for premium credits. If a state takes no action, the Secretary will establish and operate that state's Gateway. Gateways are established to help qualified individuals and qualified employer groups to purchase affordable health insurance and related insurance products. The Gateway will establish procedures to qualify health plans to be offered through them, develop tools to enable consumers to obtain coverage, establish open enrollment periods, and assist consumers in the purchase of long term services and supports. A new Medical Advisory Council will make recommendations to the Secretary of Health & Human Services on essential health care benefits which will qualify for income-related premium credits, affordability standards, and minimum coverage standards for individuals. States may establish Navigators to assist businesses and individuals in obtaining affordable, quality coverage.

New Title XXXI of the Public Health Service Act

Section 141

Assumptions Regarding Medicaid: Medicaid eligibility will be expanded. This provision is in the jurisdiction of the Finance committee, and decisions are ongoing as to whether or how to include or reference the intended policy in the HELP bill.

Option A: Importing Senate Finance provisions.

Option B (R): Drop the Medicaid expansion. In lieu of expansion, allow low-income individuals to enroll/auto-enroll in private health insurance plans, with subsidies above the level

provided in the general credit section. These extra subsidies would fill in most of the costs associated with premium and cost sharing for enrollees, but the plans would otherwise be identical to other plans offered in the market that meet a minimum level of coverage.

Option C (R): *Allow non-aged, blind or disabled Medicaid populations and CHIP beneficiaries to be eligible for the new credits and supplemental low-income subsidies, at the election of the beneficiary. Could allow a Medicaid wrap to provide supplemental benefits not provided under private health insurance (such as EPSDT for children).*

Option D (R): *Create incentive accounts for Medicaid beneficiaries to encourage them to modify behaviors (smoking cessation, weight reduction, diabetes management) where they could receive incentive payments that could be applied to whatever nominal cost sharing would apply in either traditional Medicaid or the new credit/subsidy program.*

Affordable Choices of Health Benefit Plans: Each state will have an Affordable Health Benefit Gateway, established either by the state or by the Department of Health & Human Services. (§ 3101)

Option A: *Gateways are established by the Federal government, but States can opt out. All Gateways are operative at the same time.*

Option B: *States have the first option to establish Gateways or to request that HHS do so. If they fail to act, the Federal government steps in. Premium credits are available only to residents of states that have enacted insurance reforms and established Gateways.*

Option C (R): *Provide federal financial incentives for states to create insurance markets. In general, the insurance mark or connector would take on very minimal regulatory functions, such as creating a website to allow consumers to price shop and get real-time premium quotes.*

Option D (R): *Allow multiple competing exchanges.*

Within 60 days of enactment, the Secretary will make planning grant awards to states to undertake activities related to establishing their own Gateway. The Gateway exists to facilitate the purchase of health insurance coverage and related insurance products at an affordable price by qualified individuals and qualified employer groups. The Gateway will establish procedures to qualify interested health plans to offer their health insurance policies through the Gateway. (§ 3101)

Public Health Insurance Option

Option A: *A public health insurance plan operated by the Federal government with a payment schedule that is set in statute and is based on Medicare.*

Option B: *A health insurance plan that, though operated under contract from DHHS, would play by the same rules as commercial health insurance carriers.*

Option C (R): *Drop public plan option.*

Gateway Functioning. The Gateway will develop tools to enable consumers to make coverage choices, and set up open enrollment periods to enroll in qualified health plans. After initial federal financial support, Gateways will become financially self-sustaining through establishing a surcharge on participating health plans. The Gateways will use risk adjustment mechanisms to remove incentives

for plans to avoid offering coverage to those with serious health needs. Gateways will establish enrollment procedures to enable individuals to sign up for coverage, including Gateway plans with premium credits, Medicaid, CHIP, and others. The Secretary of Health & Human Services will establish a website through which individuals may connect to their state Gateway to purchase coverage. States may form regional Gateways operating in more than one state; states may establish subsidiary regional Gateways, as long as each Gateway serves a distinct region. (§ 3101)

Existing Markets: If individuals like their current coverage, they can keep it. Licensed health insurers will be able to sell health insurance policies outside of the Gateway. Any resident will be able to purchase health insurance outside the Gateway, including policies which do not meet standards to be a qualified health plan. States will regulate health insurance sold outside the Gateway. State insurance regulators will perform their traditional obligations regarding consumer protection and market conduct. For qualified health plans sold through the Gateway, the Secretary of Health & Human Services will issue regulations regarding marketing, network adequacy, and understandability for consumers. The Secretary will establish policies to facilitate enrollment, including use of electronic enrollment tolls, and provide grants to enhance community-based enrollment and public education campaigns. (§ 3101)

State Participation: States have three options regarding their preferred participation in the Gateway. An "establishing state" is one that proactively seeks such status to launch its Gateway as early as possible and which meets the requirements of the law. A "participating state" requests that the Secretary establish an initial Gateway once all necessary insurance market reforms have been enacted by the state into law, and other requirements have been met. In a state that does not act to conform to the new requirements, the Secretary shall establish and operate an Gateway in the state after a period of six years – and such state will become a "participating state." Until a state becomes either and establishing or participating state, the residents of that state will not be eligible for premium credits, an expanded Medicaid match, or small business credits. (§ 3104)

Financial Responsibility: DHHS will oversee the financial integrity of Gateways, by conducting annual audits, requiring financial reporting, and other measures. The Secretary may rescind payments from state Gateways that fail to follow federal requirements. The Secretary shall also establish procedures and protections to guard against fraud and abuse. Additionally, the Comptroller General will conduct ongoing reviews of Gateway operations and administration. (§ 3102)

Seeking the Best Medical Advice on Benefit Design: (§ 3103)

There are several ways the bill may address the need to establish a benefit package eligible for subsidies through the Gateway. Some options are below.

Option A: *HHS establishes a special council to advise on benefit design. The recommendations of the council are submitted to Congress, which may disapprove them in their entirety.*

Option B: *The Secretary of Health & Human Services establishes benefit and affordability framework.*

Option C (R): *Drop new federal health board, and not allow it to set new minimum thresholds for what insurance must cover.*

Option D (R): *Set minimum benefit functions in statute, using the statute for the Federal Employee Health Benefit Plan, and allow flexibility with ranges of actuarial value.*

Option E (R): Allow further modifications of coverage requirements, based on a threshold number of states adopting the mandates.

Option F (R): Create a new board that would develop recommendations that states could then adopt.

Qualifying Coverage: Qualifying coverage includes any coverage under which an individual is enrolled on the date of enactment of the law, and – after the date of enactment – coverage the meets the criteria for minimum qualifying coverage to satisfy personal responsibility standards, and coverage which meets grandfather standards. Coverage through Medicare, Medicaid, the CHIP, TRICARE, Veteran's Health, FEHB, the medical program of the Indian Health Service, a state health benefit high risk pool, and others meet the conditions for minimum qualifying coverage. A religious exemption will also apply to these standards. (§ 3103)

Option A (R): Meaningful health plan defined as major medical insurance that includes catastrophic coverage plus first dollar coverage for preventive services, with no annual or lifetime limits.

Navigators: States will receive federal support to contract with private and public entities to act as health coverage "navigators" to assist employers, workers, and self-employed individuals seeking to obtain quality and affordable coverage through Gateways. Entities eligible to become navigators could include trade, industry and professional organizations, unions and chambers of commerce, small business development centers, and others. The navigators will conduct public education activities, distribute information about enrollment and premium credits, and provide enrollment assistance. Health insurers or parties that receive financial support from insurers to assist with enrollment are ineligible to serve as navigators. (§ 3105)

Option A (R): Limit to entities with prior experience such as SHIPs and AAA.

Subtitle C. Affordable Coverage for All Americans

Synopsis: This subtitle establishes a new subsidy structure to support the purchase of private health insurance. For those with incomes above the maximum level for Medicaid eligibility, premium assistance and cost sharing limits will facilitate health insurance affordability. Credits to defray premium costs will be provided on a sliding scale basis to enable families to purchase insurance through the Gateway. These policies will cover services recommended by the Medical Advisory Council; states may cover additional benefits and services at their own expense. Enrollment and eligibility determinations will be performed by the Gateway. Individuals may allow the Gateway to use IRS information to determine eligibility. New tax credits will be available to cover a portion of employees' insurance costs.

New Title XXXI of the Public Health Service Act (continued)

Support for Affordable Health Coverage: To reduce the economic burden of health care on vulnerable Americans, low income and moderate income Americans who enroll in plans through the Gateways will be eligible for premium credits. Credits are provided on sliding scale, so that those at lowest incomes receive the most help. Gateways, which will provide information on health insurance options, will administer these credits. (§ 3111)

The premium credits would be on a sliding scale, with those at lower receiving more. The credits could phase out when people's incomes reach:

Option A: *500% of the poverty line ($110,250 for a family of 4).*

Option B (R): *Sliding scale subsidies up to 200% fpl.*

Option C (R): *Tax credit equal to an amount based on the enrollment-weighted average premium of the qualified low coverage option offered in the service area. There would be cost sharing assistant to limit the amount of cost-sharing an individual is required to pay up to the valuation of the medium coverage option for those between 100-200% fpl.*

Geographic Adjustments: To account for regional premium variations, credits will be based on a reference premium. The reference premium will be calculated on the average premiums of the three lowest cost qualified plans offered in each area. Premiums will be risk adjusted to adjust for variations in patient characteristics or risk factors. Services not recommended by the Medical Advisory Council will not be paid for with premium credits. States are permitted to make payments for individuals that exceed required amounts or to defray costs of services not recommended by the Medical Advisory Council. (§ 3111)

Option A (R): *Create a blended subsidy, half reflecting the lowest cost plan and half reflecting national costs.*

Eligibility Determination: Gateways will conduct eligibility determinations in accordance with guidelines established by HHS. If HHS finds that Gateways are abusing the eligibility determination process, HHS may conduct such determinations itself. To enhance program integrity, Gateways may require income verification. Procedures are included to allow the Gateways to verify that individuals are not receiving more credits than there are entitled to receive. (§ 3111)

Maximizing Enrollment: Application forms may be submitted in person, by mail, telephone or electronically to the Gateway or a designated state agency. To increase access to premium credits, the Gateway or a designated state agency will assist individuals in filing applications and performing eligibility determinations. The Gateway will conduct outreach activities to provide information to eligible individuals.

Funding: The credits are funded as an entitlement, not an authorization of appropriations.

Option A (R): *Provide block grants to states and allow them to design credits or subsidies that would best provide coverage for individuals in those states.*

Small Business Tax Credits. Eligible small employers will be permitted to access tax credits based on the number of full time employees, the proportion of employees provided health insurance and employee wages. Credits will be equal to 50 percent of the average contribution small employers make for coverage. Credits phase out with increasing business size, so the firms with sizes 26 or more workers are ineligible. Credits phase out with average wages, so firms with average wages above $40,000 are ineligible. Credits are increased for those firms that did not previous offer coverage, and decreased for those that did. (§ 3112)

Option A (R): *Modify the tax credit so it is awarded only to firms with low-income workers who begin offering coverage.*

Subtitle D. Shared Responsibility for Health Care

This subtitle creates a shared responsibility framework. Individuals will be required to have health coverage that meets minimum standards and to report such coverage annually. Exemptions will be made for individuals unable to access affordable care. Employers who do not provide qualifying coverage will be required to contribute to the cost of coverage for their employees, including those who access forms of public coverage. Standards will be established to ensure efficient use of health information technology for enrollment in qualified health plans.

Conforming Change to the Internal Revenue Act

Shared Responsibility Payments: All individuals will be required to obtain health insurance coverage. Exemptions will also be made for individuals for whom affordable health care coverage is not available or for those for whom purchasing coverage creates an exceptional financial hardship. The Secretary of the Treasury in consultation with HHS will determine the minimum penalty needed to accomplish the goal of substantially increasing coverage. The mandate is not applicable in states where Gateways are not yet operating. (§ 59B)

Option A (R): Drop the individual mandate, instead provide subsidies or tax credits for individual who enroll in health insurance.

Option B (R): Auto-enrollment for low-income beneficiaries and/or those offered employer-sponsored health insurance (with an option to opt-out or change health plans) coupled with late enrollment penalties. The penalties could be financial via higher premiums (such as Medicare Parts B &D) or affect the nature of coverage (pre-existing condition exclusions for a period of time, if not enrolled during open season.)

Reporting of health insurance coverage: Health plans providing qualified health insurance will file a return containing information regarding health insurance coverage. The return shall include basic information including the number of months during which the individual was covered. Health plans shall provide this information in writing to covered individuals. The IRS shall notify individuals who file income tax returns and are not enrolled in qualifying coverage and shall include information on services available through the Gateway. (§ 6055)

Option A (R): Employers required to disclose to employees on W-2 statements the cash value of health insurance benefits provided to them.

Conforming Change to the Social Security Act

(Necessary for the operation of provisions of the Public Health Service Act)

Barring Non-Participating Doctors and Hospitals from Medicare: To assure that providers participate in the public health insurance option (as described in Option A), the bill prohibits providers who do not participate in the plan from receiving payments under Medicare.

Option A (R): Strike this section.

Helping People Who Apply for Medicaid: If a person applies for Medicaid but has an income too high to be eligible for that program, the bill requires State Medicaid programs to let that person know if he or she is eligible for support through the Gateway, and if so, to help that person enroll.

Shared Responsibility of Employer

This section outlines several options on requiring shared responsibility from employers. (§ 3113-3114)

Option A: *Pay or Play: Employers (not including small employers) that do not offer coverage that meets certain criteria, must pay a per-worker fee.*

Option B: *A Free Rider Penalty: There is no requirement that employers offer coverage, nor are standards applicable, but any large employer whose employees are on Medicaid must repay the Federal government some fraction of the Federal cost for that employee's Medicaid coverage.*

Option C: *For any employee not offered affordable coverage by an employer, where the employee enrolls in a publicly subsidized plan through a Gateway, that employer must remit to the government the amount the employer would have paid for that employee's coverage had they remained in employer-sponsored insurance.*

Option D (R): *Drop the employer mandate.*

Option E (R): *Allow employers to incentivize healthy behaviors, such as increasing the 20 percent limitation on premiums, and the gift tax that applies to prizes/rewards to employees for better behavior/participation in programs, etc.*

Definitions: (§ 3116)

Public health insurance option means a qualified health plan, sponsored by the Secretary of Health & Human Services, that provides payment for items and services equal to Medicare plus ten percent. For items not offered under Medicare, the Secretary shall set a consistent price. The premiums assessed for public health insurance option shall be sufficient to cover the costs under the plan and may be adjusted annually.

Option A (R): *Strike.*

Eligible individuals are citizens or lawfully admitted permanent residents of the U.S. who are enrolled in a qualified health plan. Those eligible for other public programs are not eligible for credits, but a special rule applies to CHIP. Those in CHIP (or their parents) are able to determine whether staying in CHIP works best for them, or whether moving to the Gateway is best. Either choice is permissible, but the individual cannot "double dip" by getting funding from both the Gateway and CHIP.

Option A (R): *Permit individual in CHIP AND Medicaid to choose CHIP/Medicaid or the Gateway.*

Qualified employer is an employer who choose to make employees eligible for a qualified health plan. If enrollment takes place through a Gateway, the employer must meet State or federal criteria. The initial federal criteria are set so that only small firms are qualified.

Option A (R): *Strike*

Qualified health plan means a plan has certification issued by a Gateway and is offered by a licensed health insurance company. The health insurer must agree to offer at least one qualifying health plan with appropriate cost sharing levels, comply with regulation and pay any surcharge.

Option A (R): *Permit plans not selling through the Gateway to be qualified health plans.*

Option B (R: *Define qualified health plan as major medical insurance that includes catastrophic coverage plus first dollar coverage for preventive services, and no annual or lifetime limits.*

Option C (R: *Set minimum benefit functions in statute, using the statute for the Federal Employee Health Benefit Plan, and allow flexibility with ranges of actuarial value.*

Additional health plan requirements: Plans must make available for enrollees and potential enrollees descriptions of benefits offered, service area, cost-sharing, premiums, access to providers and grievance/appeals procedures.

Quality standards for health plans: Plans must provide the essential health care benefits established in this Act and be accredited by the National Committee for Quality Assurance or an equivalent entity. Plans must implement incentives for high quality care and improving health outcomes through strategies such as reporting, case management, care coordination, chronic disease management compliance initiatives and prevention of hospital readmission. Plans must encourage patient safety and reduction of medical errors through best practices, evidence based medicine and health information technology.

Option A (R): *Drop new quality and other mandates on insurance plans, rather require plans to report whether they cover such items and services.*

A qualified individual is residing in a participating or establishing State, not incarcerated, not eligible for Medicare or Medicaid, TRICARE, FEHBP, or any qualifying employer-sponsored coverage.

Option A (R: *Medicaid beneficiaries can also choose to join the Exchange and be eligible for subsidies.*

An eligible employee is an individual for whom if the employer-sponsored coverage does not meet criteria for minimum qualifying coverage or is not affordable for the employee. (§165)

Option A (R): *Strike.*

Subtitle E. Improving Access to Health Care Services

Spending for Federally Qualified Health Centers (FQHCS): FY2010 - $2.9B; FY2011 - $3.8B; FY2012 - $4.9B; FY 2013 - $6.4B; FY2014 - $7.3B; FY2015 - $8.3B. (§ 171)

Funding for National Health Service Corps: FY2010 - $320M; FY2011 - $414M; FY2012 - $535M; FY2013 - $691M; FY2014 - $893M; FY2015 - $1.1B

Subtitle F. Improving Access to Health Care Services

Health information technology standards. Standards and protocols shall be developed to promote the interoperability of systems for enrollment of individuals in federal and state health and human services programs. These standards shall allow for electronic data matching, and electronic documentation. The Secretary may require State or other entities to incorporate such standards as a condition of receiving federal health IT funds. (§ 3021)

Option A (R): To be provided.

Health information technology grants. Grants shall be awarded to develop and adapt systems to implement the standards described above. (§ 166)

Option A (R): Strike.

Hawaii. Nothing in this Act shall modify or limit the application of the exemption for Hawaii's Prepaid Health Care Act under ERISA. (§ 182)

Key National Indicators: Establishes a Commission on Key National Indicators to conduct a comprehensive oversight of a newly established key national indicators system, with a required annual report to Congress. (§183)

Burr/Coburn

- States can choose to utilize auto-enrollment mechanisms at medical or state government points of services;
- Creates state health insurance exchanges that allows individuals to compare and select different health plans;
- Only reference to a minimum benefit package is the citation of Title 89, Chapter 5, the categories of items in services required under FEHBP;
- Creates an independent board to administer the Exchange, which can utilize risk adjustment among participating insurance companies
- States also may choose to utilize high risk pools or reinsurance mechanisms
- Provides an advanceable, refundable tax credit (of *at least* $2,290 individual/$5,710 family) to assist in purchasing health insurance
- Transforms Medicaid for about 15 million families (converts Medicaid dollars to $5,000 subsidies plus credit) who can purchase coverage through the exchange, accessing about twice as many providers as they can now

Gregg

- Individual coverage requirement for 18 and over;
- Guaranteed issue, modified community rating (age and geography);
- Requires insurers to offer a "meaningful health plan" in every state regulated insurance market based on defined cost structure (not benefits);
- Meaningful health plan = major medical insurance that includes catastrophic coverage plus first dollar coverage for preventive services, no annual or lifetime limits;
- States would be required to have at least 3 more comprehensive private health plans (upgrade packages) available;
- Direct subsidies (premium and deductable) sliding scale to 300% FPL;
- States must establish point of entry for enrollment and access to applicable subsidies, but retains full flexibility to design/administer mechanism (connector, etc.)
- Cap the exclusion and replace with deduction equal to cap
- Increase the HIPPA 20% limitation on premium variation in order to further incentivize healthy behaviors and outcomes.

Wyden

- Individual mandate; Employer mandate;
- State based agencies to provide information on competing health plans and determine subsidy eligibility;
- Plans must be at least as generous as FEHB plans with actuarial equivalence allowed;
- Full subsidy under 100% FPL, sliding scale from 100-400%;
- Terminates federal health benefits coverage, including coverage provided under the Federal Employees Health Benefits Program and the State Children's Health Insurance Program (SCHIP);
- Eliminates the tax exclusion for health insurance;
- New deduction for health insurance – phases out from $125,000-$250,000 with no deduction above $250,000

Subtitle G. COMMUNITY LIVING ASSISTANCE SERVICES AND SUPPORTS (CLASS)

Establishment of National Voluntary Insurance Program for Purchasing Community Living Assistance Services and Supports

> *Synopsis: This section creates a new national insurance program to help adults who have or develop functional impairments to remain independent, employed and stay a part of their communities. Financed through voluntary payroll deductions (with opt-out enrollment similar to Medicare Part B), this program will remove barriers to independence and choice (e.g., housing modifications, assistive technologies, personal assistance services, transportation) by providing a cash benefit to individuals unable to perform two or more functional activities of daily living. The large risk pool created will make added coverage more affordable and reduce incentives for people with severe impairments to spend down to Medicaid.*

Purposes: The intent is to establish a national voluntary insurance program for purchasing community living assistance services and support in order to provide individuals with functional limitations with tools that will allow them to maintain their personal and financial independence and live in the community through a new financing strategy for community living assistance services and supports, establish an infrastructure that will help address the Nation's community living assistance services and supports needs, and alleviate burdens on family caregivers. (§ 3201)

Definitions: "Active enrollee" means an individual who has enrolled and paid premiums to maintain enrollment. "Activities of daily living" include eating, toileting, transferring, bathing, dressing, and continence or the cognitive equivalent. An "eligible beneficiary" has paid premiums for at least 60 months and for at least 12 consecutive months. (§ 3203)

CLASS Independent Benefit Plan: The Secretary of Health & Human Services will develop two alternative benefit plans within specified limits. The monthly maximum premium cannot exceed the average of $65, to be inflation adjusted. For individuals with family incomes below 100 percent of the federal poverty line, and for individuals under age 22 who are active workers or full-time students, the premium cannot exceed $5, also to be inflation adjusted. There is a five year vesting period for benefit eligibility. The benefit triggers when an individual is unable to perform not less than two activities of daily living for at least 90 days. The cash benefit will be not less than $50 per day. Not later than October 1, 2012, the Secretary will designate a CLASS benefit plan, taking into consideration the recommendations of the CLASS Independence Advisory Council. (§ 3203)

Enrollment and Disenrollment: The Secretary will establish procedures to allow for voluntary automatic enrollment by employers, as well as alternative enrollment processes for self-employed, employees of non-participating employers, spouses and others. Individuals may choose to waive enrollment in CLASS in a form and manner to be established by the Secretary. Premiums will be deducted from wages or self-employment income according to procedures established by the Secretary. (§ 3204)

Benefits: Eligible beneficiaries will receive appropriate cash benefits to which they are entitled, advocacy services, and advice and assistance counseling. Cash benefits will be paid into a Life

Independence Account to purchase nonmedical services and supports needed to maintain a beneficiary's independence at home or in another residential setting, including home modifications, assistive technology, accessible transportation, homemaker services, respite care, personal assistance services, home care aides, and added nursing support. (§ 3206)

CLASS Independence Fund: The CLASS Independence Fund will be located in the Department of the Treasury and the Secretary of the Treasury will act as the Managing Trustee. The fund shall have "lock-box" protection such that neither the Senate nor the House of Representatives will be able to authorized use of funds in the Trust for any purpose not explicitly authorized in this Title. A CLASS Independence Fund Board of Trustees will include the Commissioner of Social Security, the Secretary of the Treasury, the Secretary of Labor, the Secretary of Health & Human Services, and two members of the public. (§ 3206)

CLASS Independence Advisory Council: The CLASS Independence Advisory Council, created under this Title, will include not more than 15 members, named by the President, a majority of whom will include representatives of individuals who participate or are likely to participate in the CLASS program. The Council will advise the Secretary on matters of general policy relating to CLASS. (§ 3207)

Option A (R): Strike the section

Option B (R): Strike and replace with S. 1244 (Grassley 109th Congress) - Long-Term Care and Retirement Security Act of 2005 - Amends the Internal Revenue Code to: (1) allow a tax deduction from gross income for long-term care insurance premiums; (2) include long-term care insurance in employee benefit cafeteria plans and flexible spending arrangements; (3) allow a tax credit for certain long-term care costs; (4) set forth certain consumer protections for long-term care insurance contracts; and (5) allow tax free exchanges of long-term care insurance contracts.

Title II. HEALTH QUALITY AND DELIVERY SYSTEM REFORM

Subtitle A. National Strategy to Improve Health Care Quality

Synopsis: This subtitle requires the Secretary of Health and Human services to establish a national strategy and support infrastructure necessary to improve the quality of the U.S. health care system. The strategy will target priority areas, use health information technology to incorporate quality improvements, and focus on health outcomes and population health. An interagency working group will coordinate and implement health care quality improvement initiatives. Quality measures will be identified, developed and endorsed. A streamlined and integrated quality reporting process will minimize the burden on providers.

National Strategy for Quality Improvement in Health Care: Health outcomes, as well as quality initiatives to improve them, vary widely across the country. The National Strategy aims to reduce geographic variations in care quality and reduce health disparities while improving the delivery of health care services, patient health outcomes, and population health. The Secretary will identify priority areas to improve the delivery of health care services. Additionally, quality improvements will eliminate waste and improve efficiency in the health care system. [§ 201]

Interagency Working Group on Health Care Quality: The Working Group will collaborate on planning and implementing quality improvement activities defined in the national strategy. They will also share best practices and lessons learned among all health care sectors and government agencies. The quality activities will be related to the priorities defined in the national strategy. Agencies will be required to develop individual strategic plans and then to report to both Congress and the public on the progress toward implementing the strategic plans. [§ 202]

Quality Measure Development: Quality measures will be developed in "gap" areas where no quality measures exist, or where existing quality measures need improvement, updating, or expansion. Measures will be developed according to priority areas related to care coordination, patient experience, health disparities, and the appropriateness of care. Quality measures developed through grants under this program will be made publicly available. [§ 203]

Quality Measure Endorsement, Public Reporting; Data Collection: This section provides for a streamlined process for use of quality measures for Federal health programs. The data from the reporting of these quality measures will be made available in a user-friendly format to inform providers, patients, consumers, researchers, and policymakers. [§ 204]

Collection and Analysis of Quality Measure Data: To encourage robust participation, resources will be provided to local entities to collect and aggregate quality data. The Secretary will establish standards for data aggregators and ensure health information privacy is protected. [§ 205]

Option A (R): Add Wired Act version of Gregg Medicare Quality Enhancement Act as an alternative to Section 205.

Subtitle B. Health System Quality Improvement

Synopsis: This subtitle establishes health quality initiatives to reduce medical errors, reduce hospital readmissions, improve patient safety, promote evidence-based medicine and disseminate best care practices. An integrative model of patient-centered care will be supported through the establishment of Community Health Teams. Research and informational tools will be encouraged to assist patients make informed decisions about care options available to them. In order to eliminate waste, routine administrative processes that divert scarce health resources from patients to paperwork will be streamlined.

Health care delivery system research; Quality Improvement Technical Assistance: Best practices help deliver care safely. The Patient Safety Research Center will strengthen best practice research and dissemination. Creating grants to identify and disseminate best practices to local providers and patients will prevent medical errors and reduce their associated costs. One such practice is the Pronovost Checklist, which uses ten simple steps to properly insert a catheter and eliminate line infections. [§ 211]

Community Health Teams: Community Health Teams will be established to support the development of medical homes by increasing access to comprehensive, community based, coordinated care. A patient's care is coordinated by an integrated team of providers that includes primary care providers, specialists, other clinicians and licensed integrative health professionals as well as community resources to enhance wellness and lifestyle improvements. It is patient-centered and holistic in its orientation. [§ 212]

Grants to Implement Medication Management Services in Treatment of Chronic Disease: Medication therapy management will be encouraged to reduce medical errors and improve patient adherence to therapies while reducing acute care costs. This demonstration attempts to evaluate and determine the best practices and develop quality measures specific to this service provided by pharmacists and other types of providers. [§ 213]

Regionalized Systems for Emergency Care, including Acute Trauma: This section provides funding to help improve regional coordination of emergency services. Access to the emergency medical system will be facilitated and a mechanism to ensure that patients are directed to the most appropriate medical facility will be established. Inter-facility resources will be tracked and coordinated in real time. [§ 214]

Option A (R): Strike.

Trauma Care Centers and Service Availability: This section reauthorizes and improves the trauma care program, providing grants to strengthen the nation's trauma centers. Grants are targeted to assist centers in underserved areas susceptible to funding and workforce shortages. [§ 215]

Option A (R): Strike.

Reporting and Reducing Preventable Readmissions: Hospitals will be required to report preventable readmission rates. Hospitals with high re-admission rates will be required to work with local patient safety organizations to improve their care transition practices including the effective use of discharge planning and counseling [§ 216]

Option A (R): Replace Section 216 with MedPAC's preventable readmissions proposal, but use Patient Safety Organizations for remediation.

Program to Facilitate Shared Decision Making: Educational tools will be developed, tested, and disseminated to help patients and caregivers understand their treatment options. Materials will assist patients to decide with their provider what treatments are best for them based on these beliefs and preferences, options, scientific evidence, and other circumstances. Providers will be educated on the use of these tools. Quality measures related to utilization of these tools as well as patient and caregiver experiences will be developed. [§ 217]

Option A (R): Amend Section 217 to avoid harming current providers of patient decision aids.

Presentation of Drug Information: Use of drug fact boxes in advertising and other forms of communication will be encouraged for prescription medications. A standardized, quantitative summary of the relative risks and benefits is an effort to clearly communicate drug risks and benefits and support clinician and patient decision making processes. Disclosure of relevant comparative effectiveness information also will be sought to empower patients and providers with relevant information. [§ 218]

Option A (R): Amend Section 218.

Center for Health Outcomes Research and Evaluation: The Center will promote health outcomes research and evaluation that enables patients and providers to identify which therapies work best for most people and to effectively identify where more personalized approaches to care are necessary for others. An Advisory Commission representing diverse interests will be established and public input will be sought in order to ensure research conducted is meaningful to patients and providers. [§ 219]

Option A (R): Strike.

Demonstration Program to Integrate Quality Improvement and Patient Safety training into health professionals' clinical education: Grants will be provided to develop and implement academic curricula that integrate quality improvement and patient safety into health professionals' clinical education. [§ 220]

Improving the Health of Women: This section will improve the health and the quality of care for women by making permanent women's health offices that currently exist within HHS and it's agencies. [§ 221]

Administrative Simplification: Enacted in 1996, the HIPAA law promised to simplify the administration of health care – yet that promise has gone largely unrealized. Since 1996, the potential of information technology to streamline commerce has increased exponentially, but the HIPAA standards have not kept pace. This section updates administrative simplification standards for the electronic age by requiring new technical standards designed to provide a common technical platform for more seamless administration of health care. [§ 222]

Option (R): Strike.

Fair and Reliable Medical Justice Act: Currently no provision.

Option (R): Add Fair and Reliable Medical Justice Act as a new section.

Title III: IMPROVING THE HEALTH OF THE AMERICAN PEOPLE

Synopsis: This title seeks to make preventive health and wellness services available and accessible to all Americans, regardless of age, gender, ethnicity, or physical or cognitive ability. The activities proposed by the title are designed to reduce or eliminate barriers for all Americans in achieving and maintaining optimal health.

Subtitle A: Modernizing Our Disease Prevention and Public Health Systems

Synopsis: This subtitle provides for an enhanced national strategy to prevent disease, promote health, and build our public health system. Health promotion activities will be supported and coordinated on the federal level. In addition, the most effective disease prevention strategies will be identified and promoted in a nationwide campaign.

National Prevention, Health Promotion and Public Health Council**:** Creates an interagency council dedicated to promoting healthy policies at the federal level. The Council shall consist of representatives of federal agencies that interact with federal health and safety policy, including the departments of HHS, Agriculture, Education, Labor, Transportation, and others. The Council will establish a national prevention and health promotion strategy and develop interagency working relationships to implement the strategy. The Council will report annually to Congress on the health promotion activities of the Council and progress in meeting goals of the national strategy. [S 301]

Prevention and Public Health Investment Fund**:**

Option A: *Establishes a Prevention and Public Health Investment Fund. The goal of the Investment Fund is to provide an expanded and sustained national investment in prevention and public health programs to improve health and help restrain the rate of growth in private and public sector health care costs. This will involve a dedicated, stable funding stream for prevention, wellness and public health activities authorized by the Public Health Service Act. [S 302]*

Option B (R): Drop Wellness Trust and replace with legislative authorities that allow the Director of the CDC to prioritize funds and use public health dollars more effectively.

Option C (R): Require more accountability and ensure that public health programs are reporting outcome measures.

Option D (R): Evaluate all programs and sunset any that are proven to be ineffective.

Option E (R): Authorize a Director Fund at CDC

Option F (R): Consolidate all CDC programs under PHSA to target funding and activities

Clinical and Community Preventive Services**:** Expands the efforts of, and improves the coordination between, two task forces which provide recommendations for preventive interventions. The U.S. Preventive Services Task Force is an independent panel of experts in primary care and prevention that systematically reviews the evidence of effectiveness of clinical preventive services such as colorectal cancer screening or aspirin to prevent heart disease, and develops recommendations for their use. The Community Preventive Services Task Force uses a public health perspective to review the evidence of effectiveness of population-based preventive services such as tobacco cessation, increasing physical activity and preventing skin cancer, and develops recommendations for their use. [§ 303]

Education and Outreach Campaign Regarding Preventive Benefits**:**

Option A: *Directs the Secretary to convene a national public/private partnership for the purposes of conducting a national prevention and health promotion outreach and education campaign. The goal of the campaign is to raise awareness of activities to promote health and prevent disease across the lifespan. [§ 304]*

Option B: *Requirement that CDC establish a web-based tool to allow individuals to create a personalized prevention plan to improve their health status.*

Subtitle B: Increasing Access to Clinical Preventive Services

Synopsis: This subtitle enhances access to comprehensive primary medical, dental, and behavioral health care services that are key to prevention and wellness, especially for vulnerable populations and underserved communities.

Right Choices Program**:** Establishes a temporary program giving uninsured adults access to preventive services. The Right Choices Program would provide chronic disease health risk assessment, a care plan, and referrals to community-based resources for low-income, uninsured adults until universal insurance coverage is made available through the Gateway. The program could significantly improve the health of working age adults as they enter the healthcare system, offering significant long-term cost savings. [§ 311]

School-based Health Clinics**:**

Option A: *Authorizes a grant program for the operation and development of School-based Health Clinics, which provide comprehensive and accessible preventive and primary health care services to medically underserved children and families. The goal of establishing*

such clinics is to improve the physical health, emotional well-being and academic performance of the populations they serve. The clinics will work in collaboration with schools to integrate health into the overall school environment. [§ 312]

Option B (R): Drop the School-based Health Clinics bill and work with the Committee on the initiative outside of health reform

Oral Healthcare Prevention Activities: Establishes an oral healthcare prevention education campaign at CDC focusing on preventive measures and targeted towards key populations including children and pregnant women. Creates demonstration programs on oral health delivery and strengthens surveillance capacity. [§ 313]

Subtitle C: Creating Healthier Communities

Synopsis: This subtitle enables health improvement to occur in communities as well as in medical settings. Most chronic diseases can be prevented through lifestyle and environmental changes. Community prevention programs encourage physical activity, good nutrition, and the reduction of tobacco use, making it easier for individuals to make healthy choices.

Community Transformation Grants**.**

Option A: This section authorizes the Secretary to award competitive grants to eligible entities for programs that promote individual and community health and prevent the incidence of chronic disease. Communities can carry out programs to prevent and reduce the incidence of chronic diseases associated with overweight and obesity, tobacco use, or mental illness; or other activities that are consistent with the goals of promoting healthy communities. [§ 321]

Option B (R): Drop Community Makeover Grants and the Community Health Impact Assessment program. Replace with a CDC program that allows states to streamline all CDC health promotion/disease prevention funding to target the top 3 chronic conditions that cost the state the most. States must set up a plan with the CDC and the CDC must provide technical assistance.

Healthy Aging, Living Well**:** The goal of this program is to improve the health status of the pre-Medicare-eligible population to help control chronic disease and reduce Medicare costs. The CDC would provide grants to states or large local health departments to conduct pilot programs in the 55-to-64 year old population. Pilot programs would evaluate chronic disease risk factors, conduct evidence-based public health interventions, and ensure that individuals identified with chronic disease or at-risk

for chronic disease receive clinical treatment to reduce risk. Pilot programs would be evaluated for success in controlling Medicare costs in the community.
[§ 322]

Wellness for Individuals with Disabilities**:** Amends the Americans with Disabilities Act to establish standards for accessibility of medical diagnostic equipment to individuals with disabilities. [§ 323]

Immunizations**:**

Option A: Authorizes states to purchase adult vaccines under CDC contracts. Currently, 23 states purchase vaccines under CDC contracts. These contracts for adult vaccines provide savings that range from 23-69 percent compared to the private sector cost. Authorizes a demonstration program to improve immunization coverage. Under this program, CDC will provide grants to states to improve immunization coverage of children, adolescents, and adults through the use of evidence-based interventions. States may use funds to implement interventions that are recommended by the Community Preventive Services Task Force, such as reminders or recalls for patients or providers, or home visits. Reauthorizes the Immunization Program in Section 317 of the Public Health Service Act. [§ 324]

Option B: Provide bonus grants to state that immunize 90% of the ACIP recommended populations.

Menu Labeling: This initiative represents a compromise between the Menu Education and Labeling (MEAL) Act, sponsored by Senator Harkin, and the Labeling Education and Nutrition (LEAN) Act, sponsored by Senators Carper and Murkowski. Under the terms of the compromise, a restaurant that is part of a chain with 20 or more locations doing business under the same name (other restaurants are exempt) would be required to disclose calories on the menu board and in a written form, available to customers upon request, additional nutrition information pertaining to total calories and calories from fat, as well as amounts of fat, saturated fat, cholesterol, sodium, total carbohydrates, complex carbohydrates, sugars, dietary fiber, and protein. [§ 325]

Subtitle D: Support for Prevention and Public Health Innovation

> *Synopsis: This subtitle provides support for prevention and public health research. We must develop tools and interventions to address new public health challenges and build the evidence base for public health interventions that improve the health and safety of the nation.*

Research on Optimizing the Delivery of Public Health Services**:** The Secretary, acting through the Director of CDC, shall provide funding for research in the area of public health services and systems. This research shall include examining best practices relating to prevention, analyzing the translation of interventions from academic institutions to clinics and communities, and identifying effective strategies for delivering public health services in real world settings. CDC shall annually report research findings to Congress. [§331]

Data Collection, Analysis, and Quality**:** Ensures that any ongoing or new federal health program achieve the collection and reporting of data by race, ethnicity, geographic location, socioeconomic status, health literacy, primary language and any other indicator of disparity. The Secretary shall analyze data collected to detect and monitor trends in health disparities and disseminate this information to the relevant federal agencies. The Secretary shall also award grants to develop appropriate methods to detect and assess health disparities. [§ 332]

Health Impact Assessments**:** Establishes a program at the Centers for Disease Control and Prevention to support the development of health impact assessments and dissemination of best practices related to health impact assessments. The Centers for Disease Control shall award grants to State or local governments working in coalitions with community-based organizations, public health agencies, health care providers or academic institutions to implement, further support or conduct research on health impact assessments. [§333]

CDC and Employer-based Wellness Programs**:**

Option A: *The Centers for Disease Control and Prevention will study and evaluate best employer-based wellness practices and provide an educational campaign and technical assistance to promote the benefits of worksite health promotion to employers. [§ 334]*

Option B (R): Drop CDC program to evaluate employer wellness programs

Option C (R): Increase HIPAA 20% limit to 50% to allow employers to be more creative in providing health benefits

Option D (R): Provide clarity under HIPAA and ERISA that wellness plans are legal and encouraged

Option E (R): Provide clarity that voluntary health risk assessments are legal and appropriate for workplace wellness programs

Option F (R): Establish a safe haven for small businesses to administer wellness programs under HIPAA.

Title IV. HEALTH CARE WORKFORCE

Synopsis: This title seeks to improve access to and the delivery of health care services for all individuals, particularly low income, underserved, uninsured, minority, health disparity, and rural populations by: gathering and assessing comprehensive data in order for the health care workforce to meet the health care needs of individuals, increasing the supply of a qualified health care workforce, enhancing health care workforce education and training, and providing support to the existing health care workforce to improve access to and the delivery of health care services for all individuals.

Subtitle B. Innovations in the Health Care Workforce

National Health Care Workforce Commission: Establishes national commission tasked with reviewing health care workforce and projected workforce needs. The overall goal of the commission is to provide comprehensive, unbiased information to Congress and the Administration about how to align federal health care workforce resources with national needs. Information could be utilized by the Congress when providing appropriations to discretionary programs or in restructuring other federal funding sources. The Commission would leverage existing federal resources and programs including the expertise and work of: the U.S. Department of Health and Human Service, including the Health Resources and Services Administration, the U.S. Department of Education, and the U.S. Department of Labor, and other appropriate federal agencies. (§ 411)

State health care workforce development grants: Competitive grants are established for the purpose of enabling state partnerships to complete comprehensive planning and to carry out activities leading to coherent and comprehensive health care workforce development strategies at the state and local levels. Grants would be used to support innovative approaches to increase the number of skilled health care workers such as health care career pathways for young people and adults. (§ 412)

Health care workforce program assessment: National and multiple regional centers for health workforce analysis are established to collect, analyze and report data related to Title VII. The centers will coordinate with state and local agencies collecting labor and workforce statistical information and coordinate and provide analyses and reports on Title VII programs to the Commission. (§ 413)

Option A: *Require the Secretary to collect and analyze data relating to the health professions training programs. The Secretary shall report to Congress which must include data regarding the number of health professionals trained and practicing in underserved areas.*

Option B (R): *Establish a 3-year period for third-party evaluation of each health professions program to be evaluated based on its impact on increasing the number of primary care physicians and the number of physicians in rural areas. Sunset any program that fails to meet some threshold.*

Subtitle C. Increasing the Supply of the Health Care Workforce

Federally supported student loan funds: Current law is amended to ease criteria for schools and students to qualify for loans, lower interest rates, shorten payback periods, and ease the non-compliance provision. (§ 421)

Option A (R) : Drop language that changes the interest rate and eligibility requirements for the Title VII loan repayment program.

Nursing student loan program: Increases the grant amounts and updates the years for nursing schools to establish and maintain student loan funds. (§ 422)

Health care workforce loan repayment programs: Establishes a loan repayment program for pediatric subspecialists and providers of mental and behavioral health services for children and adolescents. Awards will be prioritized to those individuals who are or will be working with high-priority populations for mental health in a Health Professional Shortage Area, Medically Underserved Area, or Medically Underserved Population. (§ 423)

Public health recruitment and retention program: Offers offer loan repayment for a relevant public health professions degree to full time employees in federal, state, local or tribal public health agencies in exchange for working at least 3 years. (§ 424)

Allied health recruitment and retention program: Offers loan repayment for a relevant allied health professions degree to full time employees in federal, state, local or tribal public health agencies or in settings where patients might require health care services, including acute care facilities, ambulatory care facilities, residences, and other settings. (§ 425)

Grants for states and local programs: Mid-career professional programs: Allows the Secretary to award grants to eligible entities for scholarships to mid-career public and allied health professionals employed in public and allied health positions at the Federal, State, tribal, or local level to receive additional training in public or allied health fields. (§ 426)

National Health Service Corps: Increases and extends the authorization of appropriations for the National Health Service Corps scholarship and loan repayment program for FY10-15, and provides increased funding. (§ 427)

Nurse-managed health clinics: Strengthens the safety-net and ensure that medically underserved have access to primary care and wellness services by creating a $50 million grant program to support nurse-managed health clinics to be administered by the Health Resources and Services Administration's Bureau of Primary Health Care. (§ 428)

Elimination of cap on Commissioned Corps: Eliminates the artificial cap on the number of Commissioned Corps members, allowing the Corps to expand to meet national public health needs. (§ 429)

Establishing a ready reserve corps: Establishes a Ready Reserve Corps within the Commissioned Corps for service in time of national emergency. Ready Reserve Corps members may be called to active duty to respond to national emergencies and public health crises and to fill critical public health

positions left vacant by members of the Regular Corps who have been called to duty elsewhere. (§ 430)

Subtitle D. Enhancing Health Care Workforce Education and Training

Training in family medicine, general internal medicine, general pediatrics, and physician assistantship: Provides grants to develop and operate training programs, financial assistance of trainees and faculty, and faculty development in primary care and physician assistant programs. This section provides grants to establish, maintain and improve academic units in primary care. Priority is given to programs that educate students in team-based approaches to care, including the patient-centered medical home. Authorization is $125 million. (§ 431)

Training opportunities for direct care workers: Authorizes $10 million over three years to establish new training opportunities for direct care workers (CNAs, home health aides and personal/home care aides) already employed in long-term care facilities. (§ 432)

Training in general, pediatric, and public health dentistry: This provision reinstates dental funding under its own Title. It makes dental programs eligible for grants now only available to medical schools, and authorizes a dental faculty loan repayment. This section allows dental schools and education programs to use grants for pre-doctoral training, faculty development, and academic administrative units. Educating dental students to provide oral health care to patients whose medical, physical, psychological, cognitive or social situations require modifying normal dental routines to provide treatment is included as a priority. Authorization for $30 million annually is provided. (§ 433)

Alternative dental health care provider demonstration project: Authorizes the Secretary to award grants to establish training programs for alternative dental health care providers to increase access to dental health care services in rural and underserved communities. (§ 434)

Geriatric education and training: Authorizes $12 million to geriatric education centers to support training in geriatrics, chronic care management, and long-term care for faculty in health professions schools and family caregivers; develops curricula and best practices in geriatrics; expands the geriatric career awards to advanced practice nurses, clinical social workers, pharmacists, and psychologists; and establish traineeships for individuals who are preparing for advanced education nursing degrees in geriatric nursing. (§ 435)

Mental and behavioral health education and training grants: Grants are awarded to schools for development, expansion, or enhancement of training programs in social work, graduate psychology, professional training in child and adolescent mental health, and pre-service or in-service training to paraprofessionals in child and adolescent mental health. (§ 436)

Cultural competency, prevention and public health and individuals with disabilities training: Creates a program to support the development, evaluation, and dissemination of model curricula for cultural competency, prevention, and public health proficiency and aptitude for working with individuals with disabilities training for use in health professions schools and continuing education programs. (§ 437)

Advanced nursing education grants: Strengthens language for accredited Nurse Midwifery programs to receive advanced nurse education grants in Title VIII. (§ 438)

Nurse education, practice, and retention grants: Awards grants to nursing schools to strengthen nurse education and training programs and to improve nurse retention. (§ 439)

Loan repayment and scholarship program: Adds faculty at nursing schools as eligible individuals for loan repayment and scholarship programs. (§ 440)

Nurse faculty loan program: Establishes a federally-funded student loan repayment program for nurses with outstanding debt who pursue careers in nurse education. Nurses agree to teach at an accredited school of nursing for at least 4 years within a 6-year period. (§ 441)

Grants to promote the community health workforce: Authorizes the Secretary to award grants to states, public health departments, federally qualified health centers, and other nonprofits to promote positive health behaviors for populations in medically underserved areas through the use of community health workers. (§ 443)

Youth public health program: Establishes a youth public health program to expose and recruit high school students into public health careers. (§ 444)

Fellowship training in epidemiology, public health lab science, public health informatics, and epidemic intelligence service: Authorizes the Secretary to address workforce shortages in state and local health departments in applied public health epidemiology and public health laboratory science and informatics. (§ 445)

Subtitle E. Supporting the Existing Health Care Workforce

Centers of excellence: The Centers of Excellence program, focusing on development of a minority applicant pool to enhance recruitment, training, academic performance and other supports for minorities, is reauthorized at 150% of 2005 appropriations, $50 million. (§ 451)

Health professions training for diversity: Provides scholarships for disadvantaged students who commit to work in medically underserved areas as primary care providers. Funding is increased from $37 to $51 million for 2009 through 2013. This section increases loan repayments for individuals who will serve as members of faculties of eligible institutions from $20,000 to $30,000. (§ 452)

Interdisciplinary, community-based linkages: This section establishes community-based training and education grants for Area Health Education Centers (AHECs) and Programs. Two programs are supported—Infrastructure Development Awards and Points of Service Enhancement and Maintenance Awards targeting individuals seeking careers in the health professions from urban and rural medically underserved communities. Authorization is for $125 million annually 2009 through 2013. (§ 453)

Option A (R): Drop definitions association with rural areas.

Workforce diversity grants. Expands the allowable uses of diversity grants to include completion of associate degrees, bridge or degree completion program, or advanced degrees in nursing, as well as pre-entry preparation, advanced education preparation, and retention activities. (§ 454)

Primary Care Extension Program: Creates a Primary Care Extension Program to educate and provide to technical assistance to primary care providers about evidence-based therapies, preventive medicine, health promotion, chronic disease management, and mental health. The Center for Primary Care, Prevention, and Clinical Partnerships at the Agency for Healthcare Research and Quality (AHRQ) will award planning and program grants to state entities including state health department, state-level entities administering Medicare and Medicaid, and at least one health professions school. (§ 455)

Options:

Option A (R): Limit health professions grants to primary care providers (strike advanced practice nursing, public health providers, grants to develop faculty).

Option B (R): Create a new requirement that the Secretary cap the number of specialists residency slots and increase the number of primary care slots and increase the number of slots at rural medical centers.

Option C (R): Drop all new sections/provisions that seek to train health professionals in areas other than primary care.

Option D (R): Include a Sense of the Senate that health professions program target education individuals in primary care as opposed to specialty care.

Option E (R): Drop all new sections/provisions that create new training programs for specific areas and target program requirements to simply increase the number of providers.

Option F (R): Reauthorize expired programs and ensure that each is targeted to increase the number of primary care providers practicing in the community. The reauthorizations should seek to reign in all programs that are supporting specialized training and focus on increase the sheer number of primary care providers practicing in the field. Programs must equally benefit urban and rural communities.

Option G (R): Drop all provisions that loosen requirements to practice in underserved areas.

Option H (R): Ensure all new language that benefits urban and suburban areas also benefits rural areas.

Title V. FIGHTING HEALTH CARE FRAUD AND ABUSE

Synopsis: The National Health Care Anti-Fraud Association (NHCAA) estimates that three percent of all health care spending – or $72 billion – is lost to health care fraud perpetrated against public and private health plans. Other government and law enforcement agencies estimate losses from fraud as high as ten percent. Fraud committed against both public and private plans, increases the cost of medical care and health insurance for employers, families, and taxpayers, and undermines public trust in our health care system.

Subtitle A. Establishment of New Health and Human Services (HHS) and Department of Justice (DOJ) Health Care Fraud Positions

Synopsis: The HHS Secretary will appoint a new Senior Advisor for Health Care Fraud. The Attorney General will appoint a Senior Counsel for Health Care Fraud Enforcement.

This section creates non-career, Schedule C-level, senior positions within HHS and DOJ with primary oversight and coordination responsibility for each Department's overall health care fraud efforts, and oversight of implementation of the Program Integrity Coordinating Council's (PICC) responsibilities. Persons serving in these positions will serve as "point persons" for purposes of inter-agency coordination, coordination of program integrity efforts with respect to private plans, and coordination with State entities such as insurance regulators and State Medicaid Fraud Control Units. (§ 501, 502)

Subtitle B. Health Care Program Integrity Coordinating Council (PICC)

Synopsis: A coordinating council is established to coordinate strategic planning among federal agencies involved in health care integrity and oversight.

HIPAA established a national Health Care Fraud and Abuse Control Program (HCFAC), under the joint direction of the Secretary of Health and Human Services (HHS), acting through the Department's Inspector General (HHS-OIG), and the Attorney General of the United States. HCFAC was intended to facilitate collaboration among federal, state, and local law enforcement activities with respect to health care fraud and abuse. The proposed Health Care Program Integrity Coordinating Council (PICC) would retain the current HCFAC Program structure, and establish additional formal coordination and strategic planning roles for the federal agencies involved in health care integrity and oversight.

The PICC will develop a strategic plan to improve the efficacy of the HCFAC Program to ensure coordination of fraud prevention efforts. The PICC will develop and issue guidelines to federal agencies to carry out the HCFAC Program. The PICC will recommend measures to estimate the amount of fraud, waste and abuse in connection with public and private plans, and the annual savings resulting from specific program integrity measures. (§ 511)

Subtitle C. False Statements and Representations

Synopsis: Employees and agents of Multiple Employer Welfare Arrangements (MEWAs) will be subject to criminal penalties if they provide false statements in marketing materials regarding a plan's financial solvency, benefits provided, or regulatory status.

This section amends criminal penalties provisions in ERISA, 29 U.S.C. § 1131, to add a prohibition against false statements frequently used by corrupt operators and marketers of MEWAs without requiring that false statements be contained in ERISA-required documents. Examples of such false statements include misrepresentations regarding the financial solvency or regulatory status of a plan or other arrangement by MEWA operators undertaken to generate business and evade state regulation.

Currently, 18 U.S.C. § 1027 criminalizes the making of false statements and omissions in connection with the operation of ERISA plans, but is limited to false statements or concealments contained in documents that must be kept, published, or certified under title I of ERISA. Consequently, Section 1027 does not reach misrepresentations of fact in marketing materials used by corrupt operators and marketers to induce employers or employee organizations to purchase particular health care claims coverage for their respective employees or members. (§ 521)

Subtitle D. Federal Health Care Offense

Synopsis: The Department of Justice will be permitted to prosecute crimes involving MEWAs. The agency does not currently have this authority. This change in the law will enable the agency to seize the proceeds of health care offenses, employ administrative subpoenas, and enjoin ongoing criminal activities.

Revised section 24(a)(2) of Title 18 adds three crimes relating to MEWAs to the list of federal health care offenses. The proceeds of these federal health care offenses will become subject to criminal forfeiture under 18 U.S.C. § 982(a)(7), and the offenses themselves will also be included as specified unlawful activity for money laundering offenses at 18 U.S.C. § 1956(c)(7)(F). Designation of these crimes as federal health care offenses will permit employment of an administrative subpoena provision at 18 U.S.C. § 3486, to facilitate government investigation of fraud and abuse involving such offenses**.**

The designation authorizes the Attorney General to commence a civil action under 18 U.S.C. § 1345 to enjoin an ongoing violation of these criminal statutes. An action by the United States to promptly enjoin and prevent the future sale or marketing of a health care benefit program's health insurance product is needed where corrupt insurers are sponsoring, marketing, and selling health care insurance and claims products in multiple states. (§ 531)

Subtitle E. Uniformity in Fraud and Abuse Reporting

Synopsis: To facilitate consistent reporting by private health plans of suspected cases of fraud and abuse, a model uniform reporting form will be developed by the National Association of Insurance Commissioners, under the direction of the HHS Secretary.

This section encourages the development of a model uniform reporting form for private health plans seeking to refer suspected cases of fraud and abuse to State Insurance Departments for investigation. The current lack of uniformity is an impediment to consistent reporting that can be compared and analyzed across state lines, and thus a hindrance to more effective anti-fraud activities. The Secretary

of Health and Human services will request that the National Association of Insurance Commissioners develop recommendations for uniform reporting standards for such referrals. (§ 541)

Subtitle F. Applicability of State Law to Combat Fraud and Abuse

> *Synopsis: The Department of Labor will adopt regulatory standards and/or issue orders to prevent fraudulent MEWAs from escaping liability for their actions under state law by claiming that state law enforcement is preempted by federal law.*

Fraudulent insurance plans often escape accountability under state insurance laws and regulations by claiming that federal law preempts the application of state law to their actions. When cases are brought against fraudulent plans in state courts, plans allege that state courts do not have jurisdiction. Two laws are often abused: ERISA and the Liability Risk Reduction Act. Many fraudulent plans claim they are employer-sponsored plans subject to ERISA and not "in the business of insurance," as defined in ERISA. If the plans were "in the business of insurance" they would, under ERISA, be subject to state insurance laws and could be held responsible for their fraudulent activities.

The preemption provisions in ERISA and the Liability Risk Reduction Act are complex. Fraudulent plans take advantage of this complexity to evade justice. To circumvent fraudulent plans' efforts, the Department of Labor will be authorized to adopt regulations establishing, and issue orders relating to, when an entity engaging in the business of the insurance is subject to state law. These standards and orders will make clear when a plan is subject to state law. (§ 551)

Subtitle G. Enabling the Department of Labor to Issue Administrative Summary Cease and Desist Orders and Summary Seizures Orders against Plans in Financially Hazardous Condition.

> *Synopsis: The Department of Labor will be authorized to issue "cease and desist" orders to temporarily shut down operations of plans conducting fraudulent activities or posing a serious threat to the public, until hearings can be completed. If it appears that a plan is in a financially hazardous condition, the agency may seize the plan's assets.*

The section authorizes the Department of Labor to issue cease and desist orders if it appears to the Secretary that a plan's alleged conduct is fraudulent, or creates an immediate danger to public safety or welfare, or is causing significant, imminent, and irreparable public injury. A person adversely affected by the issuance of a cease and desist order may request a hearing regarding such order. The burden of proof in this hearing will be on the party requesting the hearing to show cause why the cease and desist order should be set aside. Based on evidence, the cease and desist order may be affirmed, modified, or set aside in whole or in part. DOL may issue a summary seizure order if it appears an entity is in financially hazardous condition. States will be empowered to act quickly through administrative orders to shut down illegal and financially hazardous insurance schemes. (§521)

Subtitle H. Requiring Multiple Employer Welfare Arrangement (MEWA) plans to file a registration form with the Department of Labor prior to enrolling anyone in the plan.

Synopsis: Multiple Employer Welfare Arrangements (MEWAs) are a type of employer-sponsored plan involving two or more employers, rather than a single employer. Employers join together to negotiate cheaper premiums. MEWAs have been prone to fraud. To protect the public, MEWAs will be required to file their federal registration forms, and thereby be subject to government verification of their legitimacy, before enrolling anyone.

MEWAs are required to file a Form M-1 with the Department of Labor each year. The annual reporting of the Form M-1 is helpful to states. In certain situations, plans are able to operate for more than a year before filing the M-1. It is helpful to states to have basic information about entities operating in their state without a time delay that works to the advantage of those who seek to operate illegally. The registration would provide basic information about the entity, where the entity will operate, and what exclusion from state authority they may claim. (§ 571)

Subtitle I—Permitting Evidentiary Privilege and Confidential Communications

Synopsis: This section permits the Department of Labor to allow confidential communication among public officials relating to investigation of fraud and abuse.

The section creates an optional federal privilege that would include all confidential communications among state regulators (and the NAIC) and federal regulators to conduct regulatory oversight of an entity subject to regulation. This will enable federal and state regulators to communicate on a confidential basis. Currently, such confidential communication requires adoption by both entities of a Memorandum of Understanding - a time-consuming process. People perpetrating fraudulent and abusive schemes seek victims and don't care whether the mechanism to do so is health, property, life, annuity or other insurance product or some other financial product. The same operators or even schemes often show up in multiple ways.

Option A (R): Strike the section and replace with a comprehensive alternative summarized below:

Improve Medicare Beneficiary Identifier System: Change from the current system of using social security numbers and use new numbers like we have on credit cards in an effort to protect beneficiaries from identity theft. New cards would have biometric ID protections. HHS would establish a process to assign a new numbers in the discovery of fraud or identity theft. Require data matching across federal agencies to check for social security numbers in Medicare and Medicaid of dead, imprisoned, or otherwise ineligible beneficiaries and providers. Direct the Secretary to levy direct financial penalties to facilities receiving Medicare or Medicaid dollars that choose to employ any physician, executive, or administrator convicted of Medicare or Medicaid fraud in any state or responsible for a settlement with the government.

Combat Fraud And Abuse: HHS will implement a real time data review of all Medicare claims to provide data analysis of claims for reimbursement and to help identify and investigate unusual billing or order practices. HHS will create a system to identify the 50 counties most vulnerable to fraud. Pre-enrollment and re-enrollment site visits and background checks for all Medicare suppliers. Data analysis to establish prepayment claim edits designed to target the claims for reimbursement that are most likely fraudulent. Secretary shall submit a report to congress annually, summarizing the effectiveness of the activities under this section, including a description of any savings from this program as well as overall administrative costs.

Improve 855S Medicare Enrollment Application and Durable Medical Equipment: Require Medicare carriers to check with the National Supplier Clearinghouse (NSC) to ensure that the supplier number is active and valid. Limit payment to providers to accredited services. Disallow payments to providers who submit claims for reimbursement that do not match the service specialty or specialties the provider indicated on the 855S enrollment form. Add to CMS-855S form that prospective DME providers must fill out the phrase, "under penalty of perjury, federal criminal prosecution, and possible imprisonment" by the signature block. Direct that the submission of a fraudulent DME claims gives HHS the immediate authority to revoke the supplier's billing number. Direct HHS within one year of enactment to establish a appeals process where appeals of billing number revocations may be appealed and resolved in no more than 60 days. Exempt Pharmacists from the requirement of a surety bond for Durable Medical Equipment.

Improve Medicare Beneficiary Identifier System: Change from the current system of using social security numbers and use new numbers, along with cards that would have biometric ID protections. HHS would establish a process to assign a new numbers in the discovery of fraud or identity theft. Require data matching across federal agencies to check for social security numbers in Medicare and Medicaid of dead, imprisoned, or otherwise ineligible beneficiaries and providers. Direct the Secretary to levy direct financial penalties to facilities receiving Medicare or Medicaid dollars that choose to employ any physician, executive, or administrator convicted of Medicare or Medicaid fraud in any state or responsible for a settlement with the government.

Combat Fraud And Abuse: HHS will implement a real time data review of all Medicare claims to provide data analysis of claims for reimbursement and to help identify and investigate unusual billing or order practices. HHS will create a system to identify the 50 counties most vulnerable to fraud. Pre-enrollment and re-enrollment site visits and background checks for all Medicare suppliers. Data analysis to establish prepayment claim edits designed to target the claims for reimbursement that are most likely fraudulent. Secretary shall submit a report to congress annually, summarizing the effectiveness of the activities under this section, including a description of any savings from this program as well as overall administrative costs.

Improve 855S Medicare Enrollment Application and Durable Medical Equipment: Require Medicare carriers to check with the National Supplier Clearinghouse (NSC) to ensure that the supplier number is active and valid. Limit payment to providers to accredited services. Disallow payments to providers who submit claims for reimbursement that do not match the service specialty or specialties the provider indicated on the 855S enrollment form. Add to CMS-855S form that prospective DME providers must fill out the phrase, "under penalty of perjury, federal criminal prosecution, and possible imprisonment" by the signature block. Direct that the submission of a fraudulent DME claims gives HHS the immediate authority to revoke the supplier's billing number. Direct HHS within one year of enactment to establish a appeals process where appeals of billing number revocations may be appealed and resolved in no more than 60 days. Exempt Pharmacists from the requirement of a surety bond for Durable Medical Equipment.

Title VI: Improving Access to Innovative Medical Therapies

Subtitle A—Biologics Price Competition and Innovation

Subtitle B—More Affordable Medicines for Children and Underserved Communities

Expanded Participation in 340B Program: Section 340B of the Public Health Service Act enables safety-net hospitals and other providers serving a large volume of low-income and uninsured patients to access significant discounts on pharmaceuticals. These discounts now are mandated only in outpatient settings. While the MMA of 2003 permits pharmaceutical companies to offer these discounts on the inpatient setting, there have been few instances of such discounts being offered. This section amends the 340B Program in these ways: 1) Expanding the drug discount program to allow participation as a covered entity by free-standing children's hospitals, rural referral centers, sole community hospitals which have a disproportionate share hospital percentage greater than eight percent, and all critical access hospitals; 2) Expanding the program to include a drug used in connection with an inpatient service by enrolled hospitals; 3) Allowing enrolled hospitals to obtain inpatient drugs through a group purchasing agreement or the 340B Prime Vendor Program; and 4) Requiring hospitals enrolled in the 340B program to provide a credit to each state on the estimated annual costs of covered drugs provided to Medicaid recipients for inpatient use. (§ 611)

Improvements to 340B Program Integrity: Improves the integrity of the 340B Program by: 1) Requiring the Secretary to carry out activities to increase compliance by manufacturers and covered entities with the requirements of the drug discount program; 2) Establishing an administrative process to resolve claims by covered entities and manufacturers of violations of such requirements; and 3) Providing clarifications about the ceiling price used to sell to 340B participants. (§ 612)