Baucus Modification to (A)

Bunning Amendment #C4 to America's Healthy Future Act of 2009
[MODIFIED]

Bunning Amendment #C4 to America's Healthy Future Act of 2009

Short Title: Transparency Amendment

Description of Amendment: This amendment requires that before the Finance Committee can vote on final passage of "America's Healthy Future Act of 2009," the ~~legislative~~ language and a ~~final and~~ complete cost analysis by the Congressional Budget Office must be publicly available on the Finance Committee's website ~~for at least 72 hours.~~

conceptual

ahead of the vote

in plain English

Baucus

B

MODIFIED

Hatch-Grassley-Crapo-Cornyn Amendment #D7 to America's Healthy Future Act of 2009

Short Title: Medicare Advantage Restoration Act

Description: This amendment would strike the Medicare Advantage provisions of the Chairman's mark if the Chief Actuary of CMS certifies that beneficiaries currently participating in the Medicare Advantage program will lose Medicare-covered plan benefits when the Medicare Part C reductions are implemented by the Centers of Medicare and Medicaid Services. The Chief Actuary of CMS is required to make this certification 3 months after the enactment of the health reform bill.

Offset: A proportionate reduction as needed in spending in the Chairman's Mark with the exception of the Medicare program.

C

Modified Menendez Amendment D#2 to Chairman's Mark of America's Healthy Future Act

Short Title: Proposed Amendment Requiring the Secretary of HHS to Conduct a Study Regarding Urban Medicare-dependent Hospitals

Description of Amendment: The Secretary of Health and Human Services will conduct a study on the need for an additional Medicare inpatient payment for urban Medicare-dependent hospitals paid under the Prospective Payment System (PPS) which receive no additional payments or adjustments under PPS, such as IME, DSH, RRC, CAH, SCH, or MDH payments. For purposes of the study, urban Medicare-dependent hospitals would be defined as those hospitals with more than 60 percent of their inpatient days or discharges paid by Medicare. The Secretary's study will examine the Medicare inpatient margins of these hospitals compared to other PPS hospitals that receive one or more of the additional payments or adjustments and consider the applicability to these urban hospitals of the existing payment adjustment for Medicare-dependent rural hospitals. The amendment directs the Secretary of HHS to submit to Congress, no later than 9 months from date of enactment, a report describing the findings and conclusions of the study as well as recommendations for legislation and administrative action.

<u>As Modified</u> Ensign Amendment #D6 to America's Healthy Future Act of 2009

D

Short Title: Medicare Savings Should be Kept within Medicare

Description of Amendment: No reductions in Medicare outlays may be utilized to offset any non-Medicare outlays.

E

Modification to Carper Amendment #D3 to Chairman's Mark of the America's Healthy Future Act of 2009

Short Title: To extend the length of time states have to repay the federal share of a Medicaid overpayment.

Co-sponsor: Rockefeller

Description of Amendment:

Under current law, states have to repay the federal share of any overpayments within 60 days of discovery; however, collections of overpayments—especially in fraud cases—seldom occur that fast.

This amendment would extend the 60 days states have to repay the federal share of a Medicaid overpayment to 1 year for fraud cases. In any case due to fraud, where the State is unable to recover within the allotted time because the amount has not been finally determined through the judicial process or the final judgment is under appeal, the state must repay the federal share within 30 days after the final judgment is made.

CBO estimates this amendment would cost $100 million over 10 years.

Offset: Expansion of Recovery Audit Contracting.

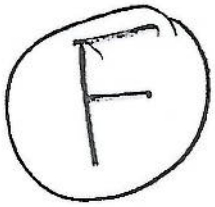
Under current law, the Centers for Medicare and Medicaid Services (CMS) is implementing a program to collect improper payments made in Medicare's fee-for-service program through the use of recovery audit contractors (RACs). The Chairman's Mark extended the program to Medicare Parts C & D and Medicaid. The amendment would require three items:

1. That CMS implement the RAC programs in Medicare Parts C and D and in Medicaid by the end of 2010.

2. That CMS coordinate the Medicaid RAC program with states, several of whom have already entered into contracts with RACs at the state level.

3. That CMS submit an annual report to Congress concerning the effectiveness of these programs and any recommendations for expanding or improving the programs.

The offset, as modified, will raise $200 million over 10 years.



Correction

Wyden Amendment #D15 to the Chairman's Mark of America's Healthy Future Act of 2009 (Modified)

Short Title: Requiring the Medicare Payment Advisory Commission to Review and Report Medicaid and Commercial Payments to Congress

Description:

This amendment adds the following to the Chairman's Mark:

"In 2012 and thereafter, to the extent feasible, MedPAC shall report aggregate Medicaid and commercial trends in spending, utilization, and financial performance for providers where, on an aggregate national basis, a significant portion of revenue and/or services is associated with Medicaid. Where appropriate, this review shall be done in consultation with the Medicaid and CHIP Payment and Access Commission (MACPAC)."

This amendment will also modify p. 61 of the Chairman's mark, by adding the following in the third sentence of the final paragraph related to expanding MACPAC's mission to include assessment of adult services in Medicaid, including for dual-eligible beneficiaries:

"This assessment shall be done in consultation with the Medicare Payment Advisory Commission (MedPAC)."

Offset: This amendment will not result in increased cost.

9

Stabenow-Lincoln MODIFIED Amendment C-7 to the Chairman's Mark

Short title/purpose: To allow stand-alone dental plans to offer the required pediatric dental services and to be offered in the individual and small group markets including within the insurance exchanges.

Description of Amendment: The Chairman's mark states that no policies could be issued in the individual or small group market (other than grandfathered plans) that did not meet the actuarial standards described and that all plans in the individual and small group markets, at a minimum, would be required to offer coverage in the silver and gold categories. Furthermore, all plans must offer pediatric services, including dental and vision. The current language precludes stand-alone dental plans, which currently provide 97 percent of the dental benefits in the United States, from competing with medical plans for pediatric dental coverage in the Exchange.

This amendment would ensure that people who like their dental plans would be able to keep them. To accomplish this, stand-alone dental plans must be allowed to offer the required pediatric dental benefits directly and to offer coverage through the Exchange and must comply with any relevant consumer protections required for participation in the Exchange.

Required pediatric dental benefits in the non-group and small group markets (in and outside an Exchange) may be separately offered and priced from other required health benefits. Coverage for these required pediatric dental benefits may be provided by any state-licensed stand-alone dental-only carrier that meets the requirements of section 2791(c)(2)(A) of the Public Health Service Act. Stand-alone dental-only together with a qualified health plan that provides all of the other required benefits satisfies the required benefits standards. Tax credits and cost-sharing assistance for the required pediatric dental health benefits would be designed to ensure they do not total more than they would have otherwise been under the Chairman's Mark.

Offset: this amendment would not score because there would be no additional funding provided for the purchase of the non-pediatric section of the dental-only plan

MODIFIED Rockefeller Delivery System Reform Amendment #10 to the America's Healthy Future Act

Modified Rockefeller Amendment #D10 to Title III Subtitle E (Ensuring Medicare Sustainability)

Short Title: Amendment to the Medicare Commission provision

Description of Amendment:

Amend Title III, Subtitle E, the Medicare Commission, to add the following provisions consistent with the concepts included in the following sections of the MedPAC Reform Act of 2009 (S. 1380):

- *Purpose.* To propose to Congress policies within the Medicare program that improve health outcomes, promote greater quality and efficiency, improve beneficiary access to necessary and evidence-based items and services, maintain affordability, and improve the long-term solvency of Medicare.

- *Responsibilities of the Commission.* In addition to the task of recommending policies that slow cost growth, this Commission would be responsible for recommending policies that improve the quality of care for beneficiaries.

- *Additional Restrictions of the Commission.* To clarify that under the Chairman's mark, the Commission would also be prohibited from presenting proposals to increase beneficiary premiums.

- *Ex-Officio Members.* The Secretary of Health and Humans Services (HHS), the Administrator of the Center for Medicare and Medicaid Services (CMS), and the Health Resources and Services Administration (HRSA) serve as non-voting members of the Commission.

- *Dual Eligibles.* The Commission would also be required to consider the unique needs of Medicare beneficiaries who are dually eligible for Medicare and Medicaid.

- *Additional Requirements of Commissioners.* The Commissioners must be free of any current conflicts-of-interest, and be held to the highest standards of disclosure and accountability.

- *GAO Study*: Initial Study – By July 1, 2015, the Comptroller General of the United States shall conduct a study on changes to payment policies, methodologies, and rates and coverage policies and methodologies under the Medicare Program under title XVIII of the Social Security Act as a result of the proposals made by the Commission. The GAO shall also provide an assessment of the effect of the Commission's decisions on the following:

- Beneficiary access to providers, items and services;
- Affordability of premiums and other cost-sharing;
- The potential impact of changes on other government or private-sector purchasers and payers of care, and;
- Quality of patient care, including patient experience, outcomes and other measures of "patient-centeredness" of care.

- *SUBSEQUENT GAO STUDIES.* -- The Comptroller General of the United States shall periodically conduct such additional studies and submit reports to Congress on changes to Medicare payment policies, methodologies, and rates and coverage policies and methodologies as he determines appropriate, in consultation with the appropriate committees of jurisdiction of the Senate and House of Representatives.

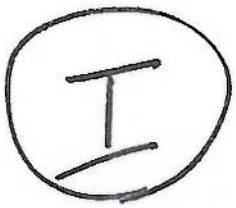
- *Authority to Inform Research Priorities for Data Collection*: The Commission shall be granted immediate authority to advise the Secretary of Health and Human Services on priorities for health services research, particularly as they pertain to payment reforms under Medicare.

- *Access to Federal Data and Reports*: The Commission shall have the same level of access to Federal data and research as do MedPAC and CBO.

- *MACPAC Technical Amendments*: Includes a requirement that the Commission engage in regular consultations with the Medicaid and CHIP Payment and Access Commission (MACPAC).

- *Lobbying Cooling-off Period for Commissioners*: Former commissioners of the Commission are barred from lobbying the Commission and other relevant Administration departments and agencies, including the Department of Health and Human Services, or relevant committees of Congress, including the Senate Finance Committee, the House Ways and Means Committee and the House Energy and Commerce Committee, for at least one year following their retirement from their position

- *Consumer Advisory Council*: Composed of 10 consumer representatives (from the ten regions established by the Centers for Medicare and Medicaid Services), the council advises the Board on the impact of Medicare payment policies on consumers. The council membership represents the interests of consumers and particular communities. Members are appointed by the Government Accountability Office and serve staggered three-year terms. Subject to the call of the Commission, the council meets at least two times a year in Washington, D.C., and the meetings are open to the public. The members elect their own officers.



Enzi Amendment #C3 as Modified

Enzi Amendment #C3 to the America's Healthy Future Act of 2009

Short Title: Ensure American workers are protected from lower wages and job loss.

Description of Amendment: Prior to implementing the employer assessments or fees described in Title 1, Subtitle D, the Secretary of Labor must certify that the implementation of such fees and assessments would not result in a reduction of workers' wages.

In order to conduct the statistical analysis necessary to certify whether the fees and assessments in Title 1, Subtitle D reduce the national average wage, the Secretary of Labor shall use the National Compensation Survey from the Bureau of Labor Statistics.

Produced by the Bureau of Labor Statistics, the National Compensation Survey provides comprehensive measures of wages and employment costs. Earnings data is available for metropolitan and rural areas, broad geographic regions and on a national basis.

The Department of Labor already administers several programs where they have an obligation to determine that an activity will not adversely affect American workers' salaries or working conditions. For example, the Department's Employment Training Administration performs that function under the foreign labor certification program. It shouldn't be difficult to replicate that function here.

J

<u>Modified</u> Menendez Amendment C# 9 to Chairman's Mark of America's Healthy Future Act

Title I, Subtitle C

Short Title: Ensuring quality health care for those with behavioral health conditions.

Description of Amendment:

Specify that all plans must provide behavioral health treatment as part of mental health and substance abuse services.

Offset: No cost.

K

Modified Menendez Amendment C# 4 to Chairman's Mark of America's Healthy Future Act

Title I

Short Title: Ensure and clarify that children qualify as exchange eligible individuals and that there shall be the option of a child-only health insurance option and subsides in the exchanges.

Description of Amendment:

Ensure that minor children qualify as exchange eligible individuals, such as children in foster care, children in kinship care, children in families when parents are covered by employers who do not offer dependent coverage, children in families whose parents are uninsured, and other citizen and lawfully present U.S. resident children. This amendment would also provide for the availability of child-only health insurance coverage in the exchanges.

Furthermore, the amendment would direct the Secretary to determine whether alternative means, such as direct subsidies to the exchanges, and refinements to tax credit eligibility determinations, are necessary to provide support for the purchase of such coverage for children.

Offset: No cost anticipated.

L

Cantwell Amendment #C-2 (AS MODIFIED) to America's Healthy Future Act of 2009

Short Title: Pharmacy Benefit Manager (PBM) Transparency for Health Plans Operating in Medicare Part D and the Health Insurance Exchanges

Description of Amendment: The amendment requires pharmaceutical benefit managers (PBM) to share information with the Secretary of HHS and with plans the PBMs contracts with through Medicare Part D or the exchanges. Plans will only be given access information on their own PBM contracts. This information will be considered confidential and must be protected by the Secretary and the plans. The PBM will be required to confidentially disclose information on: (1) the percent of all prescriptions that are provided through retail pharmacies compared to mail order pharmacies, and the generic dispensing and substitution rates in each location; 2) the aggregate amount and types of rebates, discounts and price concessions that the PBM negotiates on behalf of the plan and the aggregate amount of these that are passed through to the plan sponsor; 3) the average aggregate difference between the amount the plan pays the PBM and the amount that the PBM pays the retail and mail order pharmacy. There are no mandates that these rebates are passed through, only that they be reported to plans.

Score: This amendment is revenue neutral.

? = . FURTHER MODIFY TO APPLY SAME PENALTIES TO THE SEC OF HHS FOR DISCLOSING THIS INFORMATION AS APPLIED IN REGARDS TO MEDICAID REBATE DATA.

(M)

Grassley Amendment #D 2
(Modified -- 9/29/09)

Short Title:
Medicare Physician Payment Equity

Description of Amendment:
Amend Title III, Subtitle B of the Chairman's Mark, "Providing Equitable and Accurate Geographic Adjustments for Medicare Physician Payment."

The proposal would direct the Secretary to adjust the practice expense GPCI for 2010 to reflect 3/4 of the difference between the relative costs of employee wages and rents in each of the different fee schedule areas and the national averages (i.e. a blend of 3/4 local and 1/4 national) instead of the full difference under current law. For 2011, the adjustment would reflect 1/2 of the difference between the relative costs of employee wages and rents in each of the different fee schedule areas and the national averages (i.e. a blend of 1/2 local and 1/2 national). Relief would apply only to areas with a practice expense GPCI less than 1.0. The amendment would hold-harmless any areas negatively impacted by the adjustment.

The proposal would direct the Secretary to analyze current methods of establishing practice expense geographic adjustments under the physician fee schedule (PE GPCI) and evaluate data that fairly and reliably establishes distinctions in the costs of operating a medical practice in the different Medicare payment localities. Such analysis shall include an evaluation of: 1) the feasibility of using actual data or reliable survey data developed by recognized medical organizations such as the American Medical Association on the costs of operating a medical practice, including office rents and non-physician staff wages, in the different Medicare payment localities; 2) the office expense portion of the PE GPCI, including the extent to which types of office expenses are determined in local markets versus national markets, and 3) the weights assigned to each of the categories within the practice expense GPCI.

Based on the analysis and evaluation, the Secretary shall, no later than January 1, 2012, make appropriate adjustments to the PE GPCI to ensure accurate geographic adjustments across payment areas, including adjustments to 1) base the "office rents" category and its weight on occupancy costs only and make weighting changes in other categories as appropriate; 2) ensure that office expenses that do not vary from region to region be included in the "other" office expense category; and 3) consider a representative range of professional and non-professional personnel employed in a medical office based on the use of the American Community Survey (ACS) data or other reliable data for wage adjustments. Adjustments made in 2012 would be made without regard to the adjustments made in 2010 and 2011. If the Secretary has not completed the required analysis and evaluation and made appropriate adjustments in the Medicare Physician Fee Schedule rule for 2012 (or subsequent year), the 2011 payment rule under paragraph (1) shall remain in effect.

Score: $1.1 billion

Offset: Increased revenue from updated estimate of proposal to eliminate the deduction for the employer Part D subsidy; scoring change for Physician Quality Reporting Initiative (PQRI) proposal.

(N)

Stabenow MODIFIED Amendment C-8 to the Chairman's Mark

Short title/purpose: To ensure all insurance plans conform to the same consumer protections and market rules

Description of Amendment: This amendment would require that any state law that imposes more stringent regulatory requirements on health insurance issuers within Title I, Subtitle A, with regard to individual coverage and small group coverage shall impose such requirements in the same manner and to the same extent on all health insurance issuers that issue such coverage.

The provision ensures that all entities offering health insurance would be subject to any state regulatory requirements that exceed federal regulatory requirements within in Title I, Subtitle A. This will ensure all consumers purchasing individual or small group coverage are appropriately protected in each state.

Offset: This amendment should not score.

0

Modified Grassley Amendment #C 3

Short Title:
To require that Members of Congress and all Congressional staff purchase coverage through exchanges.

Purpose:
To require that Members of Congress and Congressional staff purchase insurance in the same manner proposed in the Chairman's mark for private citizens

Background:
The Chairman's Mark establishes state-based exchanges that are designed to provide private health insurance options for consumers to choose from.

Description:
This amendment would require that, notwithstanding any other provision of law, beginning in 2013 Members of Congress and Congressional staff must use their employer contribution (adjusted for age rating) to purchase coverage through a state-based exchange, rather than using the traditional selection of plans offered through the Federal Employees Health Benefits Plan (FEHBP).

(P)

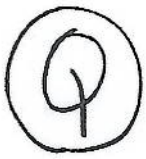
MODIFIED Menendez Amendment C# 6 to Chairman's Mark of America's Healthy Future Act

Title I

Short Title: Protecting consumers when they are in an emergency room

Description of Amendment:
Each health care plan and health care insurance issuer offering coverage in the exchange shall provide enrolled individuals coverage for emergency room services without regard to prior authorization or the emergency care provider's contractual relationship with the health plan. Further, enrollees may not be charged co-payments or cost-sharing for emergency room services furnished out-of-network that are higher than in-network rates.

Offset: No cost anticipated.



Modified Lincoln Amendment #D9 to The America's Healthy Future Act

Short Title: Expand CMS Innovation Center to consider testing direct access models of care under Medicare.

Description of Amendment:

This amendment would add to the list of models for consideration under the CMS Innovation Center on pages 91 and 92 to read:

"14. Promote greater efficiencies and timely access to outpatient services (such as physical therapy services) through models that do not require a physician or other health professional to refer the service or be involved in establishing the plan of care, when such service is provided by a health professional who has such authority under existing state law."

Offset: To be provided if necessary

Hatch Amendment #C10 to America's Healthy Future Act of 2009

R

Short Title: Restoration of funding for Abstinence Education

Description: The amendment would direct $50 million a year through FY 2014 appropriated under Title I, Subtitle I of the Chairman's Mark for Section 510 of Title V of the Social Security Act.

Offset: A proportionate reduction as needed in spending in the Chairman's Mark. with the exception of Medicare

Chairman's Side by Side: Teen Pregnancy Prevention

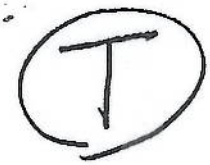
The Personal Responsibility Education for Adulthood Training

Short Title: PRE-Adulthood Training

The proposed bill would amend Title V of the Social Security Act to directly appropriate to HHS $75 million for a Personal Responsibility Education for Adulthood Training for each of the fiscal years FY2010 through FY2014.

Fifty million dollars will be available to states each year on a formula basis for programs to educate adolescents on both abstinence and contraception for prevention of teenage pregnancy and sexually transmitted infections, including HIV/AIDS. Programs must be evidence-based, medically accurate, and age appropriate and must address at least three adulthood preparation subjects. Subjects include: healthy relationships, adolescent development, financial literacy; parent-child communication, educational and career success, and healthy life skills.

The remaining funds will be available for A) innovative teen pregnancy prevention strategies and services to high-risk, vulnerable, and culturally under-represented populations, B) allotments to Indian tribes and tribal organizations, and C) research & evaluation, training, and technical assistance, including a national teen pregnancy prevention resource center.



MODIFICATION

Modification to Nelson Amendment #F1 to Title VI of America's Healthy Future Act

Short Title: An amendment to prevent the loss of tax benefits for senior citizens.

Description of Amendment:

The modified Chairman's mark increases the threshold for claiming the Section 213 itemized deduction for medical expenses from 7.5 percent to 10 percent of adjusted gross income (AGI).

This amendment would exempt individuals age 65 and older (and their spouses) from the increased AGI threshold. Individuals age 65 and older (and their spouses) would be eligible to claim the Section 213 deduction if their medical expenses exceed 7.5 percent of AGI.

The amendment would apply to taxable years beginning after December 31, 2012 and ending before January 1, 2017.

Offset:

The amendment would clarify that employer payments required for employees receiving premium credits (Title I, Subtitle D) are a nondeductible expense for the employer. This provision is effective for taxable years beginning after December 31, 2012.

Bunning Amendment #F4 (modified)

(11)

Short Title: Amendment to prevent tax increases from increasing the cost of medical care provided to veterans or reducing veteran access to treatment.

Description of Amendment:

The amendment prohibits any of the taxes or fees outlined in Title VI of the Chairman's Mark from going into effect unless the Secretary of the U.S. Department of Veterans Affairs certifies to the Secretary of the Treasury that none of provisions will (1) increase the cost of medical care provided to veterans or (2) cause any veteran to lose access to any medical device or branded drug.

The amendment is fully offset by delaying the effective date of the mandate that individuals buy insurance, and if necessary, delaying the effective date of the mandate that states expand their Medicaid programs.

AS MODIFIED ENSIGN-CARPER Amendment #C8 to America's Healthy Future Act of 2009

Short Title: Building Efforts for Wellness and Encouraging Longer Lives Amendment #2

Purpose: To codify and enhance existing regulations designed to encourage individuals to adopt healthy behaviors through voluntary participation in programs of health promotion and disease prevention.

Description of Amendment:

Current Law: The Health Insurance Portability and Accountability Act of 1996 (HIPAA) currently permits programs of health promotion and disease prevention to encourage healthy behaviors through financial incentives. These incentives include rewards in the form of discounts or rebates of premiums, waivers of all or part of a cost-sharing mechanism under the plan (such as deductibles, co-payments or coinsurance), the absence of a surcharge, or the value of a benefit which would otherwise not be provided under the plan for those who meet a particular health standard, such as stopping the use of tobacco products. Final regulations jointly issued by the Departments of Treasury, Health and Human Services, and Labor generally cap the reward at 20% of employee-only premiums, but also provide protections for plan participants that cannot meet the applicable standard due to a medical condition or because it is medically inadvisable to do so. Specifically, if it is "unreasonably difficult due to a medical standard" or "medically unadvisable" to attempt to meet the otherwise applicable standard, that person must be offered a reasonable alternative standard, and still will be entitled to receive the reward. These wellness regulations implement amendments made by HIPAA to the Internal Revenue Code (IRC), the Employee Retirement Income Security Act (ERISA) of 1974, and the Public Health Services (PHS) Act.

The HIPAA wellness regulations divide wellness programs into two categories. In the first category are programs in which rewards are based solely on program participation. Examples in the existing regulation include reimbursing enrollees for the cost of gym membership; waiving copayments for parental care; and reimbursing enrollees for the cost of smoking cessation programs, regardless of whether they successfully quit smoking. Programs in this category are automatically permissible.

Programs in the second category are those in which rewards are based on the attainment of certain health standards – for example, achieving a targeted cholesterol level; maintaining a certain body mass index; quitting smoking; or losing a specified amount of weight. Under current regulations, health plans can offer such financial incentives only if five criteria are met – one of these being that the reward cannot exceed 20% of the cost of the employee's coverage (i.e., the employee's premium plus the employer's contribution).

Amendment: The amendment would strike Title II, Subtitle C: Strengthening Employer-Sponsored Wellness Programs and insert the following language in Title I at the appropriate place:

The amendment codifies and enhances provisions of the Health Insurance Portability and Accountability (HIPAA) non-discrimination regulations, which allow rewards to be provided to employees for participation in or for meeting certain health standards related to a wellness program. Consistent with current regulation, the amendment indicates that wellness programs that do not require an individual to satisfy a standard related to health factor are not in violation of the HIPAA non-discrimination requirements (assuming that participation is made available to all similarly situated individuals). Wellness programs that meet this requirement include the following programs:

- A program that reimburses all or part of the cost for memberships in a fitness center.
- A diagnostic testing program that provides a reward for participation and does not base any part of the reward on outcomes.
- A program that encourages preventive care by waiving co-payments or deductibles under a group health plan for the costs of, for example, prenatal care or well-baby visits.
- A program that reimburses employees for the cost of smoking cessation programs without regard to whether the employee quits smoking.
- A program that provides a reward to employees for attending a monthly education seminar.

The amendment allows group health plans and health insurance issuers offering coverage in group markets to provide rewards, including insurance premium discounts or rebates, based on an individual or an employee's participation in wellness programs. Specifically, the amendment indicates that wellness programs which provide rewards based on an individual satisfying a standard that is related to a health factor do not violate the HIPAA non-discrimination rules if the program satisfies certain requirements. For these programs, the amendment would cap the reward at 30% of the employee-only coverage under the plan, but also provide protections for plan participants that cannot meet the applicable standard due to a medical condition or because it is medically inadvisable to do so and would allow the Secretaries of Health and Human Services, Department of Labor, and Department of the Treasury the discretion to take the percentage up to 50% for adherence to or participation in a reasonably designed program of health promotion and disease prevention. Specifically, if it is "unreasonably difficult due to a medical standard" or "medically unadvisable" to attempt to meet the otherwise applicable standard, then that person must be offered a reasonable alternative standard or a waiver, and still will be entitled to receive the reward. If necessary, the wellness program may require verification of these circumstances, including a statement from an individual's physician. For purposes of this paragraph, the cost of coverage is determined based on the combined amount of employers and employee contributions for the benefit package under which the employee is (or the employee and any dependents are) receiving coverage. A reward can be in the form of discount or rebate of a premium or contribution, a waiver of all or part of a cost-sharing mechanism (such as deductibles, copayments, or coinsurance), the absence of a surcharge, or the value of a benefit that would otherwise not be provided under the plan.

In addition, programs which reward based on the attainment of certain health standards would need to meet the following criteria:

- Be reasonably designed to promote health or prevent disease. A program complies with the preceding sentence if the program has a reasonable chance of improving the health of, or preventing disease in, participating individuals and it is not overly burdensome, is not a subterfuge for discriminating based on a health status factor, and is not highly suspect in the method chosen to promote health or prevent disease. The plan or issuer shall evaluate the program's reasonableness at least once per year.
- Provide individuals eligible for the program the opportunity to qualify for the reward under the program at least once a year.
- Ensure that the reward must be available to all "similarly situated" individuals. If someone's medical condition keeps them from achieving a reward under the program, or if it is medically inadvisable for them to try to achieve the reward, then a reasonable alternative standard for obtaining the reward must be made available.

- Plan materials describing the terms of the wellness program must disclose the availability of the reasonable alternative standard for similarly situated individuals, or the possibility that the standard will be waived.

The above described provisions, which allow rewards to be provided to employees for participation in or for meeting certain health standards related to a wellness program, shall be effective upon the date of enactment of this Act.

The amendment applies the above described provisions to carriers providing Federal Employee Health Benefit Plans. This will allow carriers offering coverage in the Federal Employee Health Benefits program to provide rewards, including insurance premium discounts or rebates, of up to 30% with secretarial discretion to go to 50%, based on an employee or annuitant satisfying a standard that is related to a health factor in wellness programs. Carriers may submit separate proposals relating to voluntary wellness program offerings as part of the annual call for benefit and rate proposals to the Office of Personnel Management. The Federal Employee Health Benefit Plan provision shall be effective upon date of enactment of this Act.

The amendment would require the Secretaries of Health and Human Services and the Department of Treasury to establish a 10-state pilot program in 2014, one year after the new insurance rating rules for the individual market take effect. States that choose to participate in the pilot program would be allowed to apply the above described provisions to programs of health promotion and disease prevention offered in the individual market in a manner that is similar to the manner in which such provisions apply to group health plans and health insurance issuers offering coverage in group markets. States participating in the pilot program would be required to ensure that consumer protections are met in programs of health promotion and disease prevention in the individual market, including verification that premium discounts do not create undue burdens or lead to cost shifting and that consumer data is protected under the existing HIPAA privacy laws. In 2017, the demonstration program may be expanded to include other states, pending evidence of the program's effectiveness as confirmed and approved by the Secretary of Health and Human Services and the Secretary of Treasury. Nothing in this section shall prohibit a program of health promotion or disease prevention that was established or adopted by state law prior to the date of enactment of this section.

Furthermore, this amendment requires the Secretary of Health and Human Services, the Secretary of Treasury, and the Secretary of Labor to evaluate and submit to the appropriate Committees of Congress a report examining the following issues: the effectiveness of wellness and disease prevention programs in promoting health and preventing disease; the impact of a wellness program on a participant's access to care and the affordability of coverage; and the impact of premium-based and cost-sharing incentives on employee behavior and their role in behavior change. In developing the report, the Secretaries will contact employers who provide employees with access to wellness programs to gather the above-described information. The report will be due three years after the date of enactment including recommendations for any legislative or administrative action.

Stabenow MODIFIED Amendment D-6 to the Chairman's Mark

Short title/purpose: To recommend guidelines to ensure patient access for our nation's emergency rooms

Description of Amendment: This amendment directs the Secretary of Health and Human Services to convene a working group that includes experts in emergency care, inpatient critical care, hospital operations management, nursing, and other relevant disciplines to recommend boarding and diversion standards for hospitals and guidelines, measures, and incentives for implementation, monitoring, and enforcement of such standards.

At a minimum, the membership of the working group must include two individuals who represent emergency physicians, emergency nurses, and other health care professionals who provide emergency medical services; two individuals who are elected or appointed Federal, State, or local officials and who are involved in issues and programs related to the provision of emergency medical services; two health care consumer advocates; and two individuals who represent hospitals and health systems that provide emergency medical services.

The working group shall:

(1) identify barriers contributing to delays in timely processing of patients requiring admission as inpatients who initially sought care through the hospital's emergency department;
(2) identify and examine factors in the health care delivery, financing, and legal systems that affect the effective delivery of screening and stabilization services furnished in hospitals that have emergency departments pursuant to the Emergency Medical Treatment and Labor Act;
(3) identify best practices to improve patient flow within hospitals; and
(4) report within 18 months of convening to Congress and the Secretary a detailed description of recommendations for the standards, guidelines, measures, and incentives to be developed; any identified best practices; and any recommendations with respect to federal programs, policies, and financing needed to assure the availability of such screening and stabilization services and the coordination of state, local, and federal programs for responding to disasters and emergencies.

The working group shall terminate upon submission of the report in (4).

Offset: None

10-1-09

Snowe-Bingaman-Lincoln Amendment
Modification to Snowe #F9 to America's Healthy Future Act

Short Title: This amendment makes various changes to the Modified Chairman's Mark.

Description of Amendment:

- **(Snowe F9):** This amendment provides that employer-sponsored health insurance subject to the high-premium excise tax does not include fixed indemnity health coverage that is purchased by the employee with after-tax dollars. Fixed indemnity coverage pays fixed dollar amounts based on the occurrence of qualifying events, including but not limited to the diagnosis of a specific disease, an accidental injury or a hospitalization, provided that the coverage is not coordinated with other health coverage.

- **(Bingaman D6):** This amendment directs the Secretary of Health and Human Services (Secretary) to establish a prospective payment system (PPS) for Medicare-covered services furnished by federally-qualified health centers (FQHCs), in order to update the existing payment structure, which currently underpays for these services. Similar to the existing PPS for FQHCs in Medicaid and CHIP, this payment structure would set an initial payment based on a two-year average of a health center's reasonable costs for providing care and include an appropriate annual update method developed by the Centers for Medicare and Medicaid Services (CMS). Additionally, the amendment would require the Medicare PPS to appropriately reimburse eligible preventive services when such services are provided to Medicare beneficiaries in the FQHC setting.

- **(Bingaman D4):** This amendment would allow drugs provided to patients by AIDS Drug Assistance Programs (ADAPs) or the Indian Health Service (IHS) to count toward out-of-pocket costs, allowing these individuals to qualify for Part D catastrophic benefits.

- **(Lincoln-Cantwell C3):** This amendment excludes hours worked and wages earned by seasonal workers from calculation for small business tax credit eligibility. A seasonal worker is defined as an individual who performs labor or services on a seasonal basis where, ordinarily, the employment pertains to or is the kind exclusively performed at certain seasons or periods of the year and which, from its nature, may not be continuous or carried on throughout the year. This is the same definition included in the HELP Committee bill, added by Senator Hagan.

- This amendment would be offset by striking Qualified Long Term Care Insurance from Title I, Subtitle A. This provision would raise $3.6 billion over ten years.

Cantwell Amendment #C15 (AS MODIFIED) to America's Healthy Future Act of 2009

Short Title: The Basic Health Plan

Overview: This amendment provides a federally funded, non-Medicaid, state plan which combines the innovation and quality of private sector competition with the purchasing power of the states.

Under this amendment, the federal government would provide funds to participating states in order to allow such states to provide affordable health care coverage through private health care systems under contract. People with incomes above Medicaid eligibility but below 200 percent of the federal poverty level (FPL) would be eligible for participation in these plans.

This approach takes advantage of an innovative, non-Medicaid coverage model that has worked at the state level for more than 20 years. State governments would use their share of federal dollars to negotiate with health care systems for high-quality, cost-effective coverage options to provide better value to individuals and families in their states. Eligible individuals and families would have access to several affordable pre-negotiated coverage options through the Basic Health Plans rather than being limited to independent negotiating through the Exchange with individual tax-credit subsidies. By using negotiated purchasing, Basic Health Plans could provide improved benefits and reduced costs.

Description of Amendment: The Secretary of Health and Human Services would work with participating states to establish state Basic Health Plans.

State Basic Health Plan Funding: For purposes of this amendment, a state's Basic Health Plan funding level would be based on the sum of the value of individual tax-credits which would otherwise be assumed for the eligible enrollee population in that state. Funds distributed to the states would be provided to independent state-based trusts and would be used by the states to negotiate credible coverage for Basic Health Plan enrollees only.

Eligibility: The Basic Health Plan would be available to people with incomes from 133 to 200 percent of FPL. States could enroll the following income-eligible persons in their Basic Health Plan, as of July 1, 2013: persons who (1) are under age of 65; (2) do not have access to affordable employer sponsored coverage that meets minimum creditable coverage standards; (3) are residents of an area served by the plan; (4) have gross family income above 133 percent of FPL and below 200 percent of FPL; (5) choose to obtain basic health care coverage from a participating health care plan; and (6) remain current in payment of their share of the premiums.

Benefit package and premium assistance: Minimum benefit package and premium cost sharing levels in the Basic Health Plan would be set at the levels provided for this population in the Making Coverage Affordable section of the Chairman's mark. The premium assistance for the eligible population would be available through the Basic Health Plan instead of through the tax credits otherwise provided for in the mark. The population above 200 percent FPL would have access to tax credits as available in the mark.

States would be encouraged to include innovative features in their health plan contracting, including but not limited to: care coordination and care management for enrollees, especially for those with chronic health conditions, incentives for use of preventive services, and establishment of a patient/doctor relationships that maximize patient involvement in health care decision-making, including awareness of the incentives and disincentives in using the health care plan.

Health care plan contracting: States would negotiate contracts with health care systems to ensure that coverage is available to all eligible persons in the state. The state Basic Health Plan administrators would be responsible for conducting a competitive procurement, with negotiation of payment rates and benefit packages that may exceed the minimum requirements outlined above. The Secretary of HHS would be required to verify that state Basic Health Plans are operating within federal cost and eligibility verification guidelines.

The state administrators are to consider and make suitable allowance for differences in health care needs of enrollees, and differences in local availability of health care provider resources. The state administrators would be encouraged to find ways to integrate their Basic Health Plan negotiations with any Medicaid or other state administered health care programs to maximize efficiency and improve the continuity of care between all state administered health programs. State administrators would seek to contract with managed care systems, or with systems that offer as many of the attributes of managed care as are feasible in the local health care market. A minimum medical loss ratio of 85 percent would be required of all participating plans. State administrators, in conjunction with HHS, would establish specific performance measures and standards for participating health care systems that focus on quality of care and improved health outcomes. Participating health care systems must report to the state on the measures. Their performance and quality information would be made available to the Secretary of HHS and the Basic Health Plan enrollees, to help enrollees choose the best health care system.

State administrators should seek participation by multiple health plans to allow enrollees a choice between two or more plans, whenever possible. A participating health care system can be a licensed health maintenance organization, a licensed health insurer, or a network of health care providers established to offer Basic Health Plan services. States entering into health care choice compacts outlined in the Chairman's mark would be eligible to form multi-state risk pools for the purposes of negotiating with health care systems.

COST SAVINGS: States would be able to negotiate lower cost coverage through managed health care plans than individuals could negotiate for themselves with their individual tax credit subsidies. Evidence from similar programs on the state level has shown that a savings of at least 25 percent can be achieved from state negotiations.

For purposes of this Amendment, 85% of the funds dedicated to providing individual tax credit subsidies for individuals from 133 to 200% of poverty would be distributed to states choosing to create Basic Health Plans based upon the funding formula outlined above. To the extent a state chooses to create a Basic Health Plan, no tax credit subsidy would be available to individuals otherwise eligible as members of the covered enrollee population. Tax credit subsidies would be available to citizens of states that have chosen not to create Basic Health Plans.

2

Grassley Amendment #C 11 MODIFIED

Purpose:
To protect state budgets from the maintenance of effort mandate

Background:
The Chairman's Mark requires that states maintain existing income eligibility levels for all Medicaid populations upon enactment of this bill. This maintenance of effort provision would expire when the state exchange becomes fully operational (expected January 1, 2013), except as it applies to coverage at income levels of 133 percent of FPL and below, for which it would continue through January 1, 2014.

Currently, states are operating under a maintenance of effort for their Medicaid populations. The American Recovery and Reinvestment Act (ARRA) included a provision that requires states to maintain coverage of populations in exchange for additional FMAP assistance. That assistance expires December 31, 2010.

Description:
This amendment would prevent the maintenance of effort from being enforced after from January 1, 2011 through January 1, 2014 if states do not have the additional FMAP matching rate provided in ARRA.

MODIFICATION:

This amendment would strike the maintenance of effort from January 1, 2011 through January 1, 2014 FOR OPTIONAL ADULT POPULATIONS ABOVE 133% OF THE FEDERAL POVERTY LEVEL.

Cosponsor: Senator Snowe.

ADDITIONAL MODIFICATION:

BETWEEN JANUARY 1, 2011 AND JANUARY 1, 2014, A STATE IS EXEMPT FROM THE MAINTENANCE OF EFFORT FOR OPTIONAL NON-PREGNANT NON-DISABLED ADULT POPULATIONS ABOVE 133% OF THE FEDERAL POVERTY LEVEL IF THE STATE CERTIFIES TO THE SECRETARY THAT THE STATE CURRENTLY HAS A STATE BUDGET DEFICIT OR PROJECTS TO HAVE A STATE BUDGET DEFICIT IN THE FOLLOWING STATE FISCAL YEAR. THE STATE MAY MAKE SUCH CERTIFICATION ON OR AFTER DECEMBER 1, 2010.

Cosponsor: Senator Snowe.

AA

Lincoln-Menendez-Conrad Amendment #F1 to The America's Healthy Future Act MODIFIED

Short Title: This amendment makes various changes to the Modified Chairman's Mark.

Description of Amendment:

- ***Executive Compensation (Lincoln F1)***:

This amendment would create a special rule under Section 162(m) regarding the deductibility of excessive remuneration (including deferred deduction remuneration) by an insurance provider, if at least 25 percent of the insurance provider's gross premium income from health business is derived from health insurance plans that meet the minimum creditable coverage requirements in the Chairman's mark ("covered health insurance provider"). As under section 162(m)(5), the exceptions under section 162 (m)(4) for performance based remuneration, commissions, or remuneration under existing binding contracts do not apply. Employers with self-insured plans are excluded from the definition of covered health insurance provider.

Specifically, in the case of a covered health insurance provider, no deduction shall be allowed for remuneration which is attributable to services performed by an applicable individual for such covered health insurance provider during a taxable year to the extent that such remuneration exceeds $500,000. This special rule applies without regard to whether such remuneration is paid during the taxable year or a subsequent taxable year (in applying this rule, rules similar to those in section 162(m)(5)(A)(ii) will be applied). Applicable individuals include all officers, employees, directors, and other workers or service providers (such as consultants) performing services for or on behalf of a covered health insurance provider. Further, in determining whether the remuneration of an applicable individual for a year exceeds $500,000, all remuneration from all members of any controlled group of corporations (within the meaning of section 414(b)), other businesses under common control (within the meaning of section 414(c)), or affiliated service group (within the meaning of section 414(m) and(o)) are aggregated.

The amendment would be effective for remuneration paid in taxable years beginning after 2012, with respect to services performed after 2009.

- ***Ensuring that Federally-Qualified Heath Centers (FQHCs) would not lose revenue when treating newly insured patients gaining coverage through the new Health Insurance Exchanges (Menendez C3)***:

Insurers participating in the state exchanges would be required to provide payment for services furnished to enrollees of the insurer by any electing federally-qualified health center at levels no less than such center would receive under Section 1902(bb) of the Social Security Act for such services.

Background:
Federally-Qualified Health Centers currently serve more than 18 million low-income patients in more than 7,000 communities across the country, in every state and territory. Patients at FQHCs receive comprehensive primary care services, including mental health, dental, pharmacy and

other case management services. FQHCs save the health care system more than $18 billion annually through reduced Medicaid expenditures and unnecessary use of emergency rooms.

FQHCs' current payment structure under Medicaid and CHIP (under SSA Section 1902(bb)) ensures that health centers receive adequate payment through an all?inclusive per?visit payment rate for comprehensive primary and preventive care services, in contrast to the fee?for?service reimbursement system which pays on a per?service basis. The PPS also ensures that discretionary grant funding needed to support other vital purposes (operation and expansion of health center services, care for those who remain uninsured, health?improving services that are not reimbursed, etc.) will not have to be siphoned off to cover inadequate payment rates.

This amendment would ensure that Federally-Qualified Heath Centers (FQHCs) would not lose revenue when treating newly insured patients gaining coverage through the new Health Insurance Exchanges. This would be accomplished by extending the PPS payment rate to insurance plans participating in the Exchange. Full participation and appropriate payment will assure the continued emphasis on preventive care, patient education, and effective case management of chronic conditions.

- ***Nurse Midwifery Access and Reimbursement Equity (Conrad D4):***

This provision would amend the Social Security Act to increase the Medicare payment rate for certified nurse-midwives for covered services from 65 percent of the rate that would be paid were a physician performing a service to the full rate.

This amendment would raise revenue.

BB

Grassley Amendment #F-5

Short Title:
Fail-Safe Mechanism to Ensure Health Care Reform Does Not Increase the Budget Deficit

Description of Amendment:
Amend Title VI of the Chairman's Mark, "Revenue Items" to add the requirement that beginning in 2012, the Director of the White House Office of Management and Budget (OMB) would certify annually in the President's Budget that the provisions in this bill will not increase the budget deficit in the coming year. In the event the OMB Director determines that the provisions in this bill will increase the deficit, he or she would be required to notify Congress and the aggregate amount of exchange subsidies provided would automatically be adjusted commensurate with the deficit increase.

CC

Modified Wyden #D17 – Medicare Advantage

Senators Wyden, Schumer, Nelson and Baucus

Short Title: Medicare Advantage transition to competitive bidding and increased quality bonus

Description of Amendment:

Chairman's Mark

The Chairman's Mark accepted and modified amendment #D10 filed by Senator Nelson.

Explanation of the Amendment

This amendment would change the modified Chairman's Mark in three ways: First, it would lower the threshold at which plans must bid below local fee-for-service costs from 85 percent to 75 percent in order for the area to qualify for a grandfather of extra benefits. The amount of extra benefits would be reduced by 5 percent each year beginning in 2013. (Performance bonus payments under competitive bidding would not apply to beneficiaries who receive grandfathered extra benefits.) Second, it would increase the performance bonus under competitive bidding for plans that achieve between 4 and 5 stars on a 5-star quality ranking system by 1 percentage point. Third, it would require the Secretary to provide for transitional extra benefits in 2012 to beneficiaries who enroll in Medicare Advantage plans and experience a significant reduction in extra benefits under competitive bidding. The Secretary would provide for these transitional benefits in certain areas: 1) the 2 largest metropolitan areas of the country if extra benefits in those areas are greater than $100 per member per month, and 2) counties where the MA benchmark amount in 2011 is equal to the legacy urban floor amount, the Medicare Advantage enrollment penetration is greater than 30 percent, and the MA plans bid below the local fee-for-service costs. The Secretary could also provide transitional benefits in counties contiguous to these areas. In addition, the Secretary would be required to review plan bids to ensure that transitional benefits made available are passed on to beneficiaries. The total amount available for transitional benefits would be $5 billion and available through 2019.

Offset: None needed.

DD

SCHUMER-SNOWE AMENDMENT C3 - FINANCING (MODIFIED)

Short Title: Reduce individual mandate penalty

Under the Chairman's Mark, a maximum penalty of up to $3800 was to be assessed for failing to obtain family coverage. The Chairman's modification has reduced the maximum assessment to $1900.

This amendment would further reduce the personal responsibility assessment to no more than $750 per adult, and phase in its application as follows: For 2013, $0; $200 for 2014; $400 for 2015; $600 in 2016; and $750 for 2017. Under this amendment non-compliance with the individual mandate shall incur no criminal penalty; and neither civil penalty nor interest shall accrue for failure to pay such assessment in a timely manner. Collection shall be limited to withholding of federal payments due.

This amendment would also modify the Chairman's Mark to reduce the level of income at which the affordability waiver applies – such that individuals are exempt from personal responsibility assessments – if the cost of lowest cost coverage exceeds 8 percent of income.

The amendment further requires that the Government Accountability Office shall undertake a study of the affordability of coverage, including the impact of the provision of small business and individual tax credits in maintaining and expanding coverage, the availability of affordable plans, and the ability of Americans to meet the personal responsibility requirement. Such report shall be made to the Congressional committees of jurisdiction no later February 1, 2014. Such committees shall report legislation no later than April 1, 2014 to examine the implementation and assessment of this Act and such legislation shall be brought to the floor in each chamber within 15 days of reporting by such committees. In the Senate, this legislation shall be subject to 30 hours of debate. Once passed by both chambers, the conference report shall be limited to 10 hours of debate in the Senate.

Cost: CBO has confirmed that this amendment will generate modest savings, an exact amount could not be provided, however.

EE

Wyden Amendment #D10 to the Chairman's Mark of America's Healthy Future Act (Modified)

Short Title: Personalized Medicine and Independence at Home

Cosponsors: Carper

Description:

Access to Critical Lab Tests
Present Law

In cases when a laboratory test is ordered less than 14 days after a beneficiary leaves a hospital, the hospital collecting the sample must bill for the laboratory services.

This amendment adds the following Proposed Change to the Chairman's Mark.

This amendment would provide that for a two-year period, the laboratory furnishing the test could bill for the test provided the test meets the following criteria:

- The test is an analysis of DNA, RNA, chromosomes, proteins, or metabolites that detects, identifies, or quantitates genotypes, mutations, chromosomal changes, biochemical changes, cell response, protein expression, or gene expression or similar method or is a cancer chemotherapy sensitivity assay or similar method, but does not include methods principally comprising routine chemistry or routine immunology;
- The test is developed and performed by a laboratory that is independent of the hospital where the sample was collected;
- The test is not furnished by the hospital where the sample was collected directly or under arrangements; and
- The sample was collected during a hospital encounter or stay, and is performed after the beneficiary leaves a hospital.

The provision would be effective with respect to complex diagnostic lab tests furnished after July 1, 2011 and would no longer apply with respect to such tests furnished on or before the earlier of two dates: July 1, 2013 or the date on which the CMS actuary informs the Committees on Ways and Means and Energy and Commerce of the House and Finance of the Senate that $100M has been spent from Medicare Part B that: 1) would not otherwise have been spent in the absence of this change or 2) that has been paid directly to laboratories for tests furnished within 14 days of the patient's discharge from the hospital.

Independence at Home

Description: Medicare beneficiaries with multiple chronic conditions account for a disproportionate amount of Medicare spending, receive poor care, and account for a majority of

hospital admissions, prescriptions, and physician visits. Interdisciplinary teams of health care professionals caring for patients with multiple chronic conditions in their residences can reduce hospital and emergency room visits and achieve significant savings.

This amendment adds the following to the Chairman's Mark.

The IAH program:

- Creates a chronic care coordination pilot project to bring primary care services to the highest cost Medicare beneficiaries with multiple chronic conditions in their home.
- Generates savings by providing better, more coordinated care to beneficiaries with multiple chronic conditions, reducing duplicative and unnecessary services, and avoiding unnecessary hospitalizations and emergency room visits.
- Holds providers accountable for quality outcomes, patient satisfaction and achieving cost savings to Medicare.
- Creates incentives for providers to develop better and lower cost health care for the highest cost beneficiaries.
- Is based on successful house calls programs operating by the Veteran's Administration and other providers across the country.

Modifications to ensure savings from the IAH program:

- The Secretary shall limit the number of Independence at Home medical practices selected for participation under the pilot so that no more than 10,000 applicable beneficiaries are expected to participate.
- Payments are based on shared savings only.
- An independence at home medical practice should have a minimum of 200 beneficiaries per practice, however practices can join into larger groups to meet this requirement.

- The Secretary shall establish target spending levels in such a manner as to account for normal variation in expenditures for items and services covered under parts A and B of this title, for Independence at Home Medical Practices based upon the size of the practice, characteristics of the enrolled individuals, and such other factors as the Secretary determines appropriate.

- Applicable beneficiaries are beneficiaries who are not enrolled in Medicare Advantage, PACE programs, medical homes, ACOs, or other shared savings programs.

Cost: $100 million over 10 years

Offset: There is to be a commensurate across-the-board cut to the clinical lab fee schedule.

PF

Rockefeller Coverage Amendment #21
America's Healthy Future Act
(Modified)

Rockefeller Amendment #C21 to Title I, Subtitle G (Role of Public Programs)

Part II – Children's Health Insurance Program

Co-Sponsor: Senator Hatch

Short Title: Remove the Children's Health Insurance Program (CHIP) from the exchange

Description:

Chairman's Mark

The Chairman's Mark would change the structure of CHIP. Upon enactment, states would be required to maintain income eligibility levels for currently eligible children. This requirement would expire as of September 30, 2013. There would be no other Federal changes to CHIP prior to the end of the current reauthorization period (September 30, 2013) or until the Secretary of HHS determines that the state exchange is fully operational, whichever occurs later. After such date, the Chairman's Mark would establish a Federal floor for CHIP eligibility at 250 percent of FPL – requiring states to offer CHIP to all children between 134 and 250 percent of FPL.

After the above date, CHIP income eligibility would be based on modified adjusted gross income, the same measurement that would be used in Medicaid and the state exchanges. No income disregards would be allowed.

After the above date, the CHIP benefit package would include state exchange coverage and state wrap-around benefits. CHIP enrollees would receive tax credits in the state exchanges (described above in the Coverage section). Wrap-around benefits would be arranged by the states to provide coverage for health services of an amount, type, and scope that exceeds the limits of state exchange coverage (to the full extent of EPSDT). This may include contracting with plans to provide wrap-around benefits to CHIP beneficiaries or providing wrap-around benefits directly. The CHIP cost-sharing rules and out-of-pocket limit of five percent of family income would continue to apply.

As in current law, states would be reimbursed at the enhanced CHIP match for the cost of this coverage.

Explanation of Provision

This amendment would maintain the current CHIP structure. Upon enactment, states would be required to maintain income eligibility levels for currently eligible children in Medicaid (up to the CHIP eligibility level) and CHIP. This requirement would expire as

of December 31, 2019. States would be able to expand their current income eligibility levels at any time. CHIP-eligible children who cannot enroll in CHIP due to federal allotment caps would be eligible for tax credits in the state exchange.

The Medicaid and CHIP enrollment bonuses included in the Children's Health Insurance Program Reauthorization Act of 2009 would not apply beyond the current reauthorization period. This amendment calls for the reauthorization of CHIP by September 30, 2013.

CHIP eligibility would be based on existing income eligibility rules, including the use of income disregards.

The CHIP benefit package and cost-sharing rules would continue as under current law.

States would receive the enhanced CHIP match rate for federal fiscal years 2010-2013. Beginning in 2014, states would receive a 23 percentage point increase in the CHIP match rate, subject to a cap of 100 percent. This 23 percentage point increase would continue through federal fiscal year 2019. States would also receive an increase of 0.15 percentage points in their Medicaid match rate to offset the additional state costs due to the Medicaid maintenance of effort provision.

Offset: According to CBO, this amendment would save approximately $15-25 billion over ten years, relative to the Chairman's Mark.

Savings go into health improvement fund.

JJ

Rockefeller #F1 [*Modified*] to America's Healthy Future Act

Short Title: This amendment makes various changes to the Modified Chairman's Mark.

Description of Amendment:

- **To clarify policy in Title III, Subtitle E: Medicare Commission**

  Clarifies that the Commission (and Secretary) may not propose changes to beneficiary premiums under sections 1818, 1818A, and 1839 of the Social Security Act.

  Inserts the following in the Commission and Secretary's scope of proposals:

  "As appropriate, the Commission shall include recommendations to reduce expenditures under Part C and Part D, such as through reductions in federal premium subsidies to MA-PD and PDP plans and performance bonuses to MA plans. In the case of a recommendation related to payments to plans under Parts C or D, such recommendations shall apply to plan years beginning January 1st of the year following the submission of such recommendations.

  In its proposals to Congress prior to December 31, 2019, the Commission may include supplemental, non-binding recommendations regarding improvements to payment systems for providers who are otherwise not subject to the scope of the Commission's proposals. These supplemental recommendations shall not be included in the Commission's proposals to reduce excess cost growth in a given year.

  The Secretary shall begin the rulemaking process to implement the Commission's proposal upon delivery of such proposals to Congress on January 1. The Secretary may use interim final rulemaking to implement the changes proposed by the Commission."

  Inserts "prior to December 31, 2019," after "(6)" on page 156

- **Modification of Bingaman #C1**

  The amendment directs the Secretary of Health and Human Services, working in conjunction with the Secretary of the Treasury, to establish a system of application, enrollment, and retention for Medicaid, CHIP and tax credits that meets the following requirements:

1. A single, streamlined form can be used to apply for all three subsidy programs (Medicaid, CHIP, and tax credits) with one exception: the Secretary is authorized to allow use of a supplemental or alternative form when individuals apply for a category of Medicaid eligibility that is not determined based on MAGI.

2. The form can be filed on line, in person, by mail, or by telephone.

3. The form can be filed with the Exchange, Medicaid, or CHIP.

4. After the form has been satisfactorily filed, the applicant, without any need to complete additional paperwork, receives a notice of his or eligibility for Medicaid, CHIP, and tax credits.

5. Exchanges and state Medicaid and CHIP agencies operate satisfactory systems to ensure a secure electronic interface sufficient to allow a determination of eligibility for all three programs based on the single, streamlined form (described above) or reliable third-party data (described below).

6. Whenever possible, reliable, third-party data (such as income reports from employers to State Workforce Agencies and income tax data) are used to establish, verify and update eligibility.

7. To safeguard program integrity, the state exchanges will regularly engage in data matches with the Internal Revenue Service, the Social Security Administration, the National Directory of New Hires, the applicable State Workforce Agency, or any other source of data that, under current law, may be used to verify eligibility for Medicaid or CHIP. Data matches for this purpose shall be limited to individuals receiving tax credits (and, at state option, Medicaid or CHIP). When such data match show a change in income or other relevant household circumstances, eligibility for tax credits (and, at state option, Medicaid or CHIP) is automatically adjusted, with notice to the household.

To accomplish these goals, the Secretary may promulgate model agreements and enter into interagency agreements concerning data-sharing, consistent with safeguards of privacy and data integrity. Nothing in the legislation shall be construed to either (a) prevent the exchange and a state Medicaid agency from entering into a contract through which the latter agency determines eligibility for Medicaid, CHIP, and tax credits for state residents, so long as that contract meets requirements promulgated by the Secretary of HHS (after consulting with the Secretary of the Treasury) ensuring that such a contract lowers overall administrative costs and reduces the likelihood of eligibility errors and disruptions in coverage; or (b) change the requirement in current law that Medicaid eligibility must be determined by public agencies. Nothing in the legislation changes data sharing protections currently established within the Chairman's Mark. This amendment does not change the criteria being used to determine eligibility – it simply streamlines the process by which data is collected and transmitted.

- **Modification of Rockefeller #F1**

The Chairman's Modified Mark increases the excise tax threshold amount for retired individuals over the age of 55 and for plans that cover employees engaged in high risk professions by $750 for individual coverage and $2,000 for family coverage. This amendment would increase the threshold amount for retired individuals over the age of 55 and for plans that cover employees engaged in high risk professions to $1,850 for individuals and $5,000 for families. This is an additional $1,100 for individuals and $3,000 for families.

- **Modification of Menendez #F1**

Description of Modification: Modeled after existing tax credits for investments in qualifying advanced energy projects (IRC §48C), the proposal would create a temporary credit subject to an overall cap of $1 billion to encourage investments in new therapies to prevent, diagnose, and treat acute and chronic diseases.

The proposal would have the following features:

- Limited to "small companies" defined as a business having 250 or fewer employees.
- Credit amount would be equal to 50% of investments in "qualified therapeutic discovery projects".
- Qualified therapeutic discovery project" would include projects that are designed to–
  (a) treat or prevent diseases or conditions by conducting pre-clinical activities, clinical trials, or clinical studies, or carrying out research protocols, for the purpose of securing approval of a drug or biologic;
  (b) determine molecular factors related to diseases or conditions by developing molecular diagnostics to guide therapeutic decisions; or
  (c) develop processes, technologies, or products to further the delivery or administration of therapeutics.

- Qualifying investments would include those made during 2009 and 2010.
- Total of $1 billion would be allotted for the program over the 2-year period.
- Eligible companies who are unable to utilize the credits would have the option to receive such credits in the form of Treasury loans.
- Treasury, in consultation with HHS, would award certifications for qualified investments eligible for credits allocated for tax years 2009 through 2010.
- Companies would have to apply to Treasury to certify projects that include certain "qualified investments."
- Treasury, in determining qualifying projects, would:
  (A) take into consideration only those projects that show reasonable potential– (1) to result in new therapies to treat areas of unmet medical need or to prevent, detect, or treat chronic or acute disease and conditions, (2) to reduce long-term

health care costs in the United States, or (3) to significantly advance the goal of curing cancer within a 30-year period AND

(B) take into consideration which projects would have the greatest potential– (1) to create and sustain (directly or indirectly) high quality, high-paying jobs in the United States, and (2) to advance United State competitiveness in the fields of life, biological, and medical sciences.

- "Qualified therapeutic discovery project" expenditures would not qualify for the R&D credit, orphan drug credit, or bonus depreciation.

- A taxpayer that is eligible for the credit can elect, in lieu of taking the credit, to obtain a loan from the US Treasury in an amount equal to the tax credit amount.

  (A) Treasury will extend this loan via a senior note.

  (B)The note will have a 20-year term and will carry the interest rate of long-term applicable federal rate (currently 4.1% p.a.). The interest on the note is deductible to the firm.

  (C) Upon repayment of the loan (upon maturity or earlier, with no prepayment penalty), the firm could reclaim the tax credit it had temporarily waived when it had accepted the loan.

- **Modification of Wyden Amendment #C8 as modified**

  Description of Modification: Clarifies that states are able to apply for a waiver beginning in 2015 in order to provide an objective basis against which to measure performance when a waiver is being considered or once a waiver is granted.

- **Modification to Enzi Amendment #C3 as modified**

  Description of Modification: The Secretary of Labor shall review and report to Congress the effect of fees and assessments included in Title 1, Subtitle D on workers' wages.

  In order to conduct the statistical analysis necessary to conduct this review, the secretary of Labor shall use the National Compensation Survey from the Bureau of Labor Statistics.

  Produced by the BLS, the National Compensation Survey provides comprehensive measures of wages and employment costs. Earnings data is available for metropolitan and rural areas, broad geographic regions and on a national basis.

  The Department of Labor already administers several programs where they have an obligation to determine that an activity will not adversely affect American workers' salaries or working conditions. For example, the Department's Employment Training

Administration performs that function under the foreign labor certification program. It shouldn't be difficult to replicate that function here.

- **Modification to Bunning Amendment #F4 as modified**

  Description of Modification: The Secretary of the U.S. Department of Veterans Affairs shall review and report to Congress on the effect that the fees outlined in Title VI of the Chairman's Mark have on (1) the cost of medical care provided to veterans and (2) veterans' access to medical devices and branded drugs.

This amendment would be offset with funds from the Health Improvement Fund.