Chairman's Mark

America's Healthy Future Act of 2009

Scheduled for Markup
By the Senate Committee on Finance
On September 22, 2009

America's Healthy Future Act of 2009

TITLE I—HEALTH CARE COVERAGE

SUBTITLE A—INSURANCE MARKET REFORMS

Rating Rules in the Individual Market

Current Law

The individual market is currently where individuals and dependents without employer-sponsored coverage or access to a public program purchase health insurance. Some states impose rating rules on insurance carriers in the individual market. Existing state rating rules restrict an insurer's ability to price insurance policies according to the risk of the person or group seeking coverage, and vary from state to state. Such restrictions may specify the case characteristics (or risk factors) that may or may not be considered when setting a premium, such as gender. The spectrum of existing state rating limitations ranges from pure community rating, to adjusted (or modified) community rating, to rate bands, to no restrictions. Pure community rating means that premiums cannot vary based on any characteristic, including health. Adjusted community rating means that premiums cannot vary based on health, but may vary based on other key risk factors, such as age.

Rate bands allow premium variation based on health, but such variation is limited according to a range specified by the state. Rate bands are typically expressed as a percentage above and below the index (i.e., the midpoint in the allowed rating band). For example, if a state establishes a rate band of +/- 25 percent, then insurance carriers can vary premiums, based on health factors, up to 25 percent above and 25 percent below the index. Both adjusted community rating and rate bands allow premium variation based on any other permitted case characteristic, such as gender. For each characteristic, the state typically specifies the amount of allowable variation, as a ratio. For example, a 5:1 ratio for age would allow insurers to charge an individual no more than five times the premium charged to any other individual, based on age differences. As of January 2009, one state has pure community rating, seven have adjusted community rating rules, and eleven have rating bands in the individual market. The remaining states have no limitations on rating set in law.

The Federal Health Insurance Portability and Accountability Act of 1996 (HIPAA, P.L. 104-191) established Federal rules regarding guaranteed availability, guaranteed renewability, and coverage for pre-existing health conditions in the individual market for certain persons eligible for HIPAA protections. HIPAA guarantees that each issuer in the individual market make at least two policies available to all "HIPAA eligible" individuals, and renewal of individual coverage is at the option of such individuals, with some exceptions. HIPAA also prohibits individual issuers from excluding coverage for pre-existing health conditions for HIPAA eligibles. In addition, a number of states have enacted guaranteed issue and pre-existing condition exclusion rules. Guaranteed issue refers to the requirement that an issuer must accept every applicant for coverage. Guaranteed issue does not affect (and is not affected by) rating or benefits. As of January 2009, 14 states require issuers to offer some or all of their individual insurance products on a guaranteed issue basis. Moreover, 42 states reduce the period of time when coverage for pre-existing health conditions may be excluded.

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The Chairman's Mark would establish Federal rating, issue, renewability, and pre-existing condition rules for the individual market. Issuers in the individual market could vary premiums based only on the following characteristics: tobacco use, age, and family composition. Specifically, premiums could vary no more than the ratio specified for each characteristic:

- Tobacco use – 1.5:1
- Age – ~~5:1~~ 4:1
- Family composition:
    - Single – 1:1
    - Adult with child – 1.8:1
    - Two adults – 2:1
    - Family – 3:1

Premiums could also vary among, but not within, rating areas to reflect geographic differences. States would define geographic rating areas. Taking together all permissible risk factors, premiums within a family category could not vary by more than a ~~7.5:1~~ 6:1 composite ratio.

Issuers in the individual market would be required to offer coverage on a guaranteed issue basis. Under guaranteed issue, if a plan has a capacity limit and the Secretary determines that the number of individuals who elect that plan would exceed the limit, the issuer would be allowed to limit the number of enrollees according to specified rules. Also, issuers would be required to offer coverage on a guaranteed renewability basis, and rate those policies on the same factors used when initially issuing such policies. Issuers would be prohibited from excluding coverage for pre-existing health conditions and from rescinding health coverage.

Immediate Assistance for Those with Pre-existing Conditions

Current Law

No provision.

Chairman's Mark

Within a year of enactment, any uninsured individual who has been denied health care coverage due to a pre-existing condition can enroll in a high-risk pool. Premiums in the high-risk pool will be calculated based on the same rating factors described above and will be 100 percent of the standard premium rate for a Bronze plan (described below). Currently covered individuals must be uninsured for six months before gaining access to the high-risk pool. The high-risk pool will exist until 2013 and $5 billion in funding will be provided to subsidize premiums in the pool.

Rating Rules for Small Group Market

Current Law

The small group market is where small businesses, typically 2-50 employees but up to 100 employees in some states, purchase health care coverage. Similar to the individual market, some states currently impose rating rules on insurance carriers in the small group market. As of January 2009, two states have pure community rating rules, ten have adjusted community rating rules, and 35 have rate bands in the small group market. In the states with rate bands, many exceed variation of 25:1.

HIPAA established Federal rules regarding guaranteed issue, guaranteed renewability, and coverage for pre-existing health conditions for certain persons and groups. HIPAA requires that coverage sold to firms with 2-50 employees must be sold on a guaranteed issue basis. That is, the issuer must accept every small employer that applies for coverage. HIPAA also guarantees renewal of both small and large group coverage at the option of the plan sponsor (e.g., employer), with some exceptions. And HIPAA limits the duration that coverage for pre-existing health conditions may be excluded for "HIPAA eligible" individuals with group coverage. In addition, a number of states have enacted their own guaranteed issue and pre-existing condition exclusion rules, sometimes exceeding Federal rules. All states require issuers to offer policies to firms with 2-50 workers on a guaranteed issue basis and limit the period of time when coverage for pre-existing health conditions may be excluded, in compliance with HIPAA. As of January 2009, 13 states also require issuers to offer policies on a guaranteed issue basis to self-employed "groups of one," and 21 states had pre-existing condition exclusion rules that provided consumer protection above the Federal standard.

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The rules for the small group market would be the same as those for the individual market, except that they would be phased in over a period of up to five years beginning ~~January 1, 2013~~ July 1, 2013, as determined by each state with approval from the Secretary.

Cafeteria Plans for Small Employers

Current Law

Definition of a Cafeteria Plan. If an employee receives a qualified benefit based on the employee's election between the qualified benefit and a taxable benefit under a cafeteria plan, the qualified benefit generally is not includable in gross income.[1] However, if a plan offering an employee an election between taxable benefits (including cash) and nontaxable qualified benefits does not meet the requirements for being a cafeteria plan, the election between taxable and nontaxable benefits results in gross income to the employee, regardless of what benefit is elected and when the election is made.[2] A cafeteria plan is a separate written plan under which all

[1] Sec. 125(a).

[2] Proposed Treas. Reg. sec. 1.125-1(b)

participants are employees, and participants are permitted to choose among at least one permitted taxable benefit (for example, current cash compensation) and at least one qualified benefit. Finally, a cafeteria plan must not provide for deferral of compensation, except as specifically permitted in sections 125(d)(2)(B), (C), or (D).

Qualified Benefits. Qualified benefits under a cafeteria plan are generally employer provided benefits that are not includable in gross income under an express provision of the Code. Examples of qualified benefits include employer provided health insurance coverage, group term life insurance coverage not in excess of $50,000, and benefits under a dependent care assistance program. In order to be excludible, any qualified benefit elected under a cafeteria plan must independently satisfy any requirements under the Code section that provides the exclusions. However, some employer provided benefits that are not includable in gross income under an express provision of the Code are explicitly not allowed in a cafeteria plan. These benefits are generally referred to as nonqualified benefits. Examples of nonqualified benefits include scholarships;[3] employer-provided meals and lodging;[4] educational assistance;[5] and fringe benefits.[6] A plan offering any nonqualified benefit is not a cafeteria plan.[7]

Flex-credits Under a Cafeteria Plan. Employer flex-credits are non-elective employer contributions that an employer makes available for every employee eligible to participate in the cafeteria plan, to be used at the employee's election only for one or more qualified benefits (but not as cash or other taxable benefits).

Employer Contributions Through Salary Reduction. Employees electing a qualified benefit through salary reduction are electing to forego salary and instead to receive a benefit which is excludible from gross income because it is provided by employer contributions. Section 125 provides that the employee is treated as receiving the qualified benefit from the employer in lieu of the taxable benefit. For example, active employees participating in a cafeteria plan may be able to pay their share of premiums for employer provided health insurance on a pre-tax basis through salary reduction.[8]

Nondiscrimination Requirements. Cafeteria plans and certain qualified benefits (including group term life insurance, self insured medical reimbursement plans, and dependent care assistance programs) are subject to nondiscrimination requirements to prevent discrimination in favor of highly compensated individuals generally as to eligibility for benefits and as to actual contributions and benefits provided. There are also rules to prevent disproportionate benefits to

[3] Sec. 117

[4] Sec. 119

[5] Sec.127

[6] Sec. 132

[7] Proposed Treas. Reg. sec. 1.125-1(q). Long-term care services are also not qualified benefits. Contributions to Archer Medical Savings Accounts (sections 220, 106(b)), group term life insurance for an employee's spouse, child or dependent, and elective deferrals to section 403(b) plans are also nonqualified benefits.

[8] Sec. 125.

key employees (within the meaning of section 416(i)).[9] In general, the failure to satisfy the nondiscrimination rules results in a loss of the tax exclusion by the highly compensated individuals. Although the basic purpose for the nondiscrimination rules is the same, the specific rules for satisfying the relevant nondiscrimination requirements, including the definition of highly compensated individual,[10] vary for cafeteria plans generally and for each qualified benefit. An employer maintaining a cafeteria plan in which any highly compensated individual participates must make sure that both the cafeteria plan and each qualified benefit satisfies the relevant nondiscrimination requirements, or the participating highly compensated employees may not be able to exclude from income the otherwise qualified benefits.

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The Chairman's Mark would provide for a safe harbor from the nondiscrimination requirements for cafeteria plans for an eligible small employer. The safe harbor under the Mark also applies to the nondiscrimination requirements for specified qualified benefits offered under the cafeteria plan, including group term life insurance, coverage under a self insured group health plan, and benefits under a dependent care assistance program. The safe harbor requires that the cafeteria plan satisfy minimum eligibility and participation requirements and minimum flex-credit contribution requirements.

Eligibility Requirement. The eligibility requirement is met only if all employees (other than excludible employees) are eligible to participate, and each employee eligible to participate is able to elect any benefit available under the plan (subject to the terms and conditions applicable to all participants). However, a cafeteria plan will not fail to satisfy this eligibility requirement merely because the plan excludes employees who: (1) have not attained the age of 21 (or a younger age provided in the plan) before the close of a plan year; (2) had fewer than 1,000 hours of service for the preceding plan year; (3) have less than one year of service with the employer as of any day during the plan year; (4) are covered under an agreement which the Secretary of Labor finds to be a collective bargaining agreement if there is evidence that the benefits covered under the cafeteria plan were the subject of good faith bargaining between employee

[9] A key employee generally is an employee who, at any time during the year is (1) a five-percent owner of the employer, or (2) a one-percent owner with compensation of more than $150,000 (not indexed), or (3) an officer with compensation more than $160,000 (for 2009). A special rule limits the number of officers treated as key employees. If the employer is a corporation, a five-percent owner is a person who owns more than five percent of the outstanding stock or stock possessing more than five percent of the total combined voting power of all stock. If the employer is not a corporation, a five-percent owner is a person who owns more than five percent of the capital or profits interest. A one-percent owner is defined by substituting one percent for five percent in the preceding definitions. Attribution applies in determining ownership.

[10] Under section 125, a cafeteria plan must not discriminate in favor of a "highly compensated individual" with respect to eligibility to participate in the cafeteria plan or in favor of a "highly compensated participant" with respect to benefits under the plan.[10] For cafeteria plan purposes, a "highly compensated individual" is (1) an officer, (2) a five-percent shareholder, (3) an individual who is highly compensated, or (4) the spouse or dependent of any of the preceding categories.[10] A "highly compensated participant" is a participant who falls in any of those categories. "Highly compensated" is not defined for this purpose. Under section 105(h), a self-insured health plan must not discriminate in favor of a "highly compensated individual," defined as (1) one of the five highest paid officers, (2) a 10-percent shareholder, or (3) an individual among the highest paid 25 percent of all employees. Under section 129 for a dependent care assistance program, eligibility for benefits, and the benefits and contributions provided, generally must not discriminate in favor of highly compensated employees within the meaning of section 414(q).

representatives and the employer; or (5) are described in section 410(b)(3)(C) (relating to nonresident aliens working outside the United States).

Minimum Contribution Requirement. The minimum contribution requirement is met if: (1) the employer provides flex-credits available for use during the plan year equal to at least two percent of each eligible employee's compensation for the plan year; or (2) the value of employer-paid benefits is at least six percent of each eligible employee's compensation for the plan year or, if less, twice the amount of the salary reduction amount for the year of each eligible employee who is not a highly compensated (within the meaning of section 414(q))[11] or a key employee (within the meaning of section 416(i)) and who participates in the plan.

An employer is permitted to provide flex credits under the cafeteria plan in addition to the minimum required matching or non-elective contributions. However, the contribution requirement is not satisfied if the matching contributions for any highly compensated or key employee are at a greater rate than matching contributions for any employee who is not a highly compensated or key employee, with respect to salary reduction contributions.

Eligible Employer. An eligible small employer under the Chairman's Mark is, with respect to any year, an employer who employed an average of 100 or fewer employees on business days during either of the two preceding years. For purposes of the Mark, a year may only be taken into account if the employer was in existence throughout the year. If an employer was not in existence throughout the preceding year, the determination is based on the average number of employees that it is reasonably expected such employer will employ on business days in the current year. If an employer was an eligible employer for any year and maintained a simple cafeteria plan for its employees for such year, then, for each subsequent year during which the employer continues, without interruption, to maintain the cafeteria plan, the employer is deemed to be an eligible small employer until the employer employs an average of 200 or more employees on business days during any year preceding any such subsequent year.

The determination of whether an employer is an eligible small employer is determined by applying the control group rules of section 52 (a) and (b) under which all members of the controlled group are treated as a single employer. In addition, the definition of employee includes leased employees within the meaning of section 414(n) and (o). [12]

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[11] Section 414(q) generally defines a highly compensated employee as an employee: (1) who was a five-percent owner during the year or the preceding year; or (2) who had compensation of $110,000 (for 2009) or more for the preceding year. An employer may elect to limit the employees treated as highly compensated employees based upon their compensation in the preceding year to the highest paid 20 percent of employees in the preceding year. Five-percent owner is defined by cross-reference to the definition of key employee.

[12] Section 52(b) provides that, for specified purposes, all employees of all corporations which are members of a controlled group of corporations are treated as employed by a single employer. However, section 52(b) provides certain modifications to the control group rules including substituting 50 percent ownership for 80 percent ownership as the measure of control. There is a similar rule in section 52(c) under which all employees of trades or businesses (whether or not incorporated) which are under common control are treated under regulations as employed by a single employer. Section 414(n) provides rules for specified purposes when leased employees are treated as employed by the service recipient and section 414 (o) authorizes the Treasury to issue regulations to prevent avoidance of the requirements of section 414(n).

Effective Date

This section is effective for taxable years beginning after December 31, 2010.

~~Qualified Long Term Care Insurance~~

~~Current Law~~

~~A plan of an employer providing coverage under a qualified long-term care insurance contract generally is treated as an accident or health plan. Thus, employer contributions for qualified long-term care insurance for the employee, his or her spouse, and his or her dependents are excludible from gross income and from wages for employment tax purposes. Employees participating in a cafeteria plan, however, are not able to pay the portion of premiums for long-term care insurance not otherwise paid for by their employers on a pre-tax basis through salary reduction because, under current law, any product that is advertised, marketed, and offered as long-term care is a nonqualified benefit specifically not permitted to be offered under a cafeteria plan.[13]~~

~~Similarly, employee expenses for long-term care services cannot be reimbursed under a flexible spending arrangement for health coverage on a tax-free basis. A flexible spending arrangement for health coverage generally is defined as a benefit program which provides employees with coverage under which specific incurred medical care expenses may be reimbursed (subject to reimbursement maximums and other conditions) and the maximum amount of reimbursement reasonably available is less than 500 percent of the value of such coverage.[14]~~

~~A qualified long-term care insurance contract is defined as any insurance contract that provides only coverage of qualified long-term care services and that meets other requirements. The other requirements include: (1) the contract is guaranteed renewable; (2) the contract does not provide for a cash surrender value or other money that can be paid, assigned, pledged or borrowed; (3) refunds (other than refunds on the death of the insured or complete surrender or cancellation of the contract) and dividends under the contract may be used only to reduce future premiums or increase future benefits; (4) the contract generally does not pay or reimburse expenses reimbursable under Medicare (except where Medicare is a secondary payor, or the contract makes per diem or other periodic payments without regard to expenses); and (5) the contract satisfies certain consumer protection requirements.[15]~~

~~A contract does not fail to be treated as a qualified long-term care insurance contract solely because it provides for payments on a per diem or other periodic basis without regard to expenses incurred during the period.~~

~~Chairman's Mark~~

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[13] ~~Sec. 125(f).~~

[14] ~~Sec. 106(c)(2) and proposed Treas. Reg.1.125-5(a).~~

[15] ~~Sec. 7702B(b).~~

~~The Chairman's Mark would allow a cafeteria plan to offer as a qualified benefit contributions to a qualified long-term care insurance contract (as defined in section 7702B) to the extent the amount of such contributions does not exceed the eligible long-term care premiums (as defined in section 213(d)(10)) for such contract. Under the Mark, reimbursement for employee-paid premiums for a qualified long-term care insurance contract through a flexible spending arrangement (whether or not under a cafeteria plan) is similarly excludible from gross income.~~

~~*Effective Date*~~

~~The provision is effective for taxable years beginning after December 31, 2010.~~

Pooling Requirements for Individual and Small Group Markets

Current Law

Pooling refers to the industry practice of pooling the insurance risk of individuals or groups in order to determine premiums. In the individual market premiums are typically based on the risk of the applicant, such as an individual or family. In the small group market, premiums are typically based on the collective risk of the small group.

HIPAA defines small group size as those firms with 2-50 employees. Moreover, states have defined small group for health insurance purposes. As of December 2008, 12 states define small group size as those with 1-50 employees, including self-employed. The rest of the states and the District of Columbia define small groups in keeping with the Federal standard.

As part of its comprehensive health reform plan, Massachusetts merged its small and individual markets. The practical effect is that insurance risk is now spread across the larger combined pool, upon which premiums are determined.

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States would be required to apply the new Federal rating rules to two distinct markets (1) the individual market and (2) the small group market, defined as groups of 1-50 or up to 100 at state option. States would have the option to merge the pooling and rating requirements for the individual and small group markets.

Risk-adjustment. All plans in the individual and small group markets would be subject to the same system of risk-adjustment. Risk-adjustment will be applied within rating areas (described below).

The Secretary would be required to pre-qualify entities capable of conducting risk-adjustment and the states would have the option to pick among those entities. The entities pre-qualified by the Secretary cannot be owned or operated by insurance carriers. The Secretary of HHS would define qualified risk-adjustment models which can be used by states. States can also choose to develop their own risk-adjustment model but it must produce similar results and not increase Federal costs. After risk-adjustment is applied, reinsurance and risk corridors (described below) would apply.

Reinsurance. As a condition of issuing commercial, major medical health insurance policies or administering benefit plans for major medical coverage in years 2013, 2014, and 2015, all health insurance issuers would be required to contribute to a reinsurance program for individual policies that is administered by a non-profit reinsurance entity that would function as described below. This requirement would be enforced at the state level in a manner consistent with new the insurance market reforms. National Association of Insurance Commissioners (NAIC) would be directed to develop a model for states to adopt. If the NAIC does not act or a state does not adopt the new requirements, new Federal regulations would preempt state laws that conflict with the new reinsurance requirements.

In order to meet the requirement above, insurers shall contribute to a reinsurance entity that is a non-profit entity (referred to as the "Non Profit"). The purpose of the Non Profit must be to help stabilize premiums for individual coverage during the first few years of operation of the state exchanges when the risk of adverse selection related to new rating rules and market changes is greatest. A duty of the Non Profit must be to coordinate the funding and operation of a risk spreading mechanism that takes the form of reinsurance. The Non Profit will be tax exempt for Federal tax purposes.

The Non Profit must use funds collected to support a reinsurance mechanism applied to individuals (individual) enrolled in plans offered within the state exchange. The mechanism would be invisible to the individual and take the form of reinsurance for those defined as "high risk." Individuals for whom reinsurance payments are applicable must be objectively identified using a limited list of 50-100 high-risk conditions or other comparable objective method recommended by the American Academy of Actuaries (the "Academy"). The formula for reinsurance payments must be designed on a per condition basis or other comparable method recommended by the Academy that encourages the use of care coordination and care management programs for high-risk conditions. The formula shall equitably allocate the available funds through reconciliation (e.g., at year-end).

Contributions collected by the Non Profit must total $20 billion in 2013 to 2015 in order for insurers to meet the requirement. Contributions could be collected in advance or on a periodic basis throughout each applicable year as long as $10 billion in reinsurance payments could be made by the Non Profit for individual policies ~~sold in the state exchanges~~ for 2013, $6 billion for 2014, and $4 billion for 2015. In the event that all funds are not expended in the three year period, the non-profits may continue to make payments through 2017, but no new funds would be collected beyond 2015. The contribution amounts allocated and used in any of the three years may vary based on the reinsurance needs of a particular year or to reflect experience in the prior year. The contribution amount must proportionally reflect each entity's fully insured commercial book of business for all major medical products and third-party administrators (TPA) fees (e.g., based on percentage of revenue or flat, per enrollee amount). Separate contributions from insurers would fund the administrative expenses of the Non Profit. Nothing would preclude the Non Profit from collecting additional funding on a voluntary basis or in conjunction with state requirements applicable to new individual polices offered outside the state exchanges.

State insurance commissioners would be able to review the actuarial soundness of the risk spreading activities conducted by and the contributions made by the Non Profit.

Additional contributions will be made in the amount of $5 billion in 2013 to 2015 to apply to employer-sponsored retiree coverage. The program would reimburse any eligible employers or insurers 80 percent of claims between $15,000 and ends at $90,000. The thresholds would rise each year based on the Medical Care Component of the CPI-U, rounded to the nearest multiple of $1,000. It would reinsure only the claims for individual between the ages 55 to 64 year old who are not active workers or dependents of active workers and who are not Medicare-eligible. Eligible employers are those offering coverage that is appropriate for a mature population between 55 and 64, offers preventative benefits, has demonstrated programs to generate cost-savings for those with chronic and high-cost conditions, and can show actual cost of medical claims.

Risk Corridors. After reinsurance is applied, in the case of a plan that offers coverage in the individual and small group market in 2013, 2014, and 2015, risk corridors modeled after that applied to regional Participating Provider Organizations in Medicare Part D will be provided if a plan chooses to participate. For the purpose of this provision, allowable costs means the total amount of costs that the plan incurred in providing benefits covered by the plan reduced by the portion of such costs attributable to administrative expenses. The term 'target amount' means an amount equal to the total annual premium (including any premium subsidies) collectable for the enrollees for the year reduced by the amount of administrative expenses.

If the allowable costs for the plan for the year are at least 97 percent, but do not exceed 103 percent, of the target amount for the plan and year, there would be no payment adjustment for the plan and year. If the allowable costs for the plan for the year are greater than 103 percent, but not greater than 108 percent, of the target amount for the plan and year, the Secretary would make a payment to the plan equal to 50 percent of the difference between the allowable costs and 103 percent of the target amount. If the allowable costs for the plan for the year are greater than 108 percent of the target amount for the plan and year, the Secretary would make a payment to the plan equal to the sum of 2.5 percent of the target amount and 80 percent of the difference between the allowable costs and 108 percent of the target amount.

If the allowable costs for the plan for the year are less than 97 percent, but greater than or equal to 92 percent, of the target amount for the plan and year, the Secretary would receive a payment from the plan equal to 50 percent of the difference between 97 percent of the target amount and the allowable costs. If the allowable costs for the plan for the year are less than 92 percent of the target amount for the plan and year, the Secretary would receive a payment from the plan equal to the sum of 2.5 percent of the target amount; and 80 percent of the difference between 92 percent of such target amount and such allowable costs.

State Insurance Commissioners

Current Law

State insurance commissioners are responsible for protecting the interests of insurance consumers by performing functions such as antifraud efforts, addressing consumer complaints,

market analysis, producer licensing, and regulatory interventions. They are responsible for enforcing the general rules governing insurance, which include licensing insurers and rules for brokers and agents activities.

HIPAA guarantees the availability of a plan and prohibits pre-existing condition exclusions for certain eligible individuals who are moving from group health insurance to insurance in the individual market. States have the choice of either enforcing the HIPAA individual market guarantees, referred to as the "Federal fallback," or they may establish an "acceptable alternative state mechanism." In states using the Federal fallback approach, HIPAA requires all health insurance issuers operating in the individual market to offer coverage to all eligible individuals and prohibits them from placing any limitations on the coverage of any pre-existing medical condition. Insurers have options for complying, such as offering the two most popular products, and they can refuse to cover individuals seeking portability from the group market if financial or provider capacity would be impaired

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Roles and Responsibilities. State insurance commissioners would continue to provide oversight of plans with regard to consumer protections (e.g., grievance procedures, external review, agent practices and training, market conduct), rate reviews, solvency, reserve requirements, premium taxes, and all requirements imposed on insured plans as specified in this Mark. They would provide oversight of plans with regards to Federal rating rules and any additional state rating rules, facilitate risk-adjustment within service areas, and establish rate schedules for broker commissions in the state exchanges.

Enforcement Mechanism. The National Association of Insurance Commissioners (NAIC) will devise an NAIC Model Regulation within 12 months of enactment that is consistent with the new Federal law with regards to Federal health insurance rating, issuance and marketing requirements. This model becomes the new Federal minimum standard without any further Congressional action. The new model should be developed by NAIC with input from all NAIC members, health insurance issuers, consumer groups and other qualified individuals. Representatives shall be selected in a manner so as to assure balanced representation among the interested parties.

Once completed, the NAIC Model is written into Federal regulation. If NAIC does not act with the 12 month time period, the Secretary of HHS promulgates regulations within six months in a manner consistent with the new Federal law. Once the Model is completed, states must adopt the new NAIC Model (or adopt the HHS Model if the NAIC did not act in the specified time period) through changes in state regulation and/or legislation. States may also, with approval from the Secretary of HHS, implement a rule or provision differently as long as it is still consistent with the intent of the new Federal law and provides the same level of consumer protections.

If a state fails to adopt the changes in conformance with the new Federal minimum standards either by adopting the NAIC Model or through Secretarial approval, conflicting state laws would be preempted. In such a case, insurers would then offer coverage under Federal law and be overseen by HHS until the state adopts the necessary changes.

States must establish an exchange that complies with the requirements set forth in the Federal law. If a state does not establish an exchange within 24 months of enactment, the Secretary of HHS shall contract with a non-governmental entity to establish a state exchange that complies with the Federal legislation.

Added in the Modification or by Amendment at Markup

The Mark would prohibit state law from imposing more stringent regulatory requirements on certain health insurance issuers that are not applied to all issuers in the individual and small group markets. All entities offering health insurance would be subject to state regulatory requirements that exceed federal requirements established under this legislation.

Rating Areas

Current Law

There are no Federally-established rating areas in the private health insurance market. However, some states have enacted rating rules in the individual and small group markets that include geography as a characteristic on which premiums may vary. In these cases, the state has established rating areas. Typically, states use counties or zip codes to define those areas.

Chairman's Mark

Rating areas would be defined by state insurance commissioners and reviewed by the Secretary for adequacy. Rating areas (1) could allow for exceptions (e.g., a high-quality plan that does not have the capacity to serve the entire rating area could be allowed to serve less than a full rating area), (2) would be required to allow for pooling of similar cost people, and (3) would be risk adjusted within each area and across all plans in each market (individual and small group).

Grandfathered Plans

Current Law

No provision.

Chairman's Mark

Individuals and groups who wish to renew coverage in an existing policy would be permitted to do so. Plans could continue to offer coverage in a grandfathered policy, but only to those who were currently enrolled, dependents, or in the case of an employer, to new employees and their dependents. Any individual who has an existing policy equal in value to the "young invincible" plan (described below) can renew that policy. The policy will be considered minimum creditable coverage for purposes of meeting the personal responsibility requirement. No tax credits would be offered for grandfathered plans.

Beginning July 1, 2013~~January 1, 2013~~, Federal rating rules would be phased in for grandfathered policies in the small group market, over a period of up to five years, as determined by the state with approval from the Secretary. These plans could continue to exist after the transition period, but would be subject to the new rating rules.

Interstate Sale of Insurance

Current Law

No provision.

Chairman's Mark

No later than 2013, the National Association of Insurance Commissioners (NAIC) shall develop model rules for the creation of "health care choice compacts." Starting in 2015, states, following action taken by the state legislature to approve participation, may form "health care choice compacts" to allow for the purchase of individual health insurance across state lines. "Health care choice compacts" may exist between two or more states. Once compacts have been agreed to, insurers would be allowed to sell policies in any state participating in the compact. Insurers selling policies through a "health care choice compact" would only be subject to the laws and regulations of the state where the policy is written or issued.

Compacts shall provide that the state where the consumer lives retains authority to address market conduct, unfair trade practices, network adequacy and consumer protection standards, including addressing disputes as to the performance of the contract. Insurers either must be licensed in both states or submit to the jurisdiction of each state with regard to these issues (including allowing access to records as if the insurer were licensed in the state.) Before selling a individual policy through a "health care choice compact," insurers must clearly notify consumers that the policy may not be subject to all the laws and regulations of the state is which the purchaser resides.

Effective Date

The effective date for this subtitle is ~~January 1~~July 1, 2013 unless otherwise indicated.

National Plans

Current Law.

No provision.

Chairman's Mark

The Chairman's Mark would allow national plans, with uniform benefit packages that are offered across state lines. These national plans must be licensed in every state that they choose to operate and would be regulated by the states in terms of solvency and other key consumer

protections and would offer coverage through the state exchanges. States are permitted to opt-out of the national plan. Legislative action must be taken at the state level in order for a state to opt-out. A state that has opted-out can also take legislative action to opt back into the national plan.

Such national plans must be compliant with the benefit levels and categories detailed in the Mark, but would preempt state benefit mandates– thereby allowing these national plans to offer a single, uniform benefit package. The National Association of Insurance Commissioners (NAIC), in consultation with consumer groups, business interests, including small businesses, the insurance industry, federal regulators, and benefit experts, will develop standards as to how benefit categories should be implemented (e.g., what constitute prescription drug coverage) taking into consideration how each benefit is offered in a majority (26) of the states. After NAIC publishes these standards, the state insurance commissioners will ensure that insurance companies offering national plans are providing plans that are compliant.

Premiums for national plans will be determined based on rating rules in each state and will reflect geographic variation among rating areas. National plans would be subject to the requirement to offer silver and gold benefit levels. If an insurer offers a national plan(s) in one state, it must offer the same plan(s) in any other state in which it chooses to participate. For national plans, the NAIC will also develop harmonization standards for processes of state insurance regulation that pertain to form filing and rate filing.

State Opt-Out

Beginning in 2015, the Chairman's Mark provides an opportunity for states to apply for a waiver to opt out of certain aspects of this Act through a waiver process. States may be granted a waiver if the state applies to the Secretary to provide health care coverage that is at least as comprehensive as required under the Chairman's Mark. States may seek a waiver through a process similar to Medicaid and CHIP. If the State submits a waiver to the Secretary, the Secretary must respond no later than 180 days and if the Secretary refuses to grant a waiver, the Secretary must notify the State and Congress about why the waiver was not granted.

The Mark requires states to meet the requirements of this Act such that all residents have affordable, quality insurance coverage shall be eligible for a waiver of applicable Federal health-related program requirements.

In order to be eligible to receive a waiver under this section, states must demonstrate that:

(1) the state plan provides health care coverage to its residents that is at least as comprehensive as the coverage required under an exchange plan and with citizen input through a referenda or similar means;
(2) the state plan will ensure that all residents have coverage;
(3) the state submits an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require, including a comprehensive description of the State legislation or plan for implementing the State-based health plan; and

(4) the state submits a ten-year budget for the plan that is budget neutral to the Federal government.

The Secretary must respond to the state within 180 days after the application has been received. Approve of the plan would be granted only if it meets criteria consistent with that of the America's Healthy Future Act, including that it shall lower health care spending growth, improve the delivery system performance, provide affordable choices for all its citizens, expand protections against excessive out-of-pocket spending, provides coverage to the same number of uninsured and not increase the Federal deficit. If the Secretary determines that a waiver should be granted under this section, the Secretary shall notify the State involved of such determination and the terms and effectiveness of such waiver.

If the Secretary refuses to grant a waiver under this section, the Secretary would be required to do the following:

(1) notify the state of such determination, and the reasons for denial; and
(2) notify the appropriate Committees of Congress of the determination and the reasons for the denial.

The Secretary would determine the scope of a waiver granted to a State under this section, including which Federal laws and requirements will not apply to the State under the waiver. Waiver authority only relates to laws under the authority of the Secretary of HHS and does not apply to laws like the Civil Rights Act, ERISA, and American's with Disabilities Act or any other federal law or regulation which is not under the jurisdiction of the Secretary of HHS. Waivers are not intended to thwart or affect the intent of the reforms included in America's Health Future Act.

State Option for a Basic Health Plan

Overview. The Mark provides an opportunity for states to establish a federally-funded, non-Medicaid state plan for people with incomes above Medicaid eligibility but below 200 percent of the federal poverty level (FPL). Under this provision, 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.

States would use their share of federal funding 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.

Funding. For purposes of this amendment, a state's Basic Health Plan funding level would be based on the value of individual tax credits and cost sharing subsidies that would otherwise have been made based on enrollment in that state. This amount should be calculated on a per enrollee basis. In making this calculation, the Secretary would consider all relevant factors necessary to determine the value of individual tax credits and cost sharing subsidies that would have been

paid for enrollees in that state who are otherwise eligible. Funds distributed to the states would be provided to independent state-based trusts and would be used by the states to negotiate creditable 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.

Opportunity for 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.

SUBTITLE B—STATE EXCHANGES AND CONSUMER ASSISTANCE

State Exchanges and Marketing Requirements

Current Law

No specific provision exists in Federal law today regarding a health insurance exchange. At the state level, however, Massachusetts established a health insurance Connector, which is described below for illustrative purposes.

In 2006, in tandem with substantial private health insurance market reforms, Massachusetts created the Health Insurance Connector Authority, governed by a Board of Directors, to serve as an intermediary that assists individuals in acquiring health insurance. In this role, the Health Connector manages two programs. The first is Commonwealth Care, which offers a government-subsidized plan at three benefit levels from a handful of health insurers to individuals up to 300 percent of the Federal poverty level (FPL) who are not otherwise eligible for traditional Medicaid or other coverage (e.g., job-based coverage). The second is Commonwealth Choice, which offers an unsubsidized selection of four benefit tiers (gold, silver, bronze, and young adult) from six insurers to individuals and small groups.

Under state law, the Board of Directors, with its 11 board members, has numerous responsibilities, including the following: determining eligibility for and administering subsidies through the Commonwealth Care program, awarding a seal of approval to qualified health plans offered through the Connector's Commonwealth Choice program, developing regulations defining what constitutes "creditable coverage," constructing an affordability schedule to determine if residents have access to "affordable" coverage and may therefore be subject to tax

penalties if they are uninsured, and developing a system for processing appeals related to eligibility decisions for the Commonwealth Care program and the individual mandate.

Chairman's Mark

Plan Participation. Beginning in 2013, all private insurers in the individual and small group markets that operate nationally, regionally, statewide, or locally must be available in a newly established state exchanges, if the insurers are licensed by a state (that is, a state has determined that the plans meet all the market-reform requirements).

Added in the Modification or by Amendment at Markup

Internal Appeals Process. Plans and health insurance carriers offering coverage in the exchange would be required to have an internal claims appeal process.

Child-only and Dental Plans. The Mark provides for the availability of child-only health insurance coverage through the exchange and would direct the Secretary to determine whether alternative means – such as direct subsidies, and refinements to tax credit eligibility determinations, are necessary to provide support for the purchase of such coverage for children. Stand-alone dental plans also would be permitted to offer pediatric dental benefits directly and to offer coverage through the exchange. These plans must comply with all consumer protection requirements in order to participate in the exchange.

Emergency Room Protections. The Mark would require that health plans and health insurers offering coverage in the exchange would be required to 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.

Establishment of State Exchanges. States would be required to establish an exchange for the individual market and a Small Business Health Options Program (SHOP) exchange for the small group market, with technical assistance from the Secretary, in 2010. This requirement may encompass a single exchange with separate resources for individual and small-group customers. The Secretary would be required to establish and maintain a database of plan offerings for use by state exchanges. The database would enable the review of state-specific information. The Secretary could contract out to a private entity for the operation of the plan database and can also enter into an agreement with a Sub-Exchange in carrying out its functions.

In 2010, 2011 and 2012, plans with annual and lifetime limits and so-called "mini-medical" plans with limited benefits and low annual caps would be prohibited from being offered in the state exchanges. All other policies would be offered in the state exchange. Beginning ~~January 1, 2013~~ July 1, 2013, all plans offered in the individual and small group market, whether through the exchange or outside of the exchange, would have to comply with the rating reforms and benefit options detailed in the Chairman's Mark.

Agents and brokers are permitted to enroll individuals and employers in any health insurance option available in the state exchanges.

Legal U.S. residents will be able to obtain insurance through the state exchanges. Parents who are in the country illegally will not be able to buy personal insurance coverage through the state exchange but will be able to buy insurance for their U.S. citizen or lawfully present children.

Functions Performed by Secretary and/or States. The Secretary and/or states would do the following:

1. After consultation with state insurance commissioners, develop a standard enrollment application for eligible individuals and small businesses seeking health insurance through the state exchange, whether done electronically or on paper;

2. Provide a standardized format for presenting insurance options in the state exchange, including benefits, premiums, and provider networks (allowing for customized information so that individuals could sort by factors such as ZIP code or providers);

3. Develop standardized marketing requirements consistent with the NAIC model regulation;

4. Develop a rating system for plans entering the state exchange based on relative quality and price compared to other plans offering products in the same benefit level, which would be displayed on the state exchange website;

5. Maintain call center support for customer service that includes multilingual assistance — the center would have the ability to mail relevant information to residents based on their inquiry and ZIP code;

6. Enable consumers to enroll in health care plans in local hospitals, schools, Departments of Motor Vehicles, local Social Security offices, and any other offices designated by the state;

7. Develop a model template for a Web portal for use by the states that directs individuals and small businesses to available insurance options in their state, provides a tax credit calculator so individuals and small businesses can determine their true cost of coverage, informs individuals of eligibility for public programs, and presents standardized information related to insurance options, including quality ratings;

8. Conduct eligibility determinations for tax credits and subsidies ~~(as performed by a Federal agency that also reports the information to the Internal Revenue Service (IRS) for end-of-year reconciliation)~~ and enable enrollment of individuals and small businesses;

9. Establish procedures for granting an annual certification upon request of a resident who has sought health insurance coverage through the state exchange, attesting that, for the purposes of enforcing the individual requirement, no health benefit plan which meets the

definition of creditable coverage was deemed affordable by the exchange for that individual—and maintain a list of individuals for whom certificates have been granted and share this information with the Secretary and Treasury Secretary in order for the IRS to effectively enforce the personal responsibility requirement;

10. Establish procedures for appeals of eligibility decisions for subsidies; and

11. Establish a plan for publicizing the existence of the state exchange and the annual open-enrollment period.

State Exchange Related Functions Performed by State Insurance Commissioners. State insurance commissioners would establish procedures for reviewing plans to be offered through the state exchanges and would develop criteria for determining whether certain health benefit plans can be available for sale in the market.

~~***Multiple Exchanges.*** After states adopt Federal rating rules and the exchange is functional for at least three years, states could permit other entities to operate an exchange — but only if it met specified requirements, and subject to approval by the Secretary.~~

Regional Exchanges. States could, through interstate compacts, form regional exchanges, subject to approval by the Secretary.

SHOP Exchange. States would assist small employers that opt to use the SHOP exchange as the enrollment option for their employees. Small firms offering through the exchange could not self-insure. Small employers that made age-adjusted contributions on behalf of their employees would be granted a safe harbor from non-discrimination rules.

Administrator. The Secretary of HHS would designate an office within the Department to provide technical assistance to states on incorporating small businesses into SHOP exchanges.

Large Employers. Beginning in 2015, states must allow small businesses up to 100 employees purchase coverage through the SHOP health insurance exchange and states may allow employers with more than 100 employees into the state exchange beginning in 2017. Businesses that grow beyond the upper employee limit in the SHOP exchange may continue to purchase health insurance through the SHOP exchange. ~~In 2017, states must develop and submit to the Secretary a phase-in schedule (not to exceed five years), including applicable rating rules, for incorporating firms with 50 or more (or 100 or more for those states that already included firms with 51-100 employees) into the state exchanges. The Secretary must develop regulations to address the potential for any risk selection issues associated with allowing larger employers into the state exchanges. Initial phase in for these firms would begin in plan years in 2018 and beyond.~~

Enrollment by Members of Congress and ~~Federal~~ Congressional Employees. Notwithstanding any other provision of law, beginning July 1, 2013, Members of Congress and congressional employees would be required to use their employer contribution (adjusted for age rating) to purchase coverage through a state-based exchange, rather than using the traditional Federal Employees Health Benefits Plan (FEHBP).

Study on Use of Electronic Health Records. The Secretary or his/her designate is instructed to conduct a study on methods that entities offering insurance plans through the exchange can use to encourage increased meaningful use of electronic health records by health care providers

Funding for Operation of the Exchanges. The state exchanges would receive initial Federal funding but then would be self-sustaining in future years.

Effective Date

The effective date for this subtitle is July 1, 2010 unless otherwise indicated.

SUBTITLE C—MAKING COVERAGE AFFORDABLE

Benefit Options

Current Law

Generally, Federal law has certain requirements regarding actuarially equivalent benefit options only in the context of private plan offerings through Federal health insurance programs (e.g., Medicare Parts C and D, the State Children's Health Insurance Program). There is no Federal law regarding actuarially equivalent benefit options in group and individual private health insurance. However, states may have such standards.

For example, Massachusetts defines a standard gold benefit package for private health insurance available in its Connector. According to the states' 2006 guidance to health insurers, a plan with a different design could be qualified as "gold" if it had an actuarial value within five percent of the standard gold's value. The state permits two other benefit packages available to all individuals in the Connector: Insurers were instructed that "silver" benefit packages were to be 80 percent of gold (plus or minus 7.5 percent), and "bronze" packages were to be 60 percent of gold (plus or minus two percent). However, these amounts were not set in statute and have changed somewhat over time. An additional option is available to young adults in Massachusetts; plans may exclude prescription drugs and/or limit annual plan benefit payments.

Federal law does not define a minimum creditable coverage (MCC) benefit package for purposes of individual (individual), small group (employers with 2-50 workers (1-50 in some states) or up to 100 in some states), and other group private health insurance. States have the primary responsibility of regulating the business of insurance and may define what qualifies as minimum creditable coverage. However, Federal law requires that private health insurance include certain benefits and protections. HIPAA and subsequent amendments require, for example, that group health plans and insurers cover minimum hospital stays for maternity care, provide parity in annual and lifetime mental health benefits, and offer reconstructive breast surgery if the plan covers mastectomies.

Definition of Four Benefit Categories. Four benefit categories would be available: bronze, silver, gold and platinum. No policies could be issued in the individual or small group market (other than grandfathered plans) that did not meet the actuarial standards described below. All health insurance plans in the individual and small group market would be required, at a minimum, to offer coverage in the silver and gold categories.

All plans must provide preventive[16] and primary care, emergency services, hospitalization, physician services, outpatient services, day surgery and related anesthesia, diagnostic imaging and screenings (including x-rays), maternity and newborn care, pediatric services (including dental[17] and vision), medical/surgical care, prescription drugs, radiation and chemotherapy, and mental health and substance abuse services[18] that at least meet minimum standards set by Federal and state laws. In addition, plans could charge no cost-sharing (e.g., deductibles, copayments) for preventive care services, except in cases where value-based insurance design[19] is used. Plans could also not include lifetime limits on coverage or annual limits on any benefits. Any insurer that rates on tobacco use must also provide coverage for comprehensive tobacco cessation programs including counseling and pharmacotherapy (prescription and non-prescription). The provisions in this paragraph would all be within the actuarial value of the appropriate benefit level.

The Secretary of HHS would be required to define and update the categories of covered treatments, items and services within benefit classes no less than annually through a transparent and public process that allows for public input, including a public comment period. The Secretary cannot define a package that is more extensive than the typical employer plan as certified by the Centers for Medicare and Medicaid Services, Office of the Actuary. Some flexibility in plan design is allowed but the Secretary must ensure that plan design does not encourage adverse selection. The Secretary would be required to update or modify these definitions to account for changes in medical evidence or scientific advancement or to address any gaps in access or changes in the evidence base.

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[16] Preventive services include those recommended by the U.S. Preventive Services Task Force and immunizations recommended by the Advisory Committee on Immunization Practices (ACIP).

[17] 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 benefits may be provided by state-licensed stand-alone dental-only carriers that meet requirements of section 2791(c)(2)(A) of the Public Health Services Act. Stand-alone dental-only together with a qualified health plan that provides all of the other required benefits would satisfy the required benefit standard. 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 this Mark.

[18] Mental health and substance abuse services include behavioral health treatment and must be in compliance with the "Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008" (P.L. 110-343).

[19] Value-based insurance design (VBID) -- A benefit design that identifies clinically beneficial preventive screenings, lifestyle interventions, medications, immunizations, diagnostic tests and procedures, and efficacious treatments for which cost-sharing (co-payments or coinsurance and deductibles) should be eliminated or reduced due to their high value and effectiveness.

Each plan design for products in the state exchanges would be required to apply parity for cost-sharing for treatment of conditions within each of the following categories of benefits: (1) inpatient hospital; (2) outpatient hospital; (3) physician services; and (4) other items and services, except in cases where value-based insurance design is used. Each plan design would also be required to meet the class and category of drug coverage requirements specified in Medicare Part D. (Generally, Part D plans must offer two drugs in each class or category.) States may permit some flexibility in plan design to encourage widely agreed upon cost and quality effective services. These requirements would not add to or change the actuarial value of the benefit designs.

Insurers participating in the state exchanges would be required to charge the same price for the same products in the entire service area as defined by the state regardless of how an individual purchases the policy (i.e., whether the policy is purchased inside or outside the state exchange from the carrier or an agent).

Insurers participating in the state exchanges would be required to provide payment for services furnishes 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.

Definition of Levels. The bronze benefit package, which would represent minimum creditable coverage (MCC), would be equal to the actuarial value of 65 percent with an out-of-pocket limit up to the Health Savings Account (HSA) current law limit ($5,950 for individuals and $11,900 for families in 2010) indexed to the per capita growth in premiums for the insured market as determined by the Secretary of HHS. The silver benefit package would have an actuarial value of 70 percent with the out-of-pocket limits for MCC. The gold benefit package would have an actuarial value of 80 percent with the out-of-pocket limits for MCC. The platinum benefit package would have an actuarial value of 90 percent with the out-of-pocket limits for MCC. A separate "young invincible" policy would be available for those 25 years or younger. This plan would be a catastrophic only policy in which the catastrophic coverage level would be set at the HSA current law limit, but prevention benefits would be exempt from the deductible.

For those between 100-200 percent of FPL, the benefit will include an out-of-pocket limit equal to one-third of the HSA current law limit. For those between 200-300 percent of FPL, the benefit will include an out-of-pocket limit equal to one-half of the HSA current law limit. And for those between 300-400 percent of the Federal poverty level, within the same actuarial value, the benefit will include an out-of-pocket limit equal to two-thirds of the HSA current law limit.

Small employers purchasing coverage through the exchange would be required to offer a plan with a deductible that does not exceed $2,000 for individuals and $4,000 for families, unless offering contributions through a health reimbursement account or some other mechanism that would offset a deductible above these limits. This deductible limit would not affect the actuarial value of the plan, including Bronze plans and does not apply to "young invincible" plans.

Stand-alone Dental Plans. 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 each 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 coverage 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 would be designed to ensure they do not total more than they would have otherwise been if they were combined.

State insurance commissioners are permitted to allow de minimus variation around the benefit target valuations to account for differences in actuarial estimates.

Health Care Affordability Tax Credits

Current Law

Currently there is no tax credit that is generally available to low or middle income individuals or families for the purchase of health insurance. Some individuals may be eligible for health coverage through state Medicaid programs which consider income, assets, and family circumstances. However, these Medicaid programs are not in the tax code.

Health Coverage Tax Credit. Certain individuals are eligible for the health coverage tax credit (HCTC). The HCTC is a refundable tax credit equal to 80 percent of the cost of qualified health coverage paid by an eligible individual. In general, eligible individuals are individuals who receive a trade adjustment allowance (and individuals who would be eligible to receive such an allowance but for the fact that they have not exhausted their regular unemployment benefits), individuals eligible for the alternative trade adjustment assistance program, and individuals over age 55 who receive pension benefits from the Pension Benefit Guaranty Corporation. The credit is available for "qualified health insurance," which includes certain employer-based insurance, certain State-based insurance, and in some cases, insurance purchased in the individual market. The credit is available on an advance basis through a program established and administered by the Treasury Department. The credit generally is delivered as follows: the eligible individual sends his or her portion of the premium to the Treasury, and the Treasury then pays the full premium (the individual's portion and the amount of the refundable tax credit) to the insurer. Alternatively, an eligible individual is also permitted to pay the entire premium during the year and claim the credit on his or her income tax return.

Individuals entitled to Medicare and certain other governmental health programs, covered under certain employer-subsidized health plans, or with certain other specified health coverage are not eligible for the credit.

COBRA Continuation Coverage Premium Reduction. The Consolidated Omnibus Reconciliation Act of 1985 (COBRA, P.L. 99-272) requires that a group health plan must offer continuation coverage to qualified beneficiaries in the case of a qualifying event (such as a loss of employment). A plan may require payment of a premium for any period of continuation coverage. The amount of such premium generally may not exceed 102 percent of the "applicable premium" for such period and the premium must be payable, at the election of the payor, in monthly installments.

Section 3001 of the American Recovery and Reinvestment Act of 2009 (ARRA, P.L. 111-5) provides that, for a period not exceeding nine months, an assistance eligible individual is treated as having paid any premium required for COBRA continuation coverage under a group health plan if the individual pays 35 percent of the premium. Thus, if the assistance eligible individual pays 35 percent of the premium, the group health plan must treat the individual as having paid the full premium required for COBRA continuation coverage, and the individual is entitled to a subsidy for 65 percent of the premium. An assistance eligible individual generally is any qualified beneficiary who elects COBRA continuation coverage and the qualifying event with respect to the covered employee for that qualified beneficiary is a loss of group health plan coverage on account of an involuntary termination of the covered employee's employment (for other than gross misconduct). In addition, the qualifying event must occur during the period beginning September 1, 2008, and ending December 31, 2009.

The low income tax credit also applies to temporary continuation coverage elected under the Federal Employees Health Benefits Program (FEHBP) and to continuation health coverage under State programs that provide coverage comparable to continuation coverage. The subsidy is generally delivered by requiring employers to pay the subsidized portion of the premium for assistance eligible individuals. The employer then treats the payment of the subsidized portion as a payment of employment taxes and offsets its employment tax liability by the amount of the low-income tax credit. To the extent that the aggregate amount of the subsidy for all assistance eligible individuals for which the employer is entitled to a credit for a quarter exceeds the employer's employment tax liability for the quarter, the employer can request a tax refund or can claim the credit against future employment tax liability.

There is an income limit on the entitlement to the low-income tax credit. Taxpayers with modified adjusted gross income exceeding $145,000 (or $290,000 for joint filers), must repay any subsidy received by them, their spouse, or their dependant, during the taxable year. For taxpayers with modified adjusted gross incomes between $125,000 and $145,000 (or $250,000 and $290,000 for joint filers), the amount of the subsidy that must be repaid is reduced proportionately. The subsidy is also conditioned on the individual not being eligible for certain other health coverage. To the extent that an eligible individual receives a subsidy during a taxable year to which the individual was not entitled due to income or being eligible for other health coverage, the subsidy overpayment is repaid on the individual's income tax return as additional tax. However, in contrast to the HCTC, the subsidy for COBRA continuation coverage may only be claimed through the employer and cannot be claimed at the end of the year on an individual tax return.

Chairman's Mark

Premium Credit. The Chairman's Mark would provide a refundable tax credit for eligible individuals and families who purchase health insurance through the state exchanges. The premium tax credit will subsidize the purchase of certain health insurance plans through the state exchanges and will be refundable and payable in advance directly to the insurer. The tax credit would be available for individuals (single or joint filers) with modified gross incomes (MGI) ~~Modified Adjusted Gross Incomes (MAGI)~~ up to 300 percent of the Federal poverty level (FPL). ~~MAGI would be defined as an individual's (or couple's) adjusted gross income (AGI) without regard to sections 911 (regarding the exclusion from gross income for citizen or residents living abroad), 931 (regarding the exclusion for residents of specified possessions), and 933 (regarding the exclusion for residents of Puerto Rico), plus any tax-exempt interest received during the tax year, plus any income of dependents listed on the return.~~ MGI would be defined as an individual's (or couple's) total income without regard to sections 911 (regarding the exclusion from gross income for citizen or residents living abroad), 931 (regarding the exclusion for residents of specified possessions), and 933 (regarding the exclusion for residents of Puerto Rico), plus any tax-exempt interest received during the tax year, plus the modified gross income of dependents listed on the return. In addition, under the modification, deductions from gross income that are allowed in determining adjusted gross income, such as the deduction for contributions to an individual retirement arrangement, would be disregarded.

Under the Mark, an eligible individual would enroll in a plan offered through a state exchange and would report his or her M~~A~~GI to the exchange. States are permitted to enter into contracts with state Medicaid agencies to make eligibility determinations for the credit. Based on the information provided to the state exchange, the individual would receive a premium credit based on income according to the schedule outlined below. The Treasury would pay the premium credit amount to the insurance plan in which the individual is enrolled. The individual would then pay to the plan in which he or she enrolled the dollar difference between the premium credit amount and the premium charged for the plan. Individuals who fail to pay all or part of the remaining premium amount would be given a mandatory three-month grace period prior to an involuntary termination of their participation in the plan. For employed individuals who purchase health insurance through a state exchange, the premium payments would be made through payroll deductions. Initial eligibility for the tax credit would be based on the individual's MAGI for the most recent tax year ending prior to the enrollment period. Individuals (or couples) who experience a change in marital status or other household circumstance, ~~or~~ experience a decrease in income of more than 20 percent, or receive unemployment insurance may update eligibility information or ~~can~~ request a redetermination of their tax credit eligibility.

For purposes of the tax credit, state exchange participants must provide information from their prior year tax return during the fall enrollment period for coverage during the next calendar year (e.g., tax return data on income in 2011 when applying in the fall of 2012 for subsidies to be received in 2013). The IRS is authorized to disclose to the exchange limited tax return information to verify a taxpayer's M~~A~~GI based on the most recent return information available. As described above, individuals who would not qualify for the tax credit on the basis of their prior year income may apply for the tax credit based on specified changes in circumstances. For individuals and families who have not filed a tax return in the prior tax year, the Secretary of

HHS would establish alternative income documentation that may be provided to determine income eligibility for the premium credit. In all cases, income eligibility will be reconciled annually on the individual's Federal income tax return, subject to a "safe harbor." Existing privacy and safeguard requirements would apply. For filers whose current income is less than 300 percent of FPL — and who received a tax credit in excess of the level for which they qualified — the "safe harbor" limits the amount that the taxpayer would have to repay to $250 for single filers and $400 for joint filers (and for those filing as the head of household). For filers whose current income exceeds 300 percent of FPL, however, no safe harbor would apply and they must repay any tax credit received.

Beginning in 2013, tax credits would be available on a sliding scale basis for individuals and families between 134-300 percent of FPL to help offset the cost of private health insurance premiums. Beginning in 2014, the credits are also available to individuals and families between 100-133 percent of FPL. However, individuals subject to a five-year waiting period under Medicaid or CHIP are eligible for the tax credit beginning in 2013. The credits would be based on the percentage of income the cost of premiums represents, rising from two ~~three~~ percent of income for those at 100 percent of poverty to 12~~13~~ percent of income for those at 300 percent of poverty. Individuals between 300-400 percent of FPL would be eligible for a premium credit based on capping an individual's share of the premium at a flat 12~~13~~ percent of income. For purposes of calculating household size, illegal immigrants will not be included in FPL. Liability for premiums would be capped at 12~~13~~ percent of income for the purchase of a silver plan. The share of premium enrollees pay would be held constant over time. The premium credit amount would be tied to the second lowest-cost silver plan in the area where the individual resides (by age according to standard age factors defined by the Secretary of Health and Human Services) plan.

Eligibility Verification. In order to prevent illegal immigrants from accessing the state exchanges or obtaining federal health care tax credits, the Chairman's Mark requires verification of the following personal data. Name, social security number, and date of birth will be verified with Social Security Administration (SSA) data. For individuals claiming to be U.S. citizens, if the claim of citizenship is consistent with SSA data then the claim will be considered substantiated. For individuals who do not claim to be U.S. citizens but claim to be lawfully present in the United States, if the claim of lawful presence is consistent with Department of Homeland Security (DHS) data then the claim will be considered substantiated. Individuals whose status is expected to expire in less than a year are not allowed to obtain the tax credit. Individuals whose claims of citizenship or lawful status cannot be verified with federal data must be allowed substantial opportunity to provide documentation or correct federal data related to their case that supports their contention.

Information Provided to the Exchange. All personal information submitted to the state exchange can only be used for purposes of providing insurance coverage through the state exchange, eligibility for and determination of the amount of the health care tax credit, or other administrative functions related to the efficient operation of the state exchange. Appropriate penalties will apply to the use of fraudulent information or stolen identity information in the state exchange. Such a penalty would apply to individuals accessing the exchange as well as at the

exchange and federal entity level. The penalty may also include a penalty applicable to someone who applies on behalf of an individual and supplies false information or documentation.

Cost-sharing Subsidy. A cost-sharing subsidy would be designed to buyout any difference in cost sharing between the insurance purchased and the actuarial values specified below. For individuals between 100-150 percent of FPL, the subsidy brings the value of the plan to 90 percent actuarial value. For those between 150-200 percent of FPL, the subsidy brings the value of the plan to 80 percent actuarial value. For individuals above 200 percent of FPL, no subsidy for cost sharing is provided. The amount received by an insurer in cost-sharing subsidy on behalf of an individual, as well as any spending by the individual out-of-pocket, counts towards the out-of-pocket limit. As with the premium credit, the IRS is authorized to disclose to the state exchange limited tax return information to verify a taxpayer's M~~A~~GI based on the most recent return information available.

Small Business Tax Credit

Current Law

The Code does not provide a tax credit for employers that provide health coverage for their employees. The cost to an employer of providing health coverage for its employees is generally deductible as an ordinary and necessary business expense for employee compensation.[20] In addition, the value of employer provided health insurance is not subject to employer paid Federal Insurance Contributions Act (FICA) tax.

The Code generally provides that employees are not taxed on the value of employer-provided health coverage under an accident or health plan. That is, these benefits are excluded from gross income. In addition, medical care provided under an accident or health plan for employees, their spouses, and their dependents is excluded from gross income. Active employees participating in a cafeteria plan may be able to pay their share of premiums on a pre-tax basis through salary reduction.[21] Such salary reduction contributions are treated as employer contributions and thus also are excluded from gross income.

Chairman's Mark

Small Employers Eligible for the Credit. The Chairman's Mark would provide a tax credit for a qualified small employer for contributions to purchase health insurance for its employees. A qualified small employer for this purpose generally would be an employer with no more than 25 fulltime equivalent employees (FTEs) employed during the employer's taxable year, and whose employees have annual fulltime equivalent wages that average no more than $40,000. However, the full amount of the credit would be available only to an employer with ten or fewer FTEs and whose employees have average annual fulltime equivalent wages from the employer of less than $20,000. These wage limits are indexed to CPI-U for years beginning in 2014. Under the Mark, an employer's FTEs would be calculated by dividing the total hours worked by all employees

[20] Sec. 162 of Code. However see special rules in section 419 and 419A for the deductibility of contributions to welfare benefit plans with respect to medical benefits for employees and their dependents.

[21] Sec. 125.

during the employer's tax year by 2080. For this purpose, the maximum amount of hours that would be counted for any single employee would be 2080. Wages would be defined the same as for purposes of FICA and the average wage would be determined by dividing the total wages paid by the small employer by the number of FTEs. Hours worked and wages earned by seasonal workers would be exempt from these calculations for purposes of determining eligibility for the small business tax credit. 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 of 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.

The credit would only be available to offset actual tax liability and would be claimed on the employer's tax return. The credit would not be payable in advance to the taxpayer or refundable. Thus, the employer would pay the employees' premiums during the year and claim the credit only at the end of the year on its income tax return. The credit would be a general business credit, and can be carried back for one year and carried forward for 20 years. The credit would be available for tax liability under the alternative minimum tax.

Years the Credit is Available. Phase I. Under the Mark, the credit would initially be available for a maximum of two taxable years for any qualified small business offering health insurance. Health insurance coverage for Phase I would be health insurance coverage within the meaning of Code section 9832 which is generally health insurance coverage purchased from an insurance company licensed under State law. This initial phase of the credit would be available for tax years 2011 and 2012.

Phase II. Beginning with taxable years ending after December 31, 2012, the credit would only be available for a small employer that purchases health insurance coverage for its employees through the state exchange. If a State has not yet adopted the reformed rating rules, qualifying small employers in the state would not be eligible to receive the credit. The credit would be available for the first two years that a qualified small employer purchases health insurance coverage for its employees through the state exchange. This would apply to qualified small employers.

Calculation of Credit Amount. Phase I. The credit would be equal to the applicable percentage of the small employer's contribution to the health insurance premium for each covered employee. Only non-elective contributions by the employer are taken into account in calculating the credit. Therefore, any amount contributed pursuant to a salary reduction arrangement under a cafeteria plan within the meaning of section 125 would not be treated as an employer contribution for purposes of this credit. The credit would be equal to the dollar amount of the employer's contribution multiplied by an applicable percentage. The first step in determining the applicable percentage would be to calculate the employer's contribution as a percentage of the lesser of (1) the total premium for an employee's coverage or (2) a small business bench mark premium. This tax credit would only be available if this percentage is at least 50. If the percentage is at least 50, the applicable percentage would be 35. The bench mark premium would be the average total premium cost in the small group market for employer sponsored coverage in the employer's State. The premium and the benchmark premium would vary based on the type of coverage being provided to the employee (i.e., single, adult with child, family or two adults).

Phase II. The credit would be equal to the applicable percentage of the small employer's contribution to the health insurance premium for each covered employee. Only non-elective contributions by the employer are taken into account in calculating the credit. Therefore, any amount contributed pursuant to a salary reduction arrangement under a cafeteria plan within the meaning of section 125 would not be treated as an employer contribution for purposes of this credit. The credit would be equal to the dollar amount of the employer's contribution multiplied by an applicable percentage. The first step in determining the applicable percentage would be to calculate the employer's contribution as a percentage of the lesser of (1) the total premium for an employee's coverage or (2) a small business bench mark premium. This tax credit would only be available if this percentage is at least 50. If the percentage is at least 50, the applicable percentage would be 50. The bench mark premium would be the average total premium cost in the small group market for employer sponsored coverage in the employer's State. The premium and the benchmark premium would vary based on the type of coverage being provided to the employee (i.e., single, adult with child, family or two adults).

For both the Phase I and Phase II credits, the employer would be entitled to a deduction under section 162 equal to the amount of the employer contribution minus the dollar amount of the credit. For example, if a qualified small employer pays 100 percent of the cost of its employees' health insurance coverage and the tax credit under this provision is 50 percent of that cost, the employer would be able to claim a section 162 deduction for the other 50 percent of the premium cost.

The credit would be phased out for employers with more than ten FTEs but not more than 25 FTEs by six percent of the base credit percentage for each employee above ten. Simultaneously, the credit would phase out for an employer for whom the average wages per employee is between $20,000 and $40,000 at a rate of five percent for each $1,000 increase of average wages above $20,000.

The employer would be determined by applying the employer aggregations rules in section 414(b), (c), and (m). In addition, the definition of employee would include a leased employee within the meaning of section 414(n).[22]

Organizations exempt from tax under section 501(a) by reason of being described in section 501(c)(3) (i.e., charitable organizations) that would otherwise qualify for the small business tax credit are eligible to receive the credit. However, for tax exempt organizations, the applicable percentage for the credit during Phase I is limited to 25 and the applicable percentage for the credit during Phase II is limited to 35. The small business tax credit is otherwise calculated in the same manner for tax exempt organizations that are qualified small employers as the tax credit

[22] Section 414(b) provides that, for specified employee benefit purposes, all employees of all corporations which are members of a controlled group of corporations are treated as employed by a single employer. There is a similar rule in section 414(c) under which all employees of trades or businesses (whether or not incorporated) which are under common are treated under regulations as employed by a single employer, and, in section 414(m), under which employees of an affiliated service group (as defined in that section) are treated as employed by a single employer. Section 414(n) provides that leased employees, as defined in that section, are treated as employees of the service recipient for specified purposes. Section 414(o) authorizes the Treasury to issue regulations to prevent avoidance of the certain requirement under section 414(m) and 414(n).

is calculated for all other qualified small employers. Charitable organizations will be eligible to apply the tax credit against the organization's liability as an employer for payroll taxes for the taxable year to the extent of the amount of income tax withheld from its employees under section 3401(a), the amount of hospital insurance tax withheld from its employees under section 3101(b), and the amount of the hospital tax imposed on the organization under section 3111(b). However, the charitable organization will not be eligible for a credit in excess of the amount of these payroll taxes.

Self employed individuals, including partners and sole proprietors, two percent share-holders of an S Corporation, and five percent owners of a C Corporation would not be treated as employees for purposes of this credit. There will also be a special rule for sole proprietorships to prevent them from receiving the credit for the owner and their family members. Thus, no credit would be available for contribution to the purchase of health insurance for these individuals and the individual would not be taken into account in determining the number of employees or the average full time equivalent wages.

Effective Date

The effective date for this subtitle is ~~January 1, 2013~~ July 1, 2013 unless otherwise indicated.

Application of State and Federal Laws Regarding Abortion

Current Law

The performance of and payment for abortions is regulated by both state and Federal laws. State law, for example, sometimes prescribes parental notification, waiting periods and other procedural requirements before an abortion may be performed. Under Federal law, certain kinds of Federal funds may not be used to pay for abortions and certain recipients of Federal funds may not discriminate against specified health care entities that perform or refuse to perform, pay for, provide referrals for, or provide training for abortions.

Chairman's Mark

This provision would ensure that state laws regarding the prohibition or requirement of coverage or funding for abortions, and state laws involving abortion-related procedural requirements are not preempted. The provision similarly provides that Federal conscience protections and abortion-related antidiscrimination laws would not be affected by the bill. The rights and obligations of employees and employers under Title VII of the Civil Rights Act of 1964 would also not be affected by the bill. In addition, this bill does not affect state or Federal laws, including section 1867 of the Social Security Act (EMTALA), requiring health care providers to provide emergency services.

Abortion Coverage Prohibited as Part of Minimum Benefits Package

Current Law

Currently, Federal funds may be used to pay for abortions only if a pregnancy is the result of an act of rape or incest, or where a woman suffers from a physical disorder, physical injury, or physical illness that would place the woman in danger of death unless an abortion is performed. However, many private insurance plans include coverage for abortion beyond these limited categories.

Chairman's Mark

This provision provides that abortion cannot be a mandated benefit as part of a minimum benefits package ~~except in those cases for which Federal funds appropriated for the Department of Health and Human Services are permitted~~. A qualified health plan would not be prohibited, however, from providing coverage for abortions beyond those for which Federal funds appropriated for the Department of Health and Human Services are permitted. Federal funds continue to be prohibited from being used to pay for abortions unless the pregnancy is due to rape, incest, or if the life of the mother is in danger.

Required Segregation of Public Funds

Current Law

No provision.

Chairman's Mark

No tax credit or cost-sharing credits may be used to pay for abortions beyond those permitted by the most recent appropriation for the Department of Health and Human Services. In addition, insurers participating in any state-based exchange that offer coverage for abortion beyond those permitted by the most recent appropriation for the Department of Health and Human Services must segregate from any premium and cost-sharing credits an amount of each enrollee's private premium dollars that is determined to be sufficient to cover the provision of those services.

The Secretary shall also establish a process using an estimated actuarial value by which insurers that provide coverage for abortions beyond those permitted by the most recent appropriation for the Department of Health and Human Services must demonstrate that no federal premium and cost-sharing credits are used for the purpose of paying for such abortions.

Actuarial Value of Optional Service Coverage

Current Law

No provision.

Chairman's Mark

The Secretary would be required to estimate, on an average actuarial basis, the basic per enrollee, per month cost of including coverage of abortions beyond those permitted by the most recent appropriation for the Department of Health and Human Services under a basic plan. In making such estimate, the Secretary may take into account the impact of including such coverage on overall costs, but may not consider any cost reduction estimated to result from providing such abortions, such as prenatal care. In making the estimate, the Secretary would also be required to estimate the costs as if coverage were included for the entire covered population, but the costs could not be estimated at less than $1 per enrollee, per month.

Rules Regarding Coverage of and Tax Credits for Specified Services

Current Law

No provision.

Chairman's Mark

The Secretary would ensure that in each state exchange, at least one plan provides coverage of abortions beyond those for which Federal funds appropriated for the Department of Health and Human Services are permitted. The Secretary would also ensure that in each state exchange, at least one plan does not provide coverage of abortions beyond those for which Federal funds appropriated for the Department of Health and Human Services are permitted.

No Discrimination on the Basis of Provision of Abortion

Current Law

Federal conscience clause laws prohibit recipients of certain Federal funds from discriminating against certain medical personnel and health care entities for engaging in or refusing to engage in specified activities related to abortion.

Chairman's Mark

Health benefits plans participating in state exchanges would be prohibited from discriminating against any individual health care provider or health care facility because of its willingness or unwillingness to provide, pay for, provide coverage of, or refer for abortions.

SUBTITLE D—SHARED RESPONSIBILITY

Personal Responsibility Requirement

Current Law

Federal law does not require individuals to have health insurance. Only Massachusetts, through its statewide program requires that individuals have health insurance (although this policy has been considered in other states, such as California, Maryland, Maine, and Washington). All adult residents of Massachusetts are required to have health insurance that meets "minimum creditable coverage" standards if it is deemed "affordable" at their income level under a schedule set by the board of the Massachusetts Connector. Individuals report their insurance status on state income tax forms. Individuals can file hardship exemptions from the mandate; persons for whom there are no affordable insurance options available are not subject to the requirement for insurance coverage.

Under Massachusetts law, for taxable year 2007, an individual without insurance and who was not exempt from the requirement did not qualify for a State income tax personal exemption. For taxable years beginning on or after January 1, 2008, a penalty is levied for each month an individual is without insurance. The penalty consists of an amount up to 50 percent of the lowest premium available to the individual through the Connector. The penalty is reported and paid by the individual with the individual's Massachusetts State income tax return at the same time and in the same manner as State income taxes. Failure to pay the penalty results in the same interest and penalties as apply to unpaid income tax.

Chairman's Mark

Personal Responsibility Requirement. Beginning in 2013, all U.S. citizens and legal residents would be required to purchase coverage through (1) the individual market, a public program such as Medicare, Medicaid, the Children's Health Insurance Program, Veteran's Health Care Program, or TRICARE or through an employer (or as a dependent of a covered employee) in the small group market, meeting at least the requirements of a bronze plan, or (2) in the large group market, in a plan with first dollar coverage for prevention-related services ~~as recommended by the U.S. Preventive Services Task Force~~ – except in cases where value-based insurance design is used and cannot have an unreasonable annual or lifetime limit coverage or a maximum out-of-pocket limit greater than that provided by the standards established for HSA current law limit in order to meet minimum creditable coverage. Exemptions from the requirement to have health coverage would be allowed for religious objections that are consistent with those allowed under Medicare, and for undocumented aliens. An individual enrolled in a grandfathered plan would be deemed to have met the responsibility requirement.

In order to ensure compliance, individuals would be required to report on their Federal income tax return the months for which they maintain the required minimum health coverage for themselves and all dependents under age 18. In addition to this self-attestation by individuals of qualified coverage, insurers (including employers who self-insure and therefore act as insurers), must report information on health insurance coverage information to both the covered individual

and to the Internal Revenue Service. This information includes months of coverage in the tax year and individuals covered on the policy and may include other relevant information. A similar reporting requirement would apply to employers with respect to individuals enrolled in group health plans if the reporting is not provided by the insurer (for example in the case of self-insured plans) and for those enrolled in public health insurance plans.

Open Enrollment in the Individual Market. An initial open-enrollment period for eligible individuals in the individual and small-group market (excluding grandfathered plans) would be from March 1, 2013 through May 31, 2013 ~~September 1, 2012 through November 30, 2012~~. For every year thereafter, the open enrollment period would be from October 15 through November 30. Special enrollment periods would be allowed for qualifying events, consistent with those included in the Public Health Service Act (PHSA), such as when an individual becomes a dependent through marriage or birth, or when an individual loses other health insurance coverage. There may be additional special enrollment periods allowed, consistent with those allowed under Medicare Part D (for example, special enrollment periods may be allowed for exceptional circumstances as determined by the Secretary of Health and Human Services). During the annual open enrollment period (October 15- November 30 of each year) individuals could change plans, or remain in their current plan.

Excise Tax. The consequence for not maintaining insurance would be an excise tax of $750 per adult in the household. This per adult penalty would be phased in as follows: For 2013, $0; $200 for 2014; $400 for 2015; $600 in 2016 and $750 in 2017. ~~If a taxpayer's MAGI is between 100-300 percent of FPL, the excise tax for failing to obtain coverage for an individual in a taxpayer unit (either as a taxpayer or an individual claimed as a dependent) is $750 per year. However, the maximum penalty for the taxpayer unit is $1,500. If a taxpayer's MAGI is above 300 percent of FPL the penalty for failing to obtain coverage for an individual in a taxpayer unit (either as a taxpayer or as an individual claimed as a dependent) is $950 year. However, the maximum penalty amount a family above 300 percent of FPL would pay is $3,800.~~

The excise tax would apply for any period for which the individual is not covered by a health insurance plan with the minimum required benefit but would be prorated for partial years of noncompliance. The excise tax would be assessed through the tax code and applied as an additional amount of Federal tax owed. No excise tax will be assessed for individuals not maintaining health insurance for a period less than or equal to three months in the tax year. However, assessed excise taxes for those not insured for more than three months include the entire duration the individual was uninsured during the tax year.

Non-compliance with the individual responsibility to have health coverage 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.

Exemptions from the excise tax will be made for individuals where the full premium of the lowest cost option available to them (net of subsidies and employer contribution, if any) exceeds eight ~~ten~~ percent of their AGI. Available policies are defined as an employer policy in the case of an individual who works for an employer who offers coverage and an individual policy in the

case of an individual who does not have access to an employer sponsored plan. These individuals could purchase the "young invincibles" policy regardless of age. Exemptions from the excise tax will also be made for individuals below 100 percent of FPL, any health arrangement provided by established religious organizations comprised of individuals with sincerely held beliefs (e.g., such as those participating in Health Sharing Ministries), those experiencing hardship situations (as determined by the Secretary of Health and Human Services) and an individual who is an Indian as defined in Sec. 4 of the Indian Health Care Improvement Act. Additionally, in 2013, individuals at or below 133 percent of FPL will be exempt from the excise tax. When making these determinations, income from individuals not subject to the mandate should not be considered.

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 than 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 ten hours of debate in the Senate.

Auto Enrollment. Employers with 200 or more employees must automatically enroll employees into health insurance plans offered by the employer. Employees may opt out of employer coverage, however, if they are able to demonstrate that they have coverage from another source (e.g., through a public program such as Medicare, Medicaid or the Children's Health Insurance Program or as a dependent in a spouse or other family member's health benefits).

Additionally, states will have the option to establish a process for auto-enrollment of individuals and families into policies offered in the individual and small group markets. State programs for auto enrollment must be approved by the Secretary of HHS.

Employer-Provided Health Insurance Coverage

Current Law

Currently, there is no Federal requirement that employers offer health insurance coverage to employees or their families. However, as with other compensation, the cost of employer provided health coverage is a deductible business expense under section 162 of the Code. In addition, employer-provided health insurance coverage is generally not included in an employee's gross income.

Employees participating in a cafeteria plan may be able to pay the portion of premiums for health insurance coverage not otherwise paid for by their employers on a pre-tax basis through salary

reduction.[23] Such salary reduction contributions are treated as employer contributions for purposes of the Code, and are thus excluded from gross income.

The Employee Retirement Income Security Act of 1974 (ERISA, P.L. 93-406) preempts State law relating to certain employee benefit plans, including employer-sponsored health plans. While ERISA specifically provides that its preemption rule does not exempt or relieve any person from any State law which regulates insurance, ERISA also provides that an employee benefit plan is not deemed to be engaged in the business of insurance for purposes of any State law regulating insurance companies or insurance contracts. As a result of this ERISA preemption, self-insured employer-sponsored health plans need not provide benefits that are mandated under State insurance law.

While ERISA does not require an employer to offer health benefits, it does require compliance if an employer chooses to offer health benefits, such as compliance with plan fiduciary standards, reporting and disclosure requirements, and procedures for appealing denied benefit claims. ERISA was amended (as well as the Public Health Service Act and the Internal Revenue Code) in the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA, P.L. 99-272) and the Health Insurance Portability and Accountability Act of 1996 (HIPAA, P.L. 104-191), adding other Federal requirements for health plans, including rules for health care continuation coverage, limitations on exclusions from coverage based on pre-existing conditions, and a few benefit requirements such as minimum hospital stay requirements for mothers following the birth of a child.

The Code imposes an excise tax on group health plans that fail to meet HIPAA and COBRA requirements. The excise tax generally is equal to $100 per day per failure during the period of noncompliance and is imposed on the employer sponsoring the plan.

Under Medicaid, states may establish "premium assistance" programs, which pay a Medicaid beneficiary's share of premiums for employer-sponsored health coverage. Besides being available to the beneficiary through his or her employer, the coverage must be comprehensive and cost-effective for the State. An individual's enrollment in an employer plan is considered cost-effective if paying the premiums, deductibles, coinsurance and other cost-sharing obligations of the employer plan is less expensive than the State's expected cost of directly providing Medicaid-covered services. States are also required to provide coverage for those Medicaid-covered services that are not included in the private plans. A 2007 analysis showed that 12 states had Medicaid premium assistance programs as authorized under current law.

Chairman's Mark

Employer Offer of Health Insurance Coverage. Under the Chairman's Mark as under current law, an employer would not be required to offer health insurance coverage. If an employee is offered health insurance coverage by his or her employer and chooses to enroll in the coverage, the exclusion from gross income would apply to the employer provided portion of the coverage. The tax treatment would be the same whether the employer offers coverage outside of a state exchange or the employer offers a coverage option through a state exchange.

[23] Sec. 125.

As a general matter, if an employee is offered employer-provided health insurance coverage, the individual would be ineligible for a low income premium tax credit for health insurance purchased through a state exchange. An employee who is offered coverage that does not have an actuarial value of at least 65 percent or who is offered unaffordable coverage by their employer, however, can be eligible for the tax credit. Unaffordable is defined as 10 ~~13~~ percent of the employee's income. This income limit is indexed to the per capita growth in premiums for the insured market as determined by the Secretary of HHS. For purposes of determining if coverage is unaffordable, salary reduction contributions would be treated as payments by the ~~employer~~employee. The employee would seek an affordability waiver from the state exchange and would have to demonstrate family income and the premium of the lowest cost employer option offered to them. ~~Employees~~ The state exchange would then ~~present~~ provide the waiver to the employer. The employer assessment would apply for any employee(s) receiving an affordability waiver. Within five years of implementation, the Secretary must conduct a study to determine if the definition of affordable could be lowered without significantly increasing costs or decreasing employer coverage.

A Medicaid-eligible individual can always choose to leave the employer's coverage and enroll in Medicaid. In this circumstance, the employer is not required to pay a fee.

Required Payments for Employees Receiving Premium Credits. All employers with more than 50 employees that do not offer coverage would be required to pay a fee for each employee who receives a tax credit for health insurance through a state exchange. The number of employees shall be accounted from the most recent year using the COBRA definition of employee that applies for purposes of determining if an employer is eligible for the small employer exception from continuation coverage.[24]

For each full time employee (defined as working 30 hours or more each week) enrolled in a state exchange and receiving a tax credit, the employer would be required to pay a flat dollar amount set by the Secretary of HHS and published in a schedule each year. The flat dollar amount would be equal to the national average tax credit. ~~The flat dollar amount would be equal to the average tax credit in the state exchanges.~~ These payments would not be linked to the individual, but would be contributed to a general fund. The assessment is capped for all employers at an amount equal to $400 multiplied by the total number of employees at the firm (regardless of how many are receiving the state exchange credit).

The employer would pay the lesser of the flat dollar amount multiplied by the number of fulltime employees receiving a tax credit or a fee of $400 per employee paid on its total number of fulltime employees.

For example, Employer A, who does not offer health coverage, has 100 employees, 30 of whom receive a tax credit for enrolling in a state exchange offered plan. If the flat dollar amount set by the Secretary of HHS for that year is $3,000, Employer A should owe $90,000. Since the maximum amount an employer must pay per year is limited to $400 multiplied by the total

[24] Treas. Reg. 54.4980B-3, Q&A 2.

number of employees (for Employer A, 100), however, Employer A must pay only $40,000 (the lesser of the $40,000 maximum and the $90,000 calculated fee).

The fees assessed under this section of the Chairman's Mark for employees receiving premium credits would not be deductible for U.S. income tax purposes.

The Secretary of Labor shall review and report to Congress the effect of fees and assessments included in this section 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.

Effective Date

The effective date for this subtitle is ~~January 1, 2013~~ July 1, 2013 unless otherwise indicated.

SUBTITLE E—CREATION OF HEALTH CARE COOPERATIVES

Current Law

Taxation of Insurance Companies

Taxation of Stock and Mutual Companies Providing Health Insurance. Present law provides special rules for determining the taxable income of insurance companies (subchapter L of the Code). Both mutual insurance companies and stock insurance companies are subject to Federal income tax under these rules. Separate sets of rules apply to life insurance companies and to property and casualty insurance companies. Insurance companies are subject to Federal income tax at regular corporate income tax rates.

An insurance company that provides health insurance is subject to Federal income tax as either a life insurance company or as a property insurance company, depending on its mix of lines of business and on the resulting portion of its reserves that are treated as life insurance reserves. For Federal income tax purposes, an insurance company is treated as a life insurance company if the sum of its (1) life insurance reserves and (2) unearned premiums and unpaid losses on

noncancellable life, accident or health contracts not included in life insurance reserves, comprise more than 50 percent of its total reserves.[25]

Life Insurance Companies. A life insurance company, whether stock or mutual, is taxed at regular corporate rates on its life insurance company taxable income (LICTI). LICTI is life insurance gross income reduced by life insurance deductions.[26] An alternative tax applies if a company has a net capital gain for the taxable year, if such tax is less than the tax that would otherwise apply. Life insurance gross income is the sum of: (1) premiums; (2) decreases in reserves; and (3) other amounts generally includible by a taxpayer in gross income. Methods for determining reserves for Federal income tax purposes generally are based on reserves prescribed by the National Association of Insurance Commissioners for purposes of financial reporting under State regulatory rules.

Because deductible reserves might be viewed as being funded proportionately out of taxable and tax-exempt income, the net increase and net decrease in reserves are computed by reducing the ending balance of the reserve items by a portion of tax-exempt interest (known as a proration rule).[27] Similarly, a life insurance company is allowed a dividends-received deduction for intercorporate dividends from nonaffiliates only in proportion to the company's share of such dividends.[28]

Property and Casualty Insurance Companies. The taxable income of a property and casualty insurance company is determined as the sum of the amount earned from underwriting income and from investment income (as well as gains and other income items), reduced by allowable deductions.[29] For this purpose, underwriting income and investment income are computed on the basis of the underwriting and investment exhibit of the annual statement approved by the National Association of Insurance Commissioners. [30]

Underwriting income means premiums earned during the taxable year less losses incurred and expenses incurred.[31] Losses incurred include certain unpaid losses (reported losses that have not been paid, estimates of losses incurred but not reported, resisted claims, and unpaid loss adjustment expenses). Present law limits the deduction for unpaid losses to the amount of discounted unpaid losses, which are discounted using prescribed discount periods and a

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[25] Sec. 816(a).

[26] Sec. 801.

[27] Sec. 807(b)(2)(B) and (b)(1)(B).

[28] Secs. 805(a)(4), 812. Fully deductible dividends from affiliates are excluded from the application of this proration formula (so long as such dividends are not themselves distributions from tax-exempt interest or from dividend income that would not be fully deductible if received directly by the taxpayer). In addition, the proration rule includes in prorated amounts the increase for the taxable year in policy cash values of life insurance policies and annuity and endowment contracts owned by the company (the inside buildup on which is not taxed).

[29] Sec. 832.

[30] Sec. 832(b)(1)(A).

[31] Sec. 832(b)(3). In determining premiums earned, the company deducts from gross premiums the increase in unearned premiums for the year (sec. 832(b)(4)(B)). The company is required to reduce the deduction for increases in unearned premiums by 20 percent, reflecting the matching of deferred expenses to deferred income.

prescribed interest rate, to take account partially of the time value of money.[32] Any net decrease in the amount of unpaid losses results in income inclusion, and the amount included is computed on a discounted basis.

In calculating its reserve for losses incurred, a proration rule requires that a property and casualty insurance company must reduce the amount of losses incurred by 15 percent of: (1) the insurer's tax-exempt interest; (2) the deductible portion of dividends received (with special rules for dividends from affiliates); and (3) the increase for the taxable year in the cash value of life insurance, endowment, or annuity contracts the company owns (sec. 832(b)(5)). This rule reflects the fact that reserves are generally funded in part from tax-exempt interest, from wholly or partially deductible dividends, or from other untaxed amounts.

Tax Exemption for Certain Organizations

In General. Section 501(a) generally provides for exemption from Federal income tax for certain organizations. These organizations include: (1) qualified pension, profit sharing, and stock bonus plans described in section 401(a); (2) religious and apostolic organizations described in section 501(d); and (3) organizations described in section 501(c). Sections 501(c) describes 28 different categories of exempt organizations, including: charitable organizations (section 501(c)(3)); social welfare organizations (section 501(c)(4)); labor, agricultural, and horticultural organizations (section 501(c)(5)); professional associations (section 501(c)(6); and social clubs (section 501(c)(7)).[33]

Insurance Organizations Described in Section 501(c). Organizations described in section 501(c) and exempt from tax under section 501(a) also include certain organizations that engage in insurance activities. Section 501(c)(8), for example, describes certain fraternal beneficiary societies, orders, or associations operating under the lodge system or for the exclusive benefit of their members that provide for the payment of life, sick, accident, or other benefits to the members or their dependents. Section 501(c)(9) describes certain voluntary employees' beneficiary societies that provide for the payment of life, sick, accident, or other benefits to the members of the association or their dependents or designated beneficiaries. Section

[32] Sec. 846.

[33] Certain organizations that operate on a cooperative basis are taxed under special rules set forth in Subchapter T of the Code. In general, the two principal criteria for determining whether an entity is operating on a cooperative basis are: (1) ownership of the cooperative by persons who patronize the cooperative (e.g., the farmer members of a cooperative formed to market the farmers' produce); and (2) return of earnings to patrons in proportion to their patronage. In general, cooperative members are those who participate in the management of the cooperative and who share in patronage capital. For Federal income tax purposes, a cooperative that is taxed under the Subchapter T rules generally computes its income as if it were a taxable corporation, with one exception -- the cooperative may deduct from its taxable income distributions of patronage dividends. In general, patronage dividends are the profits of the cooperative that are rebated to its patrons pursuant to a pre-existing obligation of the cooperative to do so. Certain farmers' cooperatives described in section 521 are authorized to deduct not only patronage dividends from patronage sources, but also dividends on capital stock and certain distributions to patrons from nonpatronage sources.

Separate from the Subchapter T rules, the Code provides tax exemption for certain cooperatives. Section 501(c)(12), for example, provides that certain rural electric and telephone cooperative are exempt from tax under section 501(a), provided that 85 percent or more of the cooperative's income consists of amounts collected from members for the sole purpose of meeting losses or expenses, and certain other requirements are met.

501(c)(12)(A) describes certain benevolent life insurance associations of a purely local character. Section 501(c)(15) describes certain small non-life insurance companies with annual gross receipts of no more than $600,000 ($150,000 in the case of a mutual insurance company). Section 501(c)(26) describes certain membership organizations established to provide health insurance to certain high-risk individuals.[34] Section 501(c)(27) describes certain organizations established to provide workmen's compensation insurance.

Certain Section 501(c)(3) Organizations. Certain health maintenance organizations (HMOs) have been held to qualify for tax exemption as charitable organizations described in section 501(c)(3). In *Sound Health Association v. Commissioner*,[35] the Tax Court held that a staff model HMO qualified as a charitable organization. A staff model HMO generally employs its own physicians and staff and serves its subscribers at its own facilities. The court concluded that the HMO satisfied the section 501(c)(3) community benefit standard, as its membership was open to almost all members of the community. Although membership was limited to persons who had the money to pay the fixed premiums, the court held that this was not disqualifying, because the HMO had a subsidized premium program for persons of lesser means to be funded through donations and Medicare and Medicaid payments. The HMO also operated an emergency room open to all persons regardless of income. The court rejected the government's contention that the HMO conferred primarily a private benefit to its subscribers, stating that when the potential membership is such a broad segment of the community, benefit to the membership is benefit to the community.

In *Geisinger Health Plan v. Commissioner*,[36] the court applied the section 501(c)(3) community benefit standard to an individual practice association (IPA) model HMO. In the IPA model, health care generally is provided by physicians practicing independently in their own offices, with the IPA usually contracting on behalf of the physicians with the HMO. Reversing a Tax Court decision, the court held that the HMO did not qualify as charitable, because the community benefit standard requires that an HMO be an actual provider of health care rather than merely an arranger or deliverer of health care, which is how the court viewed the IPA model in that case.

More recently, in *IHC Health Plans, Inc. v. Commissioner*,[37] the court ruled that three affiliated HMOs did not operate primarily for the benefit of the community they served. The organizations in the case did not provide health care directly, but provided group insurance that could be used at both affiliated and non-affiliated providers. The court found that the organizations primarily performed a risk-bearing function and provided virtually no free or below-cost health care services. In denying charitable status, the court held that a health-care provider must make its

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[34] When section 501(c)(26) was enacted in 1996, the House Ways and Means Committee, in reporting out the bill, stated as its reasons for change: "The Committee believes that eliminating the uncertainty concerning the eligibility of certain State health insurance risk pools for tax-exempt status will assist States in providing medical care coverage for their uninsured high-risk residents." H.R. Rep. 104-496, Part I, "Health Coverage Availability and Affordability Act of 1996," 104th Cong., 2d Sess., March 25, 1996, 124. *See also* Joint Committee on Taxation, *General Explanation of Tax Legislation Enacted in the 104th Congress*, JCS-12-96, December 18, 1996, 351.

[35] 71 T.C. 158 (1978), *acq.* 1981-2 C.B. 2.

[36] 985 F.2d 1210 (3rd Cir. 1993), *rev'g* T.C. Memo. 1991-649.

[37] 325 F.3d 1188 (10th Cir. 2003).

services available to all in the community plus provide additional community or public benefits.[38] The benefit must either further the function of government-funded institutions or provide a service that would not likely be provided within the community but for the subsidy. Further, the additional public benefit conferred must be sufficient to give rise to a strong inference that the public benefit is the primary purpose for which the organization operates.[39]

Certain Organizations Providing Commercial -Type Insurance. Section 501(m) provides that an organization may not be exempt from tax under section 501(c)(3) (generally, charitable organizations) or section 501(c)(4) (social welfare organizations) unless no substantial part of its activities consists of providing commercial-type insurance. For this purpose, commercial-type insurance excludes, among other things: (1) insurance provided at substantially below cost to a class of charitable recipients, and (2) incidental health insurance provided by an HMO of a kind customarily provided by such organizations.

When section 501(m) was enacted in 1986, the following reasons for the provision were stated: "The committee is concerned that exempt charitable and social welfare organizations that engaged in insurance activities are engaged in an activity whose nature and scope is so inherently commercial that tax exempt status is inappropriate. The committee believes that the tax-exempt status of organizations engaged in insurance activities provides an unfair competitive advantage to these organizations. The committee further believes that the provision of insurance to the general public at a price sufficient to cover the costs of insurance generally constitutes an activity that is commercial. In addition, the availability of tax-exempt status . . . has allowed some large insurance entities to compete directly with commercial insurance companies. For example, the Blue Cross/Blue Shield organizations historically have been treated as tax-exempt organizations described in sections 501(c)(3) or (4). This group of organizations is now among the largest health care insurers in the United States. Other tax-exempt charitable and social welfare organizations engaged in insurance activities also have a competitive advantage over commercial insurers who do not have tax-exempt status. . . ."[40]

Unrelated Business Income Tax. Most organizations that are exempt from tax under section 501(a) are subject to the unrelated business income tax rules of sections 511 through 515. The unrelated business income tax generally applies to income derived from a trade or business regularly carried on by the organization that is not substantially related to the performance of the organization's tax-exempt functions. Certain types of income are specifically exempt from the unrelated business income tax, such as dividends, interest, royalties, and certain rents, unless derived from debt-financed property or from certain 50 percent controlled subsidiaries.

Chairman's Mark

The Chairman's Mark authorizes $6 billion in funding the Consumer Operated and Oriented Plan (CO-OP) program to foster the creation of non-profit, member-run health insurance companies

[38] *Id.* at 1198.

[39] *Id.*

[40] H.R. Rep. 99-426, "Tax Reform Act of 1985," Report of the Committee on Ways and Means, 99th Cong., 1st Sess., December 7, 1985, 664. *See also* Joint Committee on Taxation, *General Explanation of the Tax Reform Act of 1986*, JCS-10-87, May 4, 1987, 584.

that serve individuals in one or more states. CO-OP grantees would compete in the reformed individual and small group insurance markets on a level-playing field with other plans. Federal funds would be distributed as loans and grants. Loans would be provided to assist with start-up costs, and grants would be provided to meet state solvency requirements.

In order to be eligible for Federal funds under the CO-OP program, an organization must meet the following requirements.

1. It must be organized as a non-profit, member corporation under State law.

2. It must not be an existing organization that provides insurance as of July 16, 2009, and must not be an affiliate or successor of any such organization.

3. Its governing documents incorporate ethics and conflict of interest standards protecting against insurance industry involvement and interference.

4. It must not be sponsored by a State, county, or local government, or any government instrumentality.

5. Substantially all of its activities must consist of the issuance of qualified health benefit plans in the individual and small group markets in each State in which it is licensed to issue such plans.

6. Governance of the organization must be subject to a majority vote of its members (i.e., beneficiaries).

7. As provided in regulations promulgated by the Secretary of Health and Human Services (HHS), it must be required to operate with a strong consumer focus, including timeliness, responsiveness, and accountability to members.

8. Any profits made would be required to be used to lower premiums, improve benefits, or for other programs intended to improve the quality of health care delivered to members.

Organizations participating in the CO-OP program would be permitted to enter into collective purchasing arrangements for services and items that increase administrative and other cost efficiencies, especially to facilitate start-up of the entities, including claims administration, administrative services, health information technology, and actuarial services. A purchasing council may be established to execute these collective purchasing agreements. The council shall be explicitly prohibited from setting payment rates for health care facilities and providers. There shall be no representatives of Federal, state, or local government or any employee or affiliate of an existing private insurer on the council. The council would be subject to existing anti-trust statutes.

Grant and loan awards will be made by the Secretary of HHS. Recommendations to the Secretary of HHS will be made by an advisory board chaired by the Secretary of HHS or his or her delegate ~~and the other members appointed by the Majority Leader of the Senate (four members), the Minority Leader of the Senate (three members), the Speaker of the House of Representatives (three members) and the Minority Leader of the House of Representatives (three~~

~~members)~~. Board members must be appointed within three months of enactment and must satisfy ethics and conflict of interest standards protecting against insurance industry involvement and interference. Priority in awarding grants will be given to statewide proposals, integrated care models, and applications with significant private support. In making awards, the Secretary of HHS, in consultation with the advisory board, shall ensure there is sufficient funding for at least one co-op in all 50 States and the District of Columbia. Multiple awards per state are allowed. The Secretary shall not begin distribution of funds any later than January 1, 2012. The board will sunset upon completion of their duties, but no later than December 31, 2015.

In the event that organizations participating in the CO-OP program do not form in every state, the Secretary of HHS shall be authorized to use planning grants to encourage formation of new organizations or expansion of organizations currently participating in the CO-OP program.

An organization receiving a grant or loan under the CO-OP program qualifies for exemption from Federal income tax under section 501(a) of the Code with respect to periods for which the organization is in compliance with the requirements of the CO-OP program and with the terms of any CO-OP grant or loan agreement to which such organization is a party. Such organizations would also be subject to organizational and operational requirements applicable to certain section 501(c) organizations, including the prohibitions on inurement and political activities, restriction on lobbying activities, taxation of excess benefit transactions, and taxation of unrelated business taxable income under section 511.

If a CO-OP grantee violates the terms of the CO-OP program or the requirements of its grant or loan agreement and fails to correct the violation within a reasonable period of time, the organization will be required to repay the aggregate amount of grants and loans received under the CO-OP program, plus interest. The Secretary of HHS shall inform the Secretary of the Treasury in the event of a CO-OP grantee's noncompliance. The Secretary of Treasury shall levy a termination tax of ten percent of the aggregate grant and loan amount on a CO-OP grantee in the event that Federal seed money is forfeited.

CO-OP grantees would be required to file an application for exempt status with the IRS and would subject to annual information reporting requirements. In addition, CO-OP grantees would be required to disclose on their annual information return the amount of reserves required by each state in which it operates ("solvency requirement") and the amount of reserves on hand.

In making grant awards, the Secretary must ensure that no Federal funds may be used by CO-OP plans for marketing or to lobby Congress. States in which CO-OPs operate must further ensure that CO-OP plans meet state solvency standards and comply with the state laws impacting other health insurers.

Effective Date

The effective date for this subtitle is the date of enactment, but no CO-OP can operate until a state has implemented individual and small group insurance market reforms required under this Act.

SUBTITLE F—TRANSPARENCY AND ACCOUNTABILITY

Ombudsman Program

Current Law

No provision.

Chairman's Mark

In 2010, states would be required to establish an ombudsman office to act as a consumer advocate for those with private coverage in the individual and small group markets. Policyholders whose health insurers have rejected claims and who have exhausted internal appeals, whose internal appeal process has exceeded three months, and whose appeal involves a life-threatening issue, would be able to access the ombudsman office for assistance. Policyholders would also be able to access ombudsman services for assistance in resolving problems with premium credits and cost-sharing subsidies and with assistance in filing appeals as needed once the state exchanges are implemented.

Health Insurance Consumer Assistance Grants

Current Law

No provision.

Chairman's Mark

Authorizes $30 million (and such sums as necessary after these dollars are expended) to establish a new competitive grant program to support consumer assistance organizations in each state. Grantee organizations would assist consumers in solving problems and navigating health insurance coverage transitions, as well as collect data on consumer encounters, and report to HHS on types of problems and inquiries.

Grantee organizations may include Small Business Development Centers (SBDCs) as well as commercial fishing organizations, ranching and farming organizations, and other organizations capable of conducting community based health care outreach and enrollment assistance for hard to reach and rural workers.

Informed Consumer Choices

Current Law

No Provision.

Chairman's Mark

In implementing the state exchanges, the Secretary would be required to do the following:

- Develop standard definitions for common insurance terms including premium, deductible, co-insurance, co-payment, out-of-pocket limit, preferred provider, non-preferred provider, out-of-network co-payments, UCR (usual, customary and reasonable) fees, excluded services, grievance and appeals, and such other terms as the Secretary determines.

- Develop standard definitions for medical terms including hospitalization, hospital outpatient care, emergency room care, physician services, prescription drug coverage, durable medical equipment, home health care, skilled nursing care, rehabilitation services, hospice services, emergency medical transportation, and such other terms as the Secretary determines.

- Develop several scenarios (for example, Breast Cancer) which include information that must be provided by every insurance carrier offering coverage in the individual and small group markets in describing their plans to consumers. This label should include information regarding at minimum estimated out-of-pocket cost-sharing and significant exclusions or benefit limits for such scenarios.

- Develop standards for an annual personalized statement that summarizes an individuals' use of health care services and claims paid in the previous year.

Transparency

Current Law

No provision.

Chairman's Mark

Beginning in 2010, to ensure transparency and accountability, health plans would be required to report the proportion of premium dollars that are spent on items other than medical care. Also, beginning in 2010, hospitals would be required to list standard charges for all services and Medicare DRGs.

Standardization

Current Law

No provision.

Chairman's Mark

In order to provide uniform, meaningful and actionable information to consumers concerning health insurance coverage, this provision mandates the development and utilization of uniform

outline of coverage documents. The Secretary of Health and Human Services shall request the National Association of Insurance Commissioners (referred to as the `NAIC') to develop, and submit to the Secretary not later than 12 months after the date of enactment of this Act, standards for use by health insurance issuers in compiling and providing to enrollees an outline of coverage that accurately describes the coverage under the applicable health insurance plan.

In developing such standards, the NAIC shall consult with a working group composed of representatives of consumer advocacy organizations, issuers of health insurance plans, and other qualified individuals. The goal is to achieve a common presentation for similar provisions.

The standards shall ensure that the outline of coverage is presented in a uniform format that does not exceed four pages in length and does not include print smaller than 12-point font. The standards shall ensure that the language used is presented in a manner determined to be understandable by the average health plan enrollee. The standards shall also ensure that the outline of coverage includes uniform definitions of standard insurance terms as well as a description of the coverage, including dollar amount for the following benefits: daily hospital room and board, miscellaneous hospital services, surgical services, anesthesia services, physician services, prevention and wellness services, prescription drugs, other benefits, as identified by the NAIC.

The standards should also ensure that the outline of coverage includes the exceptions, reductions and limitations on coverage; the cost-sharing provisions, including deductible, coinsurance and co-payment obligations; the renewability and continuation of coverage provisions; a statement that the outline is a summary of the policy or certificate and that the coverage document itself should be consulted to determine the governing contractual provisions; and a contact number for the consumer to call with additional questions and a web link where a copy of the actual individual coverage policy or group certificate of coverage can be reviewed and obtained. For individual policies issued prior to January 1, 2000, the health insurance issuer will be deemed compliant with the web link requirement if the issuer makes a copy of the actual policy available upon request.

If, not later than 12 months after the date of enactment of this Act, the NAIC submits to the Secretary the standards provided for, the Secretary shall, not later than 60 days after the date on which such standards are submitted, promulgate regulations to apply such standards to entities described below. If the NAIC fails to submit to the Secretary the standards within the 12-month period, the Secretary shall, not later than 90 days after the expiration of such 12-month period, promulgate regulations providing for the application of Federal standards for outlines of coverage to entities.

Not later than 24 months after enactment of legislation, each entity described below shall deliver an outline of coverage pursuant to the standards promulgated by the Secretary an applicant at the time of application; an enrollee at the time of enrollment; or a policyholder or certificate holder at the time of issuance of the policy or delivery of the certificate.

An entity described above is deemed in compliance with this section if the outline of coverage is provided in paper or electronic form. An entity includes a health insurance issuer (including a

group health plan) offering health insurance coverage within the United States (including carriers under the Federal Employee Health Benefits Program under chapter 89 of title 5, United States Code); and the Secretary with respect to coverage under the Medicare, Medicaid, and CHIP.

The standards promulgated under shall preempt any related State standards that require an outline of coverage. An entity that willfully fails to provide the information required under this section shall be subject to a fine of not more than $1,000 for each such failure. Such failure with respect to each enrollee shall constitute a separate offense for purposes of this subsection.

SUBTITLE G—ROLE OF PUBLIC PROGRAMS

PART I—MEDICAID COVERAGE FOR THE LOWEST INCOME POPULATIONS

Eligibility Standards and Methodologies

Current Law

Medicaid is a public health insurance program for low-income Americans. Eligibility for Medicaid is determined not only based on financial requirements, but also on categorical requirements – that is, to be eligible for Medicaid, one must be a member of a covered group, such as children, pregnant women, the aged, the blind, or the disabled. "Childless adults" (non-elderly adults who are not disabled, nor pregnant, nor parents of dependent children) on the other hand, are generally not eligible for Medicaid, regardless of their income. Parents are eligible for Medicaid if they would have been eligible for the former Federal cash welfare program Aid to Families with Dependent Children (AFDC) as of July 1, 1996. The upper-income threshold for AFDC eligibility in 1996 ranged across states from 11 percent to 68 percent of the Federal poverty level (FPL), although states have the flexibility to raise eligibility to higher levels (in some states, parents are eligible for Medicaid up to 200 percent of FPL) through a state plan amendment. States are required to make pregnant women and children five and under eligible for Medicaid up to at least 133 percent of FPL and six to18-year-olds up to 100 percent of FPL, but may go higher.

For some Medicaid eligibility groups, states are required to disregard certain amounts and/or types of income (and sometimes expenses, such as child care or health care costs). For some Medicaid eligibility groups, states have the flexibility to disregard additional amounts or types of income and expenses, effectively expanding eligibility to higher-income individuals. Because states must share in the costs of Medicaid, income eligibility expansions may depend on the availability of state financing.

As an alternative to providing all of the mandatory and selected optional benefits under traditional Medicaid, section 1937 of the Social Security Act, established in the Deficit Reduction Act of 2005 (DRA, P.L. 109-171), gives states the option to enroll state-specified groups in benchmark and benchmark-equivalent benefit plans when certain conditions are met. The benchmark options include the Blue Cross/Blue Shield preferred provider plan under the Federal Employees Health Benefits Program (FEHBP), a plan offered to state employees, the largest health maintenance organization (HMO) in the state, and other Secretary-approved

coverage appropriate for the targeted population. Certain groups are exempt from mandatory enrollment in benchmark or benchmark-equivalent plans, including pregnant women, blind or disabled individuals, dual eligibles, children in foster care, and other groups with special medical needs.

Benchmark-equivalent coverage under section 1937 must have the same actuarial value as one of the benchmark plans identified above. Such coverage includes: (1) inpatient and outpatient hospital services; (2) physician services; (3) lab and x-ray services; (4) well-child care, including immunizations; and (5) other appropriate preventive care (as designated by the Secretary). Such coverage must also include at least 75 percent of the actuarial value of coverage under the benchmark plan for: (1) prescribed drugs; (2) mental health services; (3) vision care; and (4) hearing services.

Chairman's Mark

The Chairman's Mark would create a new eligibility category for all non-elderly non-pregnant individuals (childless adults) otherwise ineligible for Medicaid. In 2011, states would have the option to cover childless adults through a state plan amendment (SPA). The Chairman's Mark would establish 133 percent of FPL as the new mandatory minimum Medicaid income eligibility level for all non-elderly individuals – parents, children, and childless adults – beginning on January 1, 2014. Existing law would not change for pregnant women. During 2013, individuals at or below 133 percent of FPL would not be subject to the requirement to obtain health insurance, nor would they be eligible for tax credits in the state exchanges.

States would be required to maintain existing income eligibility levels for all Medicaid populations upon enactment. This "maintenance of effort" provision would expire when the state exchange becomes fully operational (expected July 1, 2013~~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. 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 percent of the federal poverty level if the state certifies to the Secretary that the state is currently experiencing a budget deficit or projects to have a budget deficit in the following state fiscal year. The state may make such certification on or after December 1, 2010.

Effective January 1, 2014, income disregards would no longer apply, and income would be measured based on modified ~~adjusted~~ gross income (M~~A~~GI) as defined in the state exchanges. An exception to this rule would be made for the elderly and those groups that are eligible for Medicaid through another program, like foster children, low-income Medicare beneficiaries, and individuals receiving Supplemental Security Income (SSI), for whom existing income counting rules would continue to apply. Also, the change to MGI would not apply to beneficiaries who were enrolled in Medicaid on January 1, 2014 until the later of March 31, 2014 or their next redetermination date.~~Also, beneficiaries who were determined eligible prior to the change to MAGI will remain eligible until March 31, 2014 or their next redetermination date, whichever is later.~~

As part of the expansion, all newly-eligible, non-pregnant adults would receive a benchmark benefit package consistent with section 1937 of the Social Security Act. The benchmark and benchmark-equivalent packages would have to meet the requirements for minimum creditable coverage. For benchmark-equivalent plans, prescription drugs would be added to the list of benefits that must have the same actuarial value as the benchmark. Populations currently exempted from mandatory enrollment in section 1937 plans would remain exempted.

Beginning in 2014, individuals with income below 100 percent of FPL would be eligible for Medicaid and remain ineligible for tax credits in the state exchanges. Non-elderly, non-pregnant adults between 100 and 133 percent of FPL would be able to choose between Medicaid and coverage through their state exchange. States would have to ensure that all children of parents who choose the state exchange coverage would continue to receive the benefits, including early and periodic screening, diagnostic, and testing (EPSDT) benefits, to which children are entitled under Medicaid.

The Medicaid cost-sharing rules and out-of-pocket limit of five percent of family income would continue to apply to children. States would be able to provide Medicaid coverage to individuals with MGI above 133 percent of FPL through traditional Medicaid or in the form of supplemental wrap benefits. Individuals with MGI above 133 percent of FPL who receive only a benefit wrap from Medicaid may be eligible for tax credits in the state exchange.

The Chairman's Mark would require states to report on changes in Medicaid enrollment beginning in January 2015, and every year thereafter. States would be required to report on all new enrollment of: (1) parents, (2) childless adults, and (3) any other individuals, including those who were previously eligible. States would also be required to report on the outreach and enrollment processes they use to achieve such enrollment. The Secretary would be required to report to the relevant Committees of Congress beginning in April 2015, and every year thereafter, on total new enrollment in Medicaid, on a state-by-state basis and to include any recommendations to Congress for improving enrollment in Medicaid.

Medicaid Program Payments

Current Law

The Federal share for most Medicaid costs is determined by the Federal Medical Assistance Percentage (FMAP), which is based on a formula that provides higher reimbursement to states with lower per capita incomes relative to the national average (and vice versa). FMAPs have a statutory minimum of 50 percent and maximum of 83 percent.

Chairman's Mark

Under the Chairman's Mark, states would continue to receive Federal financial assistance as determined by FMAP. Beginning in 2014, additional Federal financial assistance would be provided to all states to defray the costs of covering newly-eligible beneficiaries. The Federal government would pay a greater share of the costs for individuals "newly eligible" for Medicaid based on the proposed eligibility changes. Newly eligible would be defined as (1) non-elderly,

non-pregnant individuals below 133 percent of FPL who were not previously eligible for a full or benchmark benefit package, or (2) who were eligible for such a package through a capped waiver but were not enrolled, including those on waiting lists, as of the date of enactment.

Those states that offer minimal or no coverage of the newly-eligible population currently would receive more assistance initially than those states that currently cover at least some non-elderly, non-pregnant individuals. Expansion states would be defined as states with coverage of parents and childless adults at or above 100 percent of FPL that is not based on employer or employment. Such coverage may be less comprehensive than Medicaid, but must be more than premium assistance, hospital-only benefits, or health savings accounts (HSA). Between 2014 and 2018, the additional assistance to expansion states and other states would be adjusted downward and upward, respectively, so that, in 2019, all states would receive the same level of additional assistance for covering newly eligibles.

The additional assistance would be provided through a percentage point increase in FMAP, according to the following schedule:

YEAR	EXPANSION STATE INCREASE	OTHER STATE INCREASE
2014	27.3	37.3
2015	28.3	36.3
2016	29.3	35.3
2017	30.3	34.3
2018	31.3	33.3
2019	32.3	32.3

The FMAP could not exceed 95 percent in any year as a result of the schedule above.

For any non-elderly, non-pregnant adult between 100 and 133 percent of FPL who chooses the state exchange in place of Medicaid, states would be required to pay an amount equal to the state's average cost of coverage for individuals in that same Medicaid eligibility category.

For services provided to existing eligibility groups, and under existing Medicaid waivers, the Federal and state governments would share in the costs as established under the FMAP formula.

The Chairman's Mark would provide additional assistance that would be made available to "high-need states," which are defined as states that (1) have total Medicaid enrollment that is below the national average for Medicaid enrollment as a percent of state population as of the date of enactment, and (2) had seasonally-adjusted unemployment rates of 12% or higher for August 2009. The additional assistance provided to such states would be full federal funding for the cost of providing medical assistance to newly eligible beneficiaries for the five-year period of 2014 through 2018.

Medicaid and Employer-Sponsored Insurance

Current Law

Under current Federal law, states can offer premium assistance to Medicaid-eligible individuals who are offered employer-sponsored insurance (ESI), rather than enrolling them in traditional Medicaid, if it is determined to be cost-effective and the benefits are comprehensive. A Medicaid beneficiary's enrollment in an employer health plan is considered cost-effective if paying the applicable premiums, deductible, coinsurance and other cost-sharing obligations of the employer plan is less expensive than the state's expected cost of providing Medicaid-covered services directly. To meet the comprehensiveness test under Medicaid, states are required to provide Medicaid covered services that are not included in private plans. In other words, they must provide "wrap-around" benefit coverage. It has proved difficult for many employer plans and states to meet all of these requirements. Most states operating Children's Health Insurance Program (CHIP) or Medicaid premium assistance programs are doing so under waivers that are less restrictive.

The recent CHIP Reauthorization Act (CHIPRA, P.L. 111-3) created a new state plan option for providing premium assistance for Medicaid and CHIP-eligible children and/or parents of Medicaid/CHIP children. For families that have access to ESI coverage that meets certain requirements – including that the employer pays at least 40 percent of the total premium – states can offer premium assistance through a state plan amendment. States choosing to do so are required to provide "wrap-around" benefit coverage for employer plans that do not meet CHIP benefit standards.

Chairman's Mark

Effective July 1, 2013~~January 1, 2013~~, the Chairman's Mark would require states to offer premium assistance and wrap-around benefits to Medicaid beneficiaries who are offered ESI if it is cost-effective to do so, consistent with current law requirements.

Treatment of the Territories

Current Law

Five territories (American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, and the U.S. Virgin Islands) operate Medicaid programs under rules that differ from those applicable to the 50 states and the District of Columbia (hereafter referred to as the states). The territories are not required to cover the same eligibility groups, and they use different financial standards (income and asset tests) in determining eligibility. For example, states must cover certain mandatory groups such as pregnant women, children, and qualified Medicare beneficiaries, but for the territories, these groups are optional.

In the states, Medicaid is an individual entitlement. In addition, there are no limits on Federal payments for Medicaid provided that the state contributes its share of the matching funds. In contrast, Medicaid programs in the territories are subject to annual Federal spending caps. All

five territories typically exhaust their caps prior to the end of the fiscal year. Once the cap is reached, the territories assume the full costs of Medicaid services or, in some instances, may suspend services or cease payments to providers until the next fiscal year.

The Federal share for most Medicaid service costs is determined by the Federal Medical Assistance Percentage (FMAP), which is based on a formula that provides higher reimbursement to states with lower per capita incomes relative to the national average (and vice versa). FMAPs have a statutory minimum of 50 percent and maximum of 83 percent. The FMAP for territories is set at 50 percent.

Chairman's Mark

The Chairman's Mark would increase spending caps for the territories by 30 percent and the applicable FMAP by five percentage points – to 55 percent – beginning on January 1, 2011. The cost of covering newly eligibles would not count towards the spending caps.

Medicaid Improvement Fund

Current Law

The 2008 Supplemental Appropriations Act (P.L. 110-252) established a Medicaid Improvement Fund to make funding available to the Secretary of HHS to improve the management of the Medicaid program by the Centers for Medicare & Medicaid Services (CMS), including oversight of contracts and contractors and evaluation of demonstration projects. Payments made for these activities were intended to be in addition to payments that would otherwise be made for such activities.

Chairman's Mark

The Chairman's Mark would rescind funds available in the Medicaid Improvement Fund for fiscal years 2014 through 2018 (which total $700 million).

PART II—CHILDREN'S HEALTH INSURANCE PROGRAM

Current Law

The Children's Health Insurance Program (CHIP) builds on Medicaid by providing health care coverage to low-income, uninsured children in families with income above Medicaid income standards. States may also extend CHIP to pregnant women when certain conditions are met. In designing their CHIP programs, states may choose to expand Medicaid, create a standalone program, or use a combined approach. As with Medicaid, states have the flexibility under CHIP to disregard amounts or types of income and expenses, effectively expanding eligibility to higher-income individuals. Federal appropriations are currently provided through FY2013.

In Medicaid, individuals under age 21 must be provided early and periodic screening, diagnostic, and treatment (EPSDT) services. This benefit is required for "categorically needy" beneficiaries

(the vast majority of Medicaid beneficiaries under age 21) and is optional for "medically needy" beneficiaries under age 21, but all states provide this benefit to the latter group. Through EPSDT, beneficiaries receive comprehensive screening and preventive services, including immunizations, and are guaranteed access to all Federally coverable services necessary to treat an identified problem or condition. Some CHIP programs include EPSDT benefits, but it is not a program requirement.

Like Medicaid, CHIP is a Federal-state program. For each dollar of state spending, the Federal government makes a matching payment drawn from CHIP allotments. A state's share of program spending for Medicaid is equal to 100 percent minus FMAP (described above). But for CHIP, the Federal share is higher – the enhanced FMAP for CHIP lowers the state's share of CHIP expenditures by 30 percent compared to the regular Medicaid FMAP.

Federal law permits states to impose premiums and service-related cost-sharing for some enrollees and some benefits under CHIP. States that cover CHIP-eligible children through their Medicaid programs must follow the nominal premium and cost-sharing rules applicable to Medicaid. Under these rules, the majority of such children are exempt. In general, premiums are prohibited except for children enrolled in Medicaid expansion programs with incomes above 150 percent of the Federal poverty level (FPL). Service-related cost-sharing for children enrolled in Medicaid expansion programs may vary by income level. Aggregate cost-sharing for all individuals is capped at five percent of family income.

Different cost-sharing limits apply in states that provide CHIP coverage through standalone (non-Medicaid) programs. For example, nominal premiums specified in Medicaid statute apply to children in families with income at or below 150 percent of FPL in standalone programs. Service-related cost-sharing is limited to the nominal amounts in Medicaid for the subgroup with income below 100 percent of FPL and slightly higher amounts are permitted for the subgroup with income between 100 and 150 percent of FPL. For children in families with income over 150 percent of FPL, cost-sharing can be applied in any amount, provided that cost-sharing for higher-income children is not less than cost-sharing for lower-income children and that does not exceed the out-of-pocket limit of five percent of family income.

Preventive services are exempt from all cost-sharing for all CHIP families regardless of income.

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.~~

~~The Chairman's Mark would require the Secretary to certify that (1) coverage in the state exchange is at least comparable to the level of benefits and cost-sharing in the state CHIP plan, and (2) state Medicaid agencies and plans offered through the state exchange have established adequate procedures to ensure access to the EPSDT wrap-around coverage and cost-sharing protections for eligible children prior to the transition to state exchange/EPSDT wrap-around coverage. If such a certification could not be made, the Chairman's Mark would extend the maintenance of effort provisions in Medicaid and CHIP in the Mark (as they relate to children) until such certification is made.~~

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

The Chairman's Mark 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 (P.L. 111-3) 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 current law 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.

PART III—IMPROVEMENTS TO MEDICAID

Enrollment Coordination with the State Exchange

Current Law

No provision.

Chairman's Mark

The Chairman's Mark would require states to establish a Medicaid enrollment website to promote seamless enrollment in Medicaid should a Medicaid eligible individual apply for tax credits through a state exchange website or vice versa. Such seamless enrollment should include systems to ensure a secure electronic interface sufficient to allow a determination of eligibility for the appropriate program.

The Chairman's Mark would further require the Secretary of HHS to issue guidance to states regarding standards and best practices to help improve enrollment of vulnerable populations in Medicaid and CHIP. Vulnerable populations include children, unaccompanied homeless youth, children and youth with special health care needs, pregnant women, racial and ethnic minorities, rural populations, victims of abuse or trauma, individuals with mental health or substance-related disorders, and individuals with HIV/AIDS.

Examples of methods that the Secretary should address in the guidance include: outstationing of eligibility workers, express lane eligibility, residency requirements, documentation of income and assets, presumptive eligibility, continuous eligibility, and automatic renewal. The Secretary should work with appropriate stakeholders, including the states and children's groups, to ensure that the guidance is developed and implemented effectively.

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.

The form can be filed on line, in person, by mail, or by telephone. The form can be filed with the Exchange, Medicaid, or CHIP. After the form has been satisfactory filed, the applicant, without any need to complete additional paperwork, receives notice of his or her eligibility for Medicaid, CHIP and tax credits.

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).

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.

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 entire into interagency agreements concerning data-sharing, consistent with saveguards of privacy and data integrity. Nothing in this 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 determined eligibility for Medicaid, CHIP, and tax credits for state residents, so long as that contract meets requirements promulgated by the Secretary of HHS (after consultation with the Secretary of 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 this legislation changes data sharing protections currently established within the Chairman's Mark.

Presumptive Eligibility

Current Law

Presumptive eligibility is a Medicaid option that allows states to enroll certain individuals (*e.g.*, children, pregnant women, and certain women with breast and cervical cancer) into Medicaid for a limited period of time before full Medicaid applications are filed and processed, based on a preliminary determination by a Medicaid provider of likely Medicaid eligibility. Presumptive eligibility begins on the date a qualified Medicaid provider determines that the applicant appears to meet eligibility criteria and ends on the earlier of (1) the date on which a formal determination is made regarding the individual's application for Medicaid, or (2) in the case of an individual who fails to apply for Medicaid following the presumptive eligibility determination, the last day of the month following the month in which presumptive eligibility begins. During periods of presumptive eligibility, children and certain women with breast and cervical cancer have access to the full Medicaid benefit package offered by states, while pregnant women have access to services related to pregnancy, complications of pregnancy, delivery and up to 60 days of postpartum care.

Chairman's Mark

Effective January 1, 2014, the Chairman's Mark would permit all hospitals that participate in Medicaid to make presumptive eligibility determinations, in addition to providers currently eligible to do so. Furthermore, the Mark would allow hospitals and other providers to make such

determinations for all Medicaid eligible populations, as long as the state agency verifies the hospital or provider is capable of doing so. The time period of presumptive eligibility would be consistent with current law. Current notification procedures would apply to all presumptive eligibility determinations. ~~States would decide the benefits covered during presumptive eligibility.~~

Waiver Transparency

Current Law

Section 1115 of the Social Security Act authorizes the Secretary to waive certain statutory requirements for conducting research and demonstration projects that further the goals of titles XIX (Medicaid) and XXI (CHIP). States submit proposals outlining the terms and conditions of the demonstration program to the Centers for Medicare & Medicaid Services (CMS) for approval prior to implementation.

In 1994, CMS issued program guidance that impacts the waiver approval process and includes the procedures states are expected to follow for public involvement in the development of a demonstration project. States were required to provide CMS a written description of their process for public involvement at the time their proposal was submitted.

Public involvement requirements for the waiver approval process continued through the early 2000s. In a letter to state Medicaid directors issued May 3, 2002, CMS listed examples of ways a state may meet requirements for public involvement (*e.g.*, public forums, legislative hearings, a website with information and a link for public comment).

States are required to submit a state plan describing the nature and scope of a state's Medicaid program to the Secretary of HHS for approval. The state plan must provide assurances that the program conforms to the requirements of Medicaid and to any other official program issuances (*e.g.*, rules, regulations, program guidance, etc.). After approval of the original state plan by the Secretary, any subsequent changes (*e.g.*, those required by new Federal or state statutes, rules, regulations, policy interpretations, guidance, court decisions, changes in the state's operation of the Medicaid program, etc.) must be submitted by the state to CMS in the form of a state plan amendment (SPA) so that the Secretary may determine whether the Medicaid state plan continues to meet Federal requirements. Federal regulations dictate the SPA approval process including requirements for gubernatorial review, CMS regional office review, disapproval of a SPA, and judicial review (i.e., after a state's failure to conform to Federal requirements). Federal law dictates time frames associated with the SPA review process, and requirements that the CMS Administrator must meet when notifying a state that CMS intends to withhold Federal matching payments for portions of the state plan that are out of compliance.

Chairman's Mark

The Chairman's Mark would impose statutory requirements regarding transparency in the development, implementation, and evaluation of Medicaid and CHIP section 1115 demonstration programs that impact eligibility, enrollment, benefits, cost-sharing, or financing. States would be

required to: (1) provide notice of the state's intent to develop and/or renew a section 1115 waiver and convene at least one meeting of the state's medical advisory board to discuss the impacts of the proposed changes; (2) publish for written comment a notice of the proposal that provides information on how the public can submit comments to the state and includes state projections and assumptions regarding the likely impact of the waiver; (3) post the waiver proposal on the state's Medicaid or CHIP website; and (4) convene open meetings over the course of the development of the proposal to discuss proposed changes. States could also be required to include information regarding the actions taken to meet the above-listed public notice requirements as a part of their waiver submission to CMS.

The Chairman's Mark would also impose additional transparency-related statutory requirements on the Secretary of HHS. The Secretary would be required to: (1) publish a *Federal Register* notice identifying monthly waiver submissions, approvals, denials, and information regarding methods by which comments on the waiver will be received from the public; (2) publish a copy of the proposed waiver to the CMS website; and (3) allow for, respond to, and make available public comments received about the proposal after it has been posted to the CMS website. Once approved, the Secretary would have to post waiver terms and conditions and related waiver approval documents, quarterly state-reported data and three-year evaluations to the CMS website. The Secretary would also be required to publish a *Federal Register* notice identifying monthly waiver approvals, denials, and returns to the state without action.

The Chairman's Mark would add transparency-related statutory requirements associated with the SPA approval process for proposals that limit benefits. States would have to: (1) provide notice of the state's intent to develop a SPA and convene at least one meeting of the state's medical advisory board to discuss the impacts of the changes requested in the proposed SPA; (2) publish a notice of the proposal that provides information on how the public can submit comments to the state and includes state projections and assumptions regarding the likely impact of the SPA; (3) post the SPA proposal on the state's Medicaid or CHIP website, and (4) convene at least one open meeting to discuss the proposed SPA. States would also be required to include information regarding the actions taken to meet the above-listed public notice requirements as a part of their SPA submission to CMS.

The Chairman's Mark would also impose additional transparency-related statutory requirements on the Secretary of HHS. The Secretary would be required to: (1) publish a *Federal Register* notice identifying monthly SPA submissions and information regarding methods by which comments on each SPA will be received from the public; (2) publish a copy of the proposed SPA to the CMS website; and (3) publish a *Federal Register* notice identifying monthly SPA approvals, denials, and returns to the state without action.

PART IV—MEDICAID SERVICES

Free-Standing Birth Centers

Current Law

Some Medicaid benefits are mandatory, but others are optional. Examples of optional benefits that are offered by many states include prescription drugs and skilled nursing facility services for individuals under age 21.

The Secretary has authority to modify Medicaid regulations in order to recognize free-standing birth centers for payment under Medicaid, however the Secretary has not exercised that authority.

Chairman's Mark

The Chairman's Mark would identify free-standing birthing centers as Medicaid providers.

Curative and Palliative Care for Children in Medicaid

Current Law

Currently, states have the option to offer hospice services under Medicaid. In states that offer hospice services, Medicaid beneficiaries who elect to receive such services must waive the right to all other services related to the individual's diagnosis of a terminal condition or illness, including treatment.

Chairman's Mark

The Chairman's Mark would allow children, as defined by the state, who are eligible for Medicaid, to receive hospice services without forgoing any other service to which the child is entitled under Medicaid.

Long Term Services and Supports

Current Law

A collaborative effort of the Administration on Aging (AoA) and the Centers for Medicare & Medicaid Services (CMS), the Aging and Disability Resource Center (ADRC) initiative provides grants to support states' efforts to streamline information and access to long term services and supports through funding from CMS Real Choice Systems Change grants and AoA title IV research and demonstration authority. The Older Americans Act Amendments of 2006 (OAAA, P.L. 109-365) allow for continued expansion by authorizing funds for ADRCs in all states. As of October 2008, approximately 175 ADRC pilot sites were operating in 42 states, the District of Columbia, and two territories.

Chairman's Mark

ADRC funding. The Chairman's Mark would allocate $10 million each fiscal year, beginning in FY2010 for five years to continue funding ADRCs.

Community First Choice Option. The Chairman's Mark would establish the Community First Choice Option, which would create a state plan option under section 1915 of the Social Security Act to provide community based attendant supports and services to individuals with disabilities who are Medicaid eligible and who require an institutional level of care. These services and supports include assistance to individuals with disabilities in accomplishing activities of daily living and health related tasks. States who choose the Community First Choice Option would be eligible for enhanced federal match rate of an additional six percentage points for reimbursable expenses in the program. The option would sunset after five years.

The Community First Choice Option also would require data collection to help determine how states are currently providing home and community based services, the cost of those services, and whether states are currently offering individuals with disabilities who otherwise qualify for institutional care under Medicaid the choice to instead receive home and community based services, as required by the U.S. Supreme Court in Olmstead v. L.C. (1999).

The Community First Choice Option would also modify the Money Follows the Person Rebalancing Demonstration to reduce the amount of time required for individuals to qualify for that program to 90 days.

Spousal Impoverishment. The Chairman's Mark would protect against spousal impoverishment in all Medicaid home and community based services programs by requiring states to apply the same spousal impoverishment rules currently provided to the spouses of nursing home residents in Medicaid. The provision would sunset after five years.

Home and Community Based Services. The Chairman's Mark would provide states that undertake structural reforms proven to increase nursing home diversions and access to home and community based services in their Medicaid programs a targeted increase in the federal medical assistance percentage (FMAP). The amount of the FMAP increase would be tied to the percentage of a state's long term services and supports that is offered through HCBS, with lower FMAP increases going to states that will need to make fewer reforms. States would be able to offer HCBS through a waiver or through a state plan amendment (SPA). States that choose a SPA would be able to include individuals with incomes up to 300 percent of the maximum Supplemental Security Income payment. Funding for the nursing home diversion program would be available for five years beginning in 2011.

Sense of the Senate. The Chairman's Mark would express the Sense of the Senate that this Congress should address long-term services and supports in a comprehensive way that guarantees elderly and disabled individuals the care they need. The Mark would further express the Sense of the Senate that long term services and supports should be made available in the community in addition to in institutions.

Money Follows the Person Rebalancing Demonstration

Current Law

Section 6071 of the Deficit Reduction Act of 2005 (DRA, P.L. 109-171) established the Money Follows the Person Rebalancing Demonstration. The program authorizes the Secretary of Health and Human Services (HHS) to award competitive grants with the following objectives: (1) increasing the use of home and community based, rather than institutional, services; (2) eliminating barriers that prevent or restrict the use of Medicaid funds to enable Medicaid-eligible individuals to receive support for appropriate and necessary long term care services in the settings of their choice; (3) increasing the ability of the Medicaid program to assure the provision of home and community based services to eligible individuals who choose to transition from an institutional to a community setting; and (4) ensuring that procedures are in place to provide quality assurance for eligible individuals receiving Medicaid home and community based services and to provide for continuous quality improvement in such services. Congress authorized $1.75 billion over five years (FY2007 through FY2011) for the demonstration.

Chairman's Mark

The Chairman's Mark would extend the Money Follows the Person Rebalancing Demonstration through September 30, 2016.

Family Planning Services

Current Law

States are permitted to provide family planning services under Medicaid only after a waiver has been filed and approved by the Secretary of HHS.

Chairman's Mark

The Chairman's Mark would add a new optional categorically-needy eligibility group to Medicaid. This new group would be comprised of (1) non-pregnant individuals with income up to the highest level applicable to pregnant women covered under the Medicaid or CHIP state plan, and (2) at state option, individuals eligible under the standards and processes of existing section 1115 waivers that provide family planning services and supplies. Benefits would be limited to family planning services and supplies (as per section 1905(a)(4)(C) of the Social Security Act) and would also include related medical diagnosis and treatment services.

The Chairman's Mark would also allow states to make a "presumptive eligibility" determination for individuals eligible for such services through the new optional eligibility group. That is, states may enroll such individuals for a limited period of time before completed Medicaid applications are filed and processed, based on a preliminary determination by Medicaid providers of likely Medicaid eligibility.

Under current law, such presumptive eligibility determinations can be made for children, pregnant women, and certain women with breast or cervical cancer. In addition, states would not be allowed to provide Medicaid coverage through benchmark or benchmark-equivalent plans, which are permissible alternatives to traditional Medicaid benefits, unless such coverage includes family planning services and supplies.

Added in the Modification or by Amendment at Markup

Definition of Medical Assistance. The Chairman's Mark would clarify the original intent of Congress that the term "medical assistance" as used in various sections of the Social Security Act encompasses both payment for services provided and the services themselves. The Chairman's Mark would amend section 1905(a) of the Social Security Act by inserting "or the care and services themselves, or both" before "(if provided in or after)".

The Chairman's Mark would establish a grant program to be used to fund operating expenses for school-based health centers (as defined in the Children's Health Insurance Program Reauthorization Act of 2009, P.L. 111-3). The Chairman's Mark would appropriate $100 million in FY 2010 and FY 2011, for a total of $200 million, to remain available until expended for such program. The Mark would prohibit the use of any such funds for any service that is not authorized or allowed by state or local law. The Secretary would be authorized to establish criteria and application procedures for the awarding of grants in this program. The Secretary would be directed to give preference in awarding grants to school-based health centers serving a large population of children eligible for Medicaid or CHIP.

Repayment of Medicaid Overpayment. The Mark would extend the 60 days that states have to repay the federal share of a Medicaid overpayment to one year. 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.

PART V—MEDICAID PRESCRIPTION DRUG COVERAGE

~~**Make Prescription Drugs a Mandatory Benefit**~~

~~*Current Law*~~

~~Historically, Medicaid eligibility has been divided into two basic classes, the "categorically needy" and the "medically needy." The two terms once distinguished between welfare-related (categorically needy) beneficiaries and those qualifying under special Medicaid rules that allow states to cover people whose incomes are too high to qualify for cash welfare support, but who nevertheless need help with medical bills (medically needy).~~

~~However, non-welfare groups have been added to the "categorically needy" list over the years. As a result, the terms categorically and medically needy are no longer especially meaningful in sorting out the various populations for whom mandatory or optional Medicaid coverage has been made available. However, the distinction remains important when considering certain benefits.~~

~~Some benefits are considered mandatory for categorically needy individuals, but they are optional for medically needy individuals. Other benefits are optional for both groups of beneficiaries. Some states provide optional benefits only to categorically needy individuals, while some states provide optional benefits to both groups, and still other states provide optional benefits to selected subcategories of the medically needy as well as to all categorically needy beneficiaries.~~

~~Under Medicaid, outpatient prescription drug coverage is an optional benefit, but all states have added prescription drug coverage to their Medicaid state plan. Thus, prescription drug coverage is one of the few optional Medicaid services provided by all states. When states add prescription drug coverage as a benefit, however, they must cover all categorically eligible beneficiaries, but coverage for other eligibility groups, like the medically needy, remains optional. In 2005, 33 states covered prescription drugs for medically needy individuals.~~

~~*Chairman's Mark*~~

~~The Chairman's Mark would make prescription drugs a mandatory benefit for the categorically and medically needy, effective January 1, 2014.~~

Change the Status of Some Excludable Drugs

Current Law

Federal Medicaid law excludes 11 drug classes, including barbiturates and benzodiazepines. States still may cover these and other excluded drugs, but they are subject to restriction. When Medicare Part D was implemented in January 2006, Medicare began covering prescription drugs for dual eligible individuals. Barbiturates and benzodiazepines were excluded from Part D as well as Medicaid. However, under the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA, P.L. 110-271), Medicare prescription drug plans and Medicare Advantage plans will be required to include benzodiazepines in their formularies for prescriptions dispensed on or after January 1, 2013. Barbiturates will also be required to be included in Medicare formularies for the indications of epilepsy, cancer, or chronic mental health disorder.

Chairman's Mark

The Chairman's Mark would remove smoking cessation drugs, barbiturates, and benzodiazepines from Medicaid's excluded drug list, effective January 1, 2014.

Increase the Brand-Name Drug Rebate Amount

Current Law

To sell their products in Medicaid, drug manufacturers must enter into rebate agreements with the Secretary of HHS. Under these agreements, drug manufacturers must provide Medicaid programs with rebates for the drugs dispensed to Medicaid beneficiaries, although Federal law

exempts selected purchases from Medicaid's rebate agreements. In 2005, 550 manufacturers were reported to participate in the Medicaid drug rebate program.

Under the Medicaid rebate agreements, drug makers must report two prices to the Centers for Medicare & Medicaid Services (CMS) for each outpatient drug (by dose, package size, and strength) covered by Medicaid. Drug manufacturers report: (1) the average manufacturer price (AMP), which is the average price that manufacturers receive for sales to the retail class of trade; and (2) the lowest transaction price, or "best price," that the manufacturer receives from sales to private buyers of the drug. AMP and best price serve as reference points for determining manufacturers' rebate obligations.

For the purpose of determining rebates, Medicaid distinguishes between two types of drugs: (1) single source drugs (generally, those still under patent) and innovator multiple source drugs (drugs originally marketed under a patent or original new drug application but for which generic alternatives now exists); and (2) all other, non-innovator, multiple source drugs.

Rebates for the first category of drugs – drugs still under patent or those once covered by patents – have two components: a basic rebate and an additional rebate. Medicaid's basic rebate is determined by the larger of either a comparison of a drug's quarterly AMP to the best price for the same period, or a flat percentage (15.1 percent) of the drug's quarterly AMP.

Drug manufacturers owe an additional rebate when their unit prices for individual products increase faster than inflation. A manufacturer's total per drug rebate amount is determined by adding together the basic and the additional rebates, and there is no limit on total rebate liability.

Chairman's Mark

The Chairman's Mark would increase the flat rebate percentage used to calculate Medicaid's basic rebate for outpatient brand name prescription drugs from 15.1 percent to 23.1 percent, except for clotting factors that receive a furnishing fee under section 1842(o)(5) of the Social Security Act and outpatient drugs that are approved by the Food and Drug Administration exclusively for pediatric indications, for which the basic rebate would increase to 17.1 percent.

Also, the Chairman's Mark would limit total rebate liability on an individual single source or innovator multiple source drug to 100 percent of AMP for that drug product.

Other features of the drug rebate program, such Medicaid's best price provision, would remain unchanged.

Increase the Generic Drug Rebate Amount

Current Law

Manufacturers of non-innovator drugs, which are typically referred to as generic drugs, are only subject to a basic rebate. The rebate on non-innovator, multiple source products is 11 percent of

the drug's quarterly AMP. There is no additional rebate due on excess price increases for these products.

Chairman's Mark

The Chairman's Mark would increase the rebate for non-innovator, multiple source drugs to 13 percent of AMP.

The Chairman's Mark would also require the Comptroller General to review state laws that have a negative impact on generic drug utilization in federal programs due to restrictions such as but not limited to limits on pharmacists' ability substitute a generic drug or carve-outs of certain classes of drugs from generic substitution.

Extend to and Collect Rebates on Behalf of Managed Care Organizations

Current Law

States use a variety of service delivery mechanisms to provide medical and related services to Medicaid beneficiaries. Service delivery mechanisms range from full-risk capitation agreements with managed care organizations (MCOs) to fee-for-service (FFS). Under full-risk capitation agreements, MCOs are paid a fixed amount for all the care Medicaid beneficiaries will need. MCOs are typically paid "per-member-per-month" (PMPM) fees to provide contracted services to enrolled beneficiaries. Under full risk-based arrangements, MCOs are responsible for incurred costs that exceed their PMPM payments. Full-risk contracts cover all medical and related services, including prescription drugs. Services provided to about 64 percent of Medicaid beneficiaries are paid for on a capitated or partially capitated basis. Approximately 38 percent of Medicaid beneficiaries, primarily children and non-disabled adults, receive services under full risk-based capitation contracts.

Drug manufacturers pay states rebates for Medicaid drug purchases, although certain purchases are excluded from the Medicaid drug rebates. Drug purchases excluded from the rebate agreements include drugs dispensed by Medicaid managed care organizations (when prescription drugs are included in the capitation agreement), inpatient drugs, and drugs dispensed in physicians' or dentists' offices. Some states exclude drug benefits from their Medicaid MCO contracts. In these cases, Medicaid managed care beneficiaries receive their prescribed drugs through the fee-for-service (FFS) delivery system, and states may claim manufacturer rebates for these purchases.

Chairman's Mark

Under the Chairman's Mark, brand name and generic prescription drug manufacturers would be required to pay rebates for beneficiaries who receive care under risk-based agreements similar to the way rebates are now required for FFS beneficiaries. Drug manufacturers would be required to pay the MCO rebates directly to states, as they do under FFS. The Mark would not prohibit MCOs from negotiating with manufacturers and wholesalers for rebates above Medicaid's statutory rebates.

Drugs purchased through the 340B Drug Discount Program would not be subject to the rebates collected on behalf of Medicaid MCOs.

Application of Rebates to New Formulations of Existing Drugs

Current Law

Currently, modifications to existing drugs – new dosages or formulations – are generally considered new products for purposes of reporting AMPs to CMS. As a result, drug makers can avoid incurring additional rebate obligations by making slight alterations to existing products, sometimes called line-extensions, while significantly increasing the price on these products. For example, manufacturers often develop extended-release formulations of existing products that are considered new products for the Medicaid rebate program. The extended-release formulations of these products receive a new higher base period AMP. With a higher base period AMP, drug manufacturers would not be subject to the additional rebate component of the total Medicaid rebate, since comparison of the quarterly AMP to an inflation-adjusted new baseline AMP typically would not result in much difference.

Chairman's Mark

The Chairman's Mark would treat new formulations of existing brand name drugs as if they were the original product for purposes of calculating Medicaid's additional drug rebate. When a new version of an existing drug is introduced, the additional rebate obligation for that new drug would be calculated on the original drug's baseline AMP, rather than a new baseline. However, new formulations of orphan drugs would be exempted, so the additional rebate obligation would continue to be calculated on a new baseline AMP.

Changes to Medicaid Payment for Prescription Drugs

Current Law

Medicaid requires the Secretary of HHS to establish upper limits on the Federal share of payments for prescription drug acquisition costs. These limits are intended to encourage substitution of lower-cost generic equivalents for more costly brand-name drugs. When applied to multiple source drugs, those limits are referred to as Federal upper payment limits (FULs). FULs apply to aggregate state expenditures for each drug. CMS calculates FULs and periodically publishes these prices. Under the Deficit Reduction Act of 2005 (DRA, P.L. 109-171), new FULs issued after January 2007 were to equal 250 percent of the average manufacturer price (AMP) of the least costly therapeutic equivalent (excluding prompt pay discounts). AMP is defined in statute to be the average price paid to the manufacturer by wholesalers for drugs distributed to the retail pharmacy class of trade. Manufacturers are required to report AMP to CMS. Current law allows the Secretary to contract for a survey of retail prices that represent a nationwide average of consumer prices for drugs, net of all discounts and rebates.

Chairman's Mark

The Chairman's Mark would change the FUL to no less than 175 percent of the weighted average (determined on the basis of utilization) of the most recent AMPs for pharmaceutically and therapeutically equivalent multiple source drugs available nationally through commercial pharmacies. The Mark also would clarify what transactions, discounts, and other price adjustments were included in the definition of AMP. Additionally, the Mark would clarify that retail survey prices do not include mail order and long term care pharmacies. The Mark also would expand the disclosure requirement to include monthly weighted average AMPs and retail survey prices.

PART VI—MEDICAID DISPROPORTIONATE SHARE PAYMENTS

Current Law

States pay disproportionate share (DSH) adjustments to hospitals serving a disproportionate share of low-income individuals and Medicaid beneficiaries.

Special rules apply to "low DSH states," comprised of states in which total DSH payments for FY2000 were less than three percent of the state's total Medicaid spending on benefits. DSH allotments for such states were raised for FY2004 through FY2008 to an amount that is 16 percent above the prior year's amount. For FY2009 forward, the allotment for low DSH states for each year will be equal to the prior year amount increased by the change in the CPI-U, as for all other states. States cannot obtain Federal matching payments for DSH that exceed the state's DSH allotment.

As a condition of receiving Federal Medicaid payments beginning FY2004, states are required to submit to the Secretary of HHS a detailed annual report and an independent certified audit on their DSH payments to hospitals.

States have flexibility in establishing the designation of DSH hospitals, but must include all hospitals meeting either of two minimum criteria: (1) a Medicaid inpatient utilization rate in excess of one standard deviation above the mean rate for the state, or (2) a low-income patient utilization rate of 25 percent. States may not include hospitals with a Medicaid utilization rate below one percent.

States also have flexibility in calculating DSH payment amounts to hospitals, but must pay DSH hospitals at least: (1) an amount calculated using the Medicare DSH payment methodology, or (2) an amount calculated using a payment methodology that increases each hospital's adjustment as the hospital's Medicaid inpatient utilization rate exceeds the statewide average. DSH hospital payments cannot exceed a hospital-specific cap, set at 100 percent of the costs of providing inpatient and outpatient services to Medicaid and uninsured patients, less payments received from Medicaid and uninsured patients for public hospitals.

Five states and the District of Columbia have used at least a portion of their DSH allotment to expand Medicaid eligibility through a section 1115 waiver.

Chairman's Mark

State DSH allotments would remain intact as under current law until a state trigger is tripped. The trigger would be tripped once a state's uninsured rate, as measured by the Census Bureau's American Community Survey, decreases by at least 50 percent, compared to an initial uninsured rate on the date of enactment. Once the trigger is tripped, state DSH allotments would be decreased by 50 percent. Low DSH state allotments would be decreased by 25 percent.

Each year thereafter, if the state's rate of uninsurance decreases further, the state's DSH allotment would be further reduced by a percentage equal to the product of the percentage ~~point~~ reduction in uninsurance and 35 percent. For low DSH states, the percentage ~~point~~ reduction would be multiplied by 17.5 percent. At no time in the future would a state's DSH allotment fall below 35 percent of the total allotment in 2012, adjusted for CPI-U growth.

Any portion of the state's DSH allotment that is currently being used to expand eligibility through a section 1115 waiver is exempt from such reductions.

PART VII—DUAL ELIGIBLES

Waiver Authority for Dual Eligible Demonstrations

Current Law

Some elderly individuals qualify for health insurance under both Medicare and Medicaid. In February 2009, it was estimated that 7.9 million individuals were dually eligible. These dual eligible individuals qualify for Medicare Part A and/or Parts B and D and, because they are elderly and have limited income and assets, are also eligible for Medicaid.

There are two types of dual eligibles, full- and partial-benefit. As of February 2009, there were approximately 6.3 million full-benefit beneficiaries (about 80 percent of all dual eligibles). Full-benefit duals receive Medicare and full Medicaid benefits. Medicaid pays Medicare premiums and cost-sharing and covers additional services not covered by Medicare, such as long term services and supports, dental services, vision care, and medical transportation. For partial-benefit duals, approximately 1.6 million beneficiaries (about 20 percent of all duals) in 2009, Medicaid pays Medicare premiums. Partial-benefit duals have full Medicare coverage, but do not have full Medicaid coverage.

Although dual eligibles represent small percentages of Medicare and Medicaid beneficiaries, they account for disproportionately large percentages of Medicare and Medicaid expenditures. In 2005, dual eligibles accounted for 46 percent of Medicaid expenditures and 25 percent of Medicare expenditures, yet they accounted for less than 20 percent of either program's beneficiaries.

For dual eligibles, Medicaid is always the payer of last resort. Thus, for benefits covered by both Medicare and Medicaid, Medicare is the primary payer, while Medicaid covers those costs in excess of Medicare coverage limits and services not covered by Medicare.

Under Medicaid, states may apply to the Secretary of HHS to waive some Medicaid requirements, to use Medicaid funds to target otherwise ineligible populations, or to use innovative methods for delivering or paying for Medicaid services. Section 1115 of the Social Security Act allows for the waiver of any provision of Medicaid law for demonstrations likely to assist in promoting the objectives of the program. Demonstration waivers have traditionally been granted for research purposes, like testing a program improvement (such as a new reimbursement methodology), and run for a limited period. Some demonstration waivers have been approved under both Medicaid and Medicare authorities. These Medicare and Medicaid demonstrations have mostly been statewide initiatives that have coordinated service delivery, benefit packages, and reimbursement for dual eligibles.

The Office of Management and Budget (OMB) reviews all section 1115 waivers and, since 1982, has required waivers to be budget neutral (there are no statutory requirements for determining budget neutrality). Section 1115 waivers do not have a set duration, but larger demonstrations might be extended to accommodate more startup time and more thorough evaluation.

Chairman's Mark

The Chairman's Mark would clarify that Medicaid demonstration authority for coordinating care for dual eligibles is as long as five years.

Federal Coordinated Health Care Office ~~**Office of Coordination for Dual Eligible Beneficiaries**~~

Current Law

No provision.

Chairman's Mark

~~To ensure that coordination for dual eligibles occurs, the Chairman's Mark would establish a new office within CMS, the Office of Coordination for Dual Eligible Beneficiaries (OCDEB). OCDEB would be responsible for identifying and leading agency efforts to align Medicare and Medicaid financing, administration, oversight rules, and policies for dual eligibles. The Director of OCDEB would report directly to the CMS Administrator. OCDEB would also be required to prepare annual reports that the Secretary of HHS would submit to Congress documenting dual eligible spending with separate subtotals for Medicare and Medicaid as well as dual eligibles' health outcomes and access to services by subtype of beneficiaries. OCDEB would include a statistically valid sample of indicators on the quality of care provided to dual eligibles. Further, OCDEB would coordinate benefits for "attainers" (Medicaid beneficiaries who turn age 65).~~

The Chairman's Mark would establish the Federal Coordinated Health Care Office (CHCO) within the Centers for Medicare & Medicaid Services (CMS) no later than March 1, 2010. The CHCO would report directly to the Administrator of CMS. The purpose of the CHCO would be to bring together officials of the Medicare and Medicaid programs at CMS to (1) more effectively integrate benefits under the Medicare and Medicaid programs, and (2) improve the coordination between the Federal and state governments for individuals eligible for benefits under both such programs in order to ensure that such individuals get full access to the items and services to which they are entitled. The goals of the CHCO would be:

(A) Providing dual eligible individuals full access to the benefits to which such individuals are entitled under the Medicare and Medicaid programs.
(B) Simplifying the processes for dual eligible individuals to access the items and services they are entitled to under the Medicare and Medicaid programs.
(C) Improving the quality of health care and long-term services for dual eligible individuals.
(D) Increasing beneficiary understanding of and satisfaction with coverage under the Medicare and Medicaid programs.
(E) Eliminating regulatory conflicts between rules under the Medicare and Medicaid programs.
(F) Improving care continuity and ensuring safe and effective care transitions.
(G) Eliminating cost-shifting between the Medicare and Medicaid programs and among related health care providers.
(H) Improving the quality of performance of providers of services and suppliers under the Medicare and Medicaid programs."

The Chairman's Mark would establish the specific responsibilities of the CHCO as follows:

(A) Providing states, specialized MA plans for special needs individuals (as defined in section 1859(b)(6) of the Social Security Act), physicians and other relevant entities or individuals with the education and tools necessary for developing programs that align benefits under the Medicare and Medicaid programs for dual eligible individuals.
(B) Supporting state efforts to coordinate and align acute care and long-term care services for dual eligible individuals with other items and services furnished under the Medicare program.
(C) Providing support for coordination of contracting and oversight by states and the CMS with respect to the integration of the Medicare and Medicaid programs in a manner that is supportive of the goals described above.

The Chairman's Mark would require the Secretary, as part of the budget transmitted under section 1105(a) of title 31, United States Code, to submit to Congress an annual report containing recommendations for legislation that would improve care coordination and benefits for dual eligible individuals.

PART VIII—MEDICAID QUALITY

Medicaid Quality Measures

Current Law

The Children's Health Insurance Program Reauthorization Act (CHIPRA, P.L. 111-3) included several provisions designed to improve the quality of care provided to children under Medicaid and the Children's Health Insurance Program (CHIP). The law directs the Secretary of HHS to develop child health quality measures, a standardized format for reporting information, and procedures to encourage states to voluntarily report on the quality of pediatric care in these two programs. Examples of these initiatives include: (1) grants and contracts to develop, test, update and disseminate evidence-based measures, (2) demonstrations to evaluate promising ideas for improving the quality of children's health care under Medicaid and CHIP, (3) a demonstration to develop a comprehensive and systematic model for reducing childhood obesity, and (4) a program to encourage the creation and dissemination of a model electronic health record format for children enrolled in these two programs. The Federal share of the costs associated with developing or modifying existing state data systems to store and report child health measures is based on the matching rate applicable to benefits (FMAP) rather than one of the typically lower matching rates applied to different types of administrative expenses.

CHIPRA also improved the availability of public information regarding enrollment of children in Medicaid and CHIP. Several reporting requirements are added to states' annual CHIP reports, including, for example, data on eligibility criteria, access to primary and specialty care, and data on premium assistance for employer-sponsored coverage. CHIPRA also required the Secretary to improve the timeliness of the enrollment and eligibility data for Medicaid and CHIP children contained in the Medicaid Statistical Information System (MSIS) based on annual state reported enrollment and claims data and maintained by CMS.

Chairman's Mark

Similar to the quality provisions enacted in CHIPRA, the Chairman's Mark would direct the Secretary of HHS, in consultation with the states, to develop an initial set of health care quality measures specific to adults who are eligible for Medicaid. The Mark would establish the Medicaid Quality Measurement Program which would expand upon existing quality measures, identify gaps in current quality measurement, establish priorities for the development and advancement of quality measures and consult with relevant stakeholders. The Secretary, along with states, would regularly report to Congress the progress made in identifying quality measures and implementing them in each state's Medicaid program. States would receive grant funding to support the development and reporting of quality measures.

Medicaid Reimbursement for Health Care Acquired Conditions

Current Law

Federal regulations require that Medicaid provider rates be sufficient to enlist enough providers so that covered benefits will be available to Medicaid beneficiaries at least to the same extent they are available to the general population in the same geographic area. Other Federal rules apply, particularly for inpatient facilities such as hospitals, nursing homes, Intermediate Care Facilities for the Mentally Retarded (ICF/MR), but in general states establish their own payment policies and rates for Medicaid providers.

The Deficit Reduction Act of 2005 (DRA, P.L. 109-171) authorized the Secretary to initiate a hospital acquired condition (HAC) program for Medicare. In creating the HAC program, the Secretary was to select conditions that: (1) are high cost, high volume, or both; (2) are identified as complicating conditions or major complicating conditions; and (3) are reasonably preventable through the application of evidenced-based guidelines. The Centers for Medicare & Medicaid Services (CMS) required hospitals to report whether patients had certain conditions when they were admitted starting October 1, 2007. Conditions coded as present on admission would not be considered to be acquired in the hospital and would not be subject to payment reductions starting the following fiscal year. Starting for discharges on or after October 1, 2008, Medicare would no longer pay a hospital at a higher rate for an inpatient hospital stay if the sole reason for the enhanced payment is one of the selected HACs, and the condition was acquired during the hospital stay. In January 2009, CMS issued three national coverage determinations that preclude Medicare from paying for certain serious preventable errors in medical care.

CMS issued guidance to states in July 2008 to help states appropriately align Medicaid inpatient hospital payment policies with Medicare's HAC payment policies. In the guidance, CMS indicated that for services delivered to patients eligible for both Medicare and Medicaid (dual eligibles) hospitals that were denied payment under Medicare might attempt to bill Medicaid – as the secondary payer. CMS instructed state Medicaid agencies to also deny payment when patients acquired HACs during a hospitalization, particularly for dual eligibles, but also for all Medicaid beneficiaries. CMS indicated that states could use several Medicaid authorities to deny payment appropriately for HAC conditions, but unlike Medicare, the DRA did not specifically apply the HAC initiative to Medicaid. Currently, several states have developed and implemented policies denying Medicaid payment for conditions acquired during the course of care.

Chairman's Mark

Effective July 1, 2011, the Chairman's Mark would prohibit Federal payments to states for Medicaid services related to health care acquired conditions. The Secretary would define health care acquired conditions, consistent with the definition of hospital acquired conditions under Medicare, but would not be limited to conditions acquired in hospitals. The Secretary would consider the differences between the Medicare and Medicaid programs, and their beneficiaries, in defining health care acquired conditions. The Secretary would also identify current state practices that prohibit payments for certain health care acquired conditions when implementing this provision.

Medicaid Bundled Payments Demonstration Project

Current Law

The Medicare fee-for-service program pays health care providers fixed amounts for each service provided to beneficiaries. Payments are referred to as bundled when the unit of payment includes multiple individual services. For example, hospitals receive a single bundled payment from Medicare for each discharge, and that payment covers all of the services provided by the hospital during the stay, including nursing, room and board, etc.

Chairman's Mark

The Chairman's Mark would establish a bundled payment demonstration project under Medicaid in up to eight states. Under the demonstration, the unit of payment for acute care provided in hospitals would be redefined and expanded to include post-acute care provided in acute care hospitals and nonhospital settings, and/or hospital and concurrent physicians' services. Hospitals would receive a single bundled payment from Medicaid for such services. For purposes of this demonstration, the Secretary may waive restrictions imposed by title XI of the Social Security Act. The demonstration would begin October 1, 2011.

Added in the Modification or by Amendment at Markup

The Chairman's Mark would establish a Medicaid Global Payments demonstration project available to in up to five states from 2010 to 2012, under which a large, safety net hospital system participating in Medicaid would be permitted to alter its provider payment system from a fee-for-service structure to a capitated, global payment structure. The CMS Innovation Center would conduct an evaluation of each demonstration project examining any changes in health care quality outcomes and spending. The Chairman's Mark would exempt the Innovation Center from the budget-neutrality requirements for an initial testing period. The Innovation Center would also be given the authority to terminate or modify the demonstration project during the testing period. The Secretary would be required to conduct and analysis of the demonstration project and report her findings to Congress.

The Chairman's Mark would establish a demonstration project, in which a state would apply to the Secretary to participate, which would allow pediatric medical providers who meet certain criteria to be recognized as accountable care organizations (ACOs). Participating providers would be eligible to share in the federal and state cost savings achieved for Medicaid and CHIP. States, in consultation with the Secretary, would establish a minimum level of savings that would need to be achieved by an ACO in order for it to share it the savings. The Secretary, in consultation with states and pediatric providers, would develop guidelines to ensure that the quality of care delivered by the ACOs would be at least as high as it would have been absent the demonstration project.

The Chairman's Mark would establish a three-year, $75 million demonstration project for up to eight states to expand the number of emergency inpatient psychiatric care beds available in

communities. This project – the Medicaid Emergency Psychiatric Care Demonstration Project – would allow states to cover patients in non-governmental freestanding psychiatric hospitals and receive federal Medicaid matching payments to demonstrate that covering patients in these hospitals will improve timely access to emergency psychiatric care, reduce the burden on overcrowded emergency rooms, and improve the efficiency and cost-effectiveness of inpatient psychiatric care.

PART IX—MEDICAID AND CHIP PAYMENT AND ACCESS COMMISSION

Current Law

The Children's Health Insurance Program Reauthorization Act (CHIPRA, P.L. 111-3) established a new Federal commission called the Medicaid and CHIP Payment and Access Commission, or MACPAC. This commission will review program policies under both Medicaid and CHIP affecting children's access to benefits, including: (1) payment policies, such as the process for updating fees for different types of providers, payment methodologies, and the impact of these factors on access and quality of care; (2) the interaction of Medicaid and CHIP payment policies with health care delivery generally; and (3) other policies, including those relating to transportation and language barriers. The commission will make recommendations to Congress concerning such payment and access policies.

Beginning in 2010, by March 1 of each year, the commission will submit a report to Congress containing the results of these reviews and MACPAC's recommendations regarding these policies. Also beginning in 2010, by June 1 of each year, the commission will submit another report to Congress containing an examination of issues affecting Medicaid and CHIP, including the implications of changes in health care delivery in the U.S. and in the market for health care services.

MACPAC must also create an early warning system to identify provider shortage areas or other problems that threaten access to care or the health care status of Medicaid and CHIP beneficiaries.

MACPAC would be required to consult periodically with the chairmen and ranking minority members of the House Committee on Energy and Commerce and the Senate Committee on Finance regarding MACPAC's agenda and progress toward achieving that agenda. MACPAC may conduct additional reviews and submit additional reports to these congressional committees on such topics relating to Medicaid and CHIP, as requested by such chairmen and members, and as MACPAC deems appropriate.

Chairman's Mark

The Chairman's Mark would authorize $11 million for MACPAC for FY2010. Of this total, $9 million would come from Medicaid funds, and $2 million would come from CHIP funds. Funding in subsequent years would be subject to appropriation of such sums as are necessary.

The Chairman's Mark also expands MACPAC's mission to include assessment of adult services in Medicaid, including for dual eligbles, and more detailed reporting requirements to states and Congress. This assessment shall be done in consultation with the Medicare Payment Advisory Commission (MedPAC). The Chairman's Mark would also change the reporting dates to March 15 and June 15 of each year, beginning June 2010.

PART X—AMERICAN INDIANS AND ALASKA NATIVES

Premiums and Cost-Sharing

Current Law

Federal law permits states to impose premiums and service-related cost-sharing for some beneficiaries and some benefits under Medicaid. In general, premiums and enrollment fees are prohibited for most Medicaid beneficiaries. Nominal amounts may be collected from individuals classified as "medically needy," certain families qualifying for transitional medical assistance, and pregnant women and children with incomes over 150 percent of the Federal poverty level (FPL). Service-related cost-sharing is prohibited for certain groups (*e.g.*, children under 18, pregnant women) and for certain services (*e.g.*, emergency care, family planning services and supplies, preventive services). In general, nominal amounts specified in regulations may otherwise be applied. For the working disabled and populations covered under section 1115 waivers, cost-sharing can exceed nominal amounts. Aggregate cost-sharing for all individuals is capped at five percent of family income.

Different cost-sharing rules apply under CHIP. For children in families with income under 150 percent of FPL, nominal premiums specified in Medicaid statute apply. Service-related cost-sharing is limited to nominal amounts in Medicaid regulations for the subgroup with income below 100 percent of FPL, and slightly higher amounts defined in CHIP regulations for the subgroup with income between 100 and 150 percent of FPL. For children in families with income over 150 percent of FPL, cost-sharing can be applied in any amount, provided that cost-sharing for higher-income children is not less than cost-sharing for lower-income children, and it is subject to an out-of-pocket limit of five percent of family income. Preventive services are exempt from all cost-sharing for all CHIP families regardless of income.

Chairman's Mark

The Chairman's Mark would prohibit cost-sharing (including premiums, deductibles, copayments, co-insurance, etc.) for all American Indians and Alaska Natives (AI/ANs) with incomes at or below 300 percent of FPL for state exchange plans and public programs.

Payer of Last Resort

Current Law

For individuals simultaneously covered by Medicaid and other insurance or programs, Medicaid is considered the payer of last resort. That is, other programs are the primary payer, and Medicaid is the secondary payer.

Chairman's Mark

The Chairman's Mark would ensure that Indian tribes, tribal organizations, and urban Indian organizations (I/T/Us) are the payers of last resort.

Eligibility Determination

Current Law

In determining financial eligibility for Medicaid and CHIP, states have flexibility in the types and amounts of income counted and disregarded. Under both Medicaid and CHIP, states are prohibited from considering certain classes of property from resources in determining eligibility for an AI/AN.

The Children's Health Insurance Program Reauthorization Act (CHIPRA, P.L. 111-3) created a state option to rely on a finding from specified "Express Lane" agencies (*e.g.*, those that administer programs such as Temporary Assistance for Needy Families, Medicaid, CHIP and the Supplemental Nutrition Assistance Program) to determine whether a child under age 19 (or an age specified by the state, not to exceed 21 years of age) has met one or more of the eligibility requirements (*e.g.*, income, assets or resources, citizenship, or other criteria) necessary to determine an individual's initial eligibility, eligibility redeterminations, or renewal of eligibility for medical assistance under Medicaid or CHIP.

Chairman's Mark

Under the Chairman's Mark, Indian tribes, tribal organizations, and urban Indian organizations would be added to the definition of an Express Lane Agency. Tribes would also be allowed to accept applications for ~~public programs and~~ state exchange plans.

American Indian and Alaska Native Providers and Medicare Part B

Current Law

Medicare covers specified Part B services provided by a hospital or ambulatory care clinic (whether provider-based or free-standing) that is operated by the Indian Health Service (IHS), by an Indian tribe, or by a tribal organization. These services include physician services, health practitioners (physician assistants, nurse anesthetists, certified nurse-midwives, clinical social workers, clinical psychologists, and registered dietitians or nutrition professionals) and outpatient

physical therapy services provided by physical or occupational therapists. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA, P.L. 108-173) instituted a five-year expansion of the items and services covered under Medicare Part B when furnished in Indian hospitals and ambulatory care clinics, applying to items and services on or after January 1, 2005.

Chairman's Mark

The Chairman's Mark would remove the sunset in current law to allow I/T/Us to continue to receive payment for certain Medicare covered items and services.

Other Policies Related to State Exchange Coverage

Current Law

No provision.

Chairman's Mark

The Chairman's Mark would subject AI/ANs to the responsibility to obtain insurance, but exempt them from the penalty for failing to do so. AI/ANs would be allowed a choice of providers, including I/T/Us. The Chairman's Mark also would authorize monthly special enrollment periods for AI/ANs in state exchanges.

Added in the Modification or by Amendment at Markup

Indian Tribe Health Benefits. The Chairman's Mark would provide an exclusion from gross income for the value of specified Indian tribe health benefits. The exclusion applies to the value of: (1) health services or benefits provided or purchased by the Indian Health Service ("IHS"), either directly or indirectly, through a grant to or a contract or compact with an Indian tribe or tribal organization or through programs of third parties funded by the IHS;[41] (2) medical care services (in the form of provided or purchased medical care services, accident or health insurance or an arrangement having the same effect, or amounts paid directly or indirectly, to reimburse the member for expenses incurred for medical care) provided by an Indian tribe or tribal organization to a member of an Indian tribe, including the member's spouse or dependents;[42] (3) accident or health plan coverage (or an arrangement having the same effect)

[41] The term "Indian tribe" means any Indian tribe, band, nation, pueblo, or other organized group or community, including any Alaska Native village, or regional or village corporation, as defined by, or established pursuant to, the Alaska Native Claims Settlement Act (43 U.S.C. 1601 et. seq.), which is recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians. The term "tribal organization" has the same meaning as such term in section 4(l) of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450b(1)).

[42] The terms "accident or health insurance" and "accident or health plan" have the same meaning as when used in sections 104 and 106. The term "medical care" is the same as the definition under section 213. For purposes of the provision, dependents are determined under section 152, but without regard to subsections (b)(1), (b)(2), and (d)(1)(B). Section 152(b)(1) generally provides that if an individual is a dependent of another taxpayer during a taxable year such individual is treated as having no dependents for such taxable year. Section 152(b)(2) provides

provided by an Indian tribe or tribal organization for medical care to a member of an Indian tribe and the member's spouse or dependents; and (4) any other medical care provided by an Indian tribe that supplements, replaces, or substitutes for the programs and services provided by the Federal government to Indian tribes or Indians.

The provision provides that no inference is intended as to the tax treatment of health benefits or coverage under this provision prior to the effective date. Additionally, no inference is intended with respect to the tax treatment of other benefits provided by Indian tribes not covered by this proposal.

The provision is effective for health benefits and coverage provided after the date of enactment.

SUBTITLE H—ADDRESSING HEALTH DISPARITIES

Standardized Collection of Data

Current Law

The Office of Management and Budget (OMB) Directive 15 outlines standards for the collection of race and ethnicity data on Federally-sponsored surveys, administrative forms, and other records. OMB Directive 15 does not mandate collection of such data. However, when race data are collected, Directive 15 requires a minimum of five racial categories (White, Black or African American, American Indian or Alaska Native, Asian, Native Hawaiian or Other Pacific Islander). When ethnicity information is gathered, a dichotomous identification question with the choices "Hispanic or Latino" or "not Hispanic or Latino" must be used. Data collection instruments may include additional categories such as Mexican-American, Chicano, Puerto Rican, Cuban, or Filipino, as long as these categories can be aggregated to the standard categories. When individuals are asked to self-identify (which is OMB's preferred method), Directive 15 also requires that respondents be given the opportunity to report multiple races in response to a single question. Including "multiracial" as an option is not acceptable.

In addition, when self-identification is used, race and ethnicity should be determined by first asking about ethnicity ("Hispanic or Latino" vs. "not Hispanic or Latino") and second, asking individuals to choose one of the aforementioned five racial categories. When the data are not based on self-identification, a single item race/ethnicity question inviting people to choose "all that apply" is acceptable. Finally, persons who identify as Alaska Native should also be asked for their tribal affiliation.

Generally, Federal agencies and Federally-sponsored entities must use the Directive 15 categories when collecting race and ethnicity data; however, the requirements may be waived if an organization can demonstrate that it is unreasonable to use the categories in a particular situation, or if it can be shown that race and ethnicity data are not critical to the administration of

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that a married individual filing a joint return with his or her spouse is not treated as a dependent of a taxpayer. Section 152(d)(1)(B) provides that a "qualifying relative" (i.e., a relative that qualifies as a dependent) does not include a person whose gross income for the calendar year in which the taxable year begins equals or exceeds the exempt amount (as defined under section 151).

the program seeking this information. OMB standards do not apply to state and municipal public health departments or to Medicaid. While the standards do apply to the Children's Health Insurance Program (CHIP), they are not binding on states that opt to use CHIP funding to finance a Medicaid expansion or that employ a combined approach.

While OMB Directive 15 does not address data on preferred language, CMS mandates that this information be reported for Medicaid beneficiaries. CMS does not require the collection of primary language data for CHIP enrollees and their parents. Current law does not require the collection of data on disability for any Federal health care program or other Federally-sponsored entities.

Chairman's Mark

The Chairman's Mark would establish uniform categories for collecting data on race and ethnicity, ~~gender~~ sex and primary language. The OMB Directive 15 standards and the OMB policy for aggregation and allocation of subgroups for race and ethnicity data would apply to Medicaid. CMS would be required to collect primary language data on CHIP enrollees and their parents.

Additionally, the Chairman's Mark would require CMS to collect data on individuals with disabilities. CMS would be required to survey providers in order to determine the locations where people with disabilities receive primary care services, the number of providers with accessible facilities and equipment, the number of employees trained in disability awareness and patient care of individuals with disabilities, and access to intensive care units for individuals with physical disabilities.

Sufficient Disparities Data

Current Law

While Federal data collection efforts include a broad range of data for measuring disparities in the quality of and access to health care, there are no statutory requirements to ensure that the sample size is large enough to generate reliable, statistically significant estimates for various racial and ethnic groups. Some surveys oversample minorities (*e.g.*, the National Health Interview Survey, the National Health and Nutrition Examination Survey, and the Medical Expenditure Panel Survey) in an effort to produce reliable data for blacks, Hispanics, and Asians. But no Federal surveys have large enough samples to examine smaller groups like Puerto Ricans, Cubans, Filipinos, or American Indians/Alaska Natives.

The Medicare Improvements for Patients and Providers Act of 2008 (MIPAA, P.L. 110-275) instructed the Secretary to evaluate approaches for collecting disparities data on Medicare beneficiaries and provide a report to Congress, including recommendations for reporting nationally recognized quality measures, such as Healthcare Effectiveness Data and Information Set (HEDIS) measures, on the basis of race, ethnicity, and gender. MIPAA further instructed the Secretary to implement the approaches identified in the initial report and, subsequently, report

back to Congress with recommendations for improving the identification of health care disparities among Medicare beneficiaries based on an analysis of those efforts.

Current statutorily mandated quality reporting programs for Medicare hospitals and physicians do not require the inclusion of data on race, ethnicity, or primary language.

Chairman's Mark

The Chairman's Mark would require that Federally-funded population surveys collect sufficient data on racial and ethnic subgroups to generate statistically reliable results in studies comparing health disparities populations. It would ensure that quality reporting requirements include provisions to collect data on patients by race, ethnicity, sex~~gender~~, primary language, and disability, and it would extend the MIPAA provisions regarding the collection of health disparities data on the Medicare population to Medicaid and CHIP.

Data Sharing

Current Law

There is no current law that requires the Secretary to share health disparities measures, data, and analyses with other HHS agencies. However, HHS is actively engaged in facilitating data sharing generally – for example, through the HHS Data Council, which is charged with formulating integrated data collection strategies and developing health data collection standards. The department maintains several websites which aim to facilitate the use of HHS data.

Chairman's Mark

The Chairman's Mark would require HHS to share health disparities data, measures, and analyses with other relevant agencies.

Privacy and Security

Current Law

The Privacy Act of 1974 (P. L., 93-579) established a code of fair information practices that governs the collection, maintenance, use, and dissemination of personally identifiable information about individuals that is maintained in systems of records by Federal agencies. A system of records is a group of records under the control of an agency from which information is retrieved by the name of the individual or by some identifier assigned to the individual. The Privacy Act requires that agencies give the public notice of their systems of records by publication in the *Federal Register*. The Privacy Act prohibits the disclosure of information from a system of records absent the written consent of the individual, unless the disclosure is pursuant to one of 12 statutory exceptions. The Act also provides individuals with a means to seek access to, and amendment of, their records and sets forth various agency record-keeping requirements.

Individually-identifiable health data acquired, used, and maintained by Federal programs such as Medicare and Medicaid, which meet the definition of a health care provider or health plan under the Health Insurance Portability and Accountability Act (HIPAA, P.L. 104-191), are also protected by the HIPAA privacy rule and security standards. The HIPAA privacy rule places limitations on the use and disclosure of personal health information without patient authorization. The HIPAA security standards specify certain administrative, physical, and technical measures to safeguard health information in electronic form against unauthorized access, use, and disclosure.

Chairman's Mark

The Chairman's Mark would require the Secretary of HHS to ensure all appropriate privacy and security safeguards are followed for activities relating to health disparities data collection, analysis, and sharing.

Added in the Modification or by Amendment at Markup

This provision would ensure that children aging out of the foster care system have the opportunity to designate a medical power of attorney prior to emancipation from foster care. States must supply information and an opportunity for the child to designate another individual to make medical decisions on their behalf should they be unable to participate in such decision making process as part of the transition process for children expected to age out of the foster care system. The opportunity to designate an individual to make such decisions must be made in compliance with state law in the form of a health care power of attorney, health care proxy, or other similar document recognized by state law. The importance of designating another individual to make medical treatment decisions shall be incorporated into the curriculum of Independent Living Education programs for adolescents preparing to age out of the foster system.

Added in the Modification or by Amendment at Markup

The Mark includes a rule of construction that nothing in section 1905(a) of the Social Security Act shall be construed as limiting a State from covering therapeutic foster care for eligible children in out-of-home placements.

The Mark would also provide a statutory definition of therapeutic foster care as a foster care program that provides to the eligible child structured daily activities that develop, improve, monitor, and reinforce age-appropriate social, communications, and behavioral skills; crisis intervention and crisis support services; medication monitoring; counseling; and case management services. Additionally, therapeutic foster care would include specialized training for the foster parent and consultation with the foster parent on the management of children with mental illnesses and related health and developmental conditions.

SUBTITLE I—MATERNAL, INFANT, AND EARLY CHILDHOOD VISITATION

Current Law

Title V of the Social Security Act (SSA) authorizes the Maternal and Child Health (MCH) block grant program. The MCH block grant, which is administered by Health Resources and Services Administration (HRSA), allocates funding to states based on a statutory formula. States use the Title V funds to design and implement a wide range of maternal and child health programs. The MCH block grant program seeks to: (1) reduce infant mortality; (2) increase the number of children appropriately immunized against disease; (3) increase the number of children in low-income families who receive health assessments and follow-up care; (4) provide comprehensive ~~perinatal~~ prenatal care to low-income and at-risk pregnant women; (5) provide preventive and child-care services, and rehabilitative services to disabled children; and (6) develop comprehensive, family-centered, community-based, culturally-competent, coordinated systems of care for children with special health care needs.

States must submit annual reports on Title V funded activities and demonstrate progress made towards standardized MCH status indicators (e.g., live birth rate, low birth weight, maternal death rates, and poverty levels) in order to facilitate comparison between states. The Secretary compiles the data submitted by the states in an annual report to Congress. States are required to audit and report on the use of their funds at least once every two years.

Chairman's Mark

The Chairman's Mark would add a new section 511 in title V of the Social Security Act.

The Chairman's Mark would require states, as a condition for receiving the MCH block grant, to conduct a needs assessment to identify communities that are at risk for poor maternal and child health and have few quality home visitation programs. The needs assessment, which would be separated from but coordinated with the assessments currently required under Title V and the Head Start Act, would also review the state's capacity to provide appropriate services to those communities. States would be required to submit the results of their needs assessment and their proposed activities to the Secretary.

In addition, the Mark would establish a new state grant program for early childhood home visitation. Grantees of this new program would be required to establish appropriate process and three and five year outcome benchmarks to measure improvement in maternal and child health, childhood injury prevention, school readiness, juvenile delinquency, family economic factors, and coordination with community resources. Grantees who did not demonstrate improvement in at least four of these benchmarks at the end of the third year of funding would receive expert technical assistance. The Mark lists certain core components for the home visitation programs. Grantees would be required to use an evidence-based program model that:

1. Conforms to a clear consistent home visitation model that has been in existence for at least three years and is research-based; grounded in relevant empirically-based knowledge; linked to program determined outcomes; associated with a national

organization or institution of higher education that has comprehensive home visitation program standards that ensure high quality service delivery and continuous program quality improvement; and has demonstrated significant and sustained positive outcomes, as described in the paragraph above, when evaluated using well-designed and rigorous randomized controlled, and the evaluation results have been published in a peer-reviewed journal;

2. Conforms to a clear consistent home visitation model that has been in existence for at least three years and is research-based; grounded in relevant empirically-based knowledge; linked to program determined outcomes; associated with a national organization or institution of higher education that has comprehensive home visitation program standards that ensure high quality service delivery and continuous program quality improvement; has been successfully replicated in diverse communities and with diverse families and has demonstrated significant positive outcomes, as described in the paragraph above, when evaluated using well-designed and rigorous quasi-experimental research designs.

However, they would be permitted to use 25 percent of the award to fund a promising new program model that would be rigorously evaluated. Additional requirements proposed by the Chairman's Mark would require grantees to use evidence-based practices to meet the process and outcome benchmarks, employ well-trained staff and specialists as appropriate, maintain high-quality supervision, possess strong organizational capacity and linkages in the community, and have rigorous evaluation and research methodology. The Mark would establish priority for services to be delivered to families who are determined to be at-risk by the needs assessment, and other indicators including low-income, young maternal age, and involvement with child welfare.

In order to apply for the grant, eligible entities would need to submit a description of the target population, and service delivery model, demonstrate consistency with findings of the needs assessment, procedures, and the benchmarks to be used. Grantees would be required to maintain their aggregate spending on home visitation programs at no less than their FY 2009 level.

The Chairman's Mark would require the Secretary (1) to appoint an expert panel to design the evaluation of the home visitation grants program; and (2) by grant, contract, or interagency agreement, conduct an evaluation of the statewide needs assessments, the home visitation programs, and the progress made by grantees' towards their benchmarks. The Secretary would be required to report the results of the evaluation to Congress. The Mark would require HRSA to collaborate with a number of Federal agencies including the Administration for Children and Families, National Institute of Child Health and Human Development, and the Office of Juvenile Justice and Delinquency Prevention. The Secretary would be permitted to use $10 million of the funds appropriated for this program to assist in the establishment of new home visitation programs. This grant program would not be subject to any other requirements of the MCH Block grant, except for certain administrative provisions that are outlined in the bill.

The Chairman's Mark would appropriate $1.5 billion between FY2010 and FY2014 — which includes $100M for FY 2010, $250M for FY 2011, $350M for FY 2012, $400M for FY 2013

and $400M for FY 2014 ~~$50M for FY2010, $300M for FY2011, $450M for FY2012, $700M for FY2013, and $1.5 billion for FY2014~~ — for the home visitation grants program. Of the amount appropriated for this program, three percent would be used for research and evaluation, and three percent would be used to provide home visitation services to Indian families. The Mark defines eligible entities as states, Indian tribes, tribal organizations or urban Indian organizations. The Mark would authorize the Secretary to determine which other entities, who have the capacity to carry out the program, are eligible if a state has not received a grant under this program by 2012. The Mark also defines the terms "other entities," "eligible family" and "Indian tribe, tribal organization, urban Indian organization."

Added in the Modification or by Amendment at Markup

Postpartum Depression. The Chairman's Mark would incorporate provisions of S. 324, the "Melanie Blocker Stokes Mom's Opportunity to Access Health, Education, Research, and Support for Postpartum Depression Act" to provide support services to women suffering from postpartum depression and psychosis and also help educate mothers and their families about these conditions. The Mark would also provide support for research into the causes, diagnoses and treatments for postpartum depression and psychosis.

Elder Justice Act. The Chairman's Mark would create a comprehensive approach to ensuring adequate public-private infrastructure and resolving to prevent, detect, treat, understand, intervene in, and, where appropriate, aid in the prosecution of, elder abuse, neglect, and exploitation by incorporating the Elder Justice Act (S. 795).

VA and TRICARE. Nothing in this legislation shall prohibit or penalize veterans or their eligible family members from receiving timely access to quality health care from a VA healthcare provider or in a Department of Veterans Affairs health care delivery facility.

Further, nothing in this Act shall prohibit or penalize eligible military health care beneficiaries from receiving timely access to quality health care in a Department of Defense medical treatment facility or a contracted health care provider (TRICARE or TRICARE for Life).

Assisted Suicide. The Chairman's Mark prohibits Federal funds under this Title from being used to pay for assisted suicide and offers conscience protections to providers or plans refusing to offer assisted suicide services.

Abstinence Education. The Chairman's Mark would appropriate $50 million a year through FY 2014 for abstinence education. The Mark would also appropriate $75 million each year for fiscal years FY2010 through FY2014 for a Personal Responsibility Education for Adulthood Training.

Teen Pregnancy Prevention. Of the annual amount, $50 million would 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 1) innovative teen pregnancy prevention strategies and services to high-risk, vulnerable, and culturally under-represented populations, 2) allotments to Indian tribes and tribal organizations, and 3) research & evaluation, training, and technical assistance, including a national teen pregnancy prevention resource center.

TITLE II—PROMOTING DISEASE PREVENTION AND WELLNESS

SUBTITLE A—MEDICARE

Annual Wellness Visit

Current Law

No provision.

Chairman's Mark

Beginning in 2011, Medicare beneficiaries would have access to a comprehensive health risk assessment (HRA) based on guidelines developed by the Secretary in consultation with relevant groups and entities. The assessment would identify chronic diseases, modifiable risk factors, and emergency or urgent health needs. The assessment could be provided through an interactive telephonic or web-based program or during an encounter with a health professional. The Secretary would also set standards for the electronic tools that could be used to deliver the assessment.

A comprehensive health risk assessment will be completed prior to or as part of the wellness visit. The Chairman's Mark would authorize Medicare payment for a visit to a primary care provider to create a personalized prevention plan, as part of this determination, the administration of the HRA will be taken into account. ~~Within six months of completing the comprehensive HRA, the Chairman's Mark would authorize Medicare payment for a visit to a primary care provider to create a personalized prevention plan.~~ The plan would include the following elements: review and update of medical and family history; age, gender, and risk-appropriate measurements (including height, weight, body mass index, and blood pressure); a schedule and referral for recommended, covered preventive services and immunizations; a strategy to address identified conditions and risk factors; a list of all medications currently prescribed and all providers regularly involved in the patient's care; and health advice and referral to Medicare-covered health education and preventive counseling or referral to community-based interventions to address modifiable risk factors such as weight, physical activity, smoking, and nutrition. Optional elements, if appropriate, could include a cognitive impairment ~~screening~~ assessment and administration of or referral for appropriate Medicare-covered immunizations and screening tests, among others. After the first visit, the personalized

prevention plan would be updated at each visit and health advice as well as other elements would be provided according the patients' needs.

During the first year of enrollment, Medicare beneficiaries may receive either the Initial Preventive Physical Examination (IPPE) or the "Annual Wellness Visit," but not both services in the same year.

All enrolled beneficiaries would be eligible for the wellness visit once every year. No co-payment or deductible would apply.

Removing Barriers to Preventive Services

Current Law

All currently covered Medicare preventive services and any applicable cost-sharing requirements, as well as the reduction or elimination of such requirements, are established in statute. Co-payments, deductibles, or both have been reduced or eliminated for many of the clinical preventive services, including pneumococcal and influenza vaccines, cardiovascular disease screening, and diabetes screening tests, among others. The Secretary does not have authority to modify cost-sharing requirements for preventive services. Evidence indicates that cost-sharing reduces Medicare beneficiaries' utilization of preventive services. For example, Medicare beneficiaries with supplemental insurance were substantially more like to a have had a mammogram screening than women without supplemental insurance. In addition, a National Bureau of Economic Research Working Paper concluded the elderly are "very price sensitive", finding that a $10 co-payment increase lead to an almost 20 percent decline in physician office visits.

Chairman's Mark

The Chairman's Mark would encourage beneficiaries to receive preventive screenings by removing cost-sharing (co-payment and deductible) for services covered by Medicare and recommended (rated "A" and "B") by the U.S. Preventive Services Task Force (USPSTF) for any indication or population.

Evidence-Based Coverage of Preventive Services

Current Law

Coverage for preventive services has historically required Congressional action to provide coverage for each new service. As a result, the Social Security Act outlines specific criteria for many preventive services, including factors such as the types of screening tests covered and age and risk profiles to which a service applies. As scientific evidence evolves, certain of these criteria may become outdated and the preventive services may be proven more or less effective for certain groups.

In the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA, P.L. 110-275), Congress authorized the Secretary to add coverage for additional preventive services if they were reasonable and necessary to prevent or detect an illness or disability early, appropriate for the individual entitled to benefits under Part A or enrolled under Part B, and recommended by the United States Preventive Services Task Force (USPSTF).

The USPSTF administered by the Agency for Healthcare Research and Quality (AHRQ), is an independent panel of private-sector experts in primary care and prevention that conducts rigorous, impartial assessments of scientific evidence for the effectiveness of a broad range of clinical preventive services, including screening, counseling, and preventive medications. It provides evidence-based recommendations for preventive services which may vary depending on age, gender, and risk factors for disease, among other considerations. Services are given a rating of "A", "B", "C", "D" or "I". Services rated "A" or "B" are recommended. For services rated "C", USPSTF makes no recommendation for or against its routine provision. For services rated "D", USPSTF recommends against routinely providing the service to asymptomatic patients. Finally, services rated "I" are deemed to have insufficient evidence to recommend for or against routinely providing them.

Although the Secretary has the authority to add new preventive services as evidence deems them appropriate for the Medicare population, the Secretary cannot review currently covered preventive services and compare them to scientific evidence. Instead, coverage for current preventive services remains constrained by statute regardless of the emergence of new evidence.

Chairman's Mark

The Chairman's Mark would encourage evidence-based coverage of preventive services by giving the Secretary the authority to use the same standards of evidence that apply to any new preventive services to existing preventive services. The Secretary would be allowed to modify coverage of existing preventive services to the extent that the modification is consistent with USPSTF recommendations. The Mark would also allow, but not require, the Secretary to withdraw Medicare coverage for services rated "D" or harmful by USPSTF. The Mark would provide funding for CMS to improve provider education and patient awareness of covered preventive services. The Mark would also require a GAO study to determine if any barriers exist that prevent the optimal utilization of covered primary, secondary and tertiary preventive services.

Study on Beneficiary Access to Immunizations

Current Law

Coverage of vaccines and their administration has been established in statue. Section 1861(s) of the Social Security Act provides Medicare Part B coverage of three vaccines and their administration: influenza (since 1993), pneumococcal (since 1980), and, for individuals at increased risk, hepatitis B (since 1984). The Medicare Modernization Act of 2003 (MMA, P.L. 108-173) provided coverage under Part D for any other vaccine and their administration that are

approved by the Food and Drug Administration (under section 351 of the Public Health Service Act), when prescribed by a physician.

Chairman's Mark

The Chairman's Mark would require a GAO study and report to Congress on the impact of the coverage of adult immunizations under Part D on access to those immunizations by Medicare beneficiaries.

Incentives for Healthy Lifestyles

Current Law

No provision.

Chairman's Mark

The Chairman's Mark would authorize and appropriate $100 million over five years for the Secretary to establish an initiative to provide incentives to Medicare beneficiaries who successfully participate in ~~complete~~ certain healthy lifestyle programs. Programs would target the following risk factors: high blood pressure, high cholesterol; tobacco use, overweight or obesity, diabetes and falls. The Secretary may select sites in coordination with community-based programs conducted by other agencies such as the Administration on Aging, Centers for Disease Control and Prevention, and the Agency for Healthcare Research and Quality. Each participating site ~~The Secretary~~ would establish a system to monitor beneficiary participation and validate changes in health risks and outcomes, including adoption and maintenance of health behaviors ~~the results, as well as set standards and health status targets~~ for participating beneficiaries. Prior to establishing the initiative, the Secretary would review evidence concerning healthy lifestyle programs and providing incentives to individuals for participating in such programs. The Secretary will submit interim report to Congress after on January 1, 2014 that includes a preliminary evaluation of this project, any programs or parts of the project determined to be effective are authorized to continue for another two years. The Secretary will submit a final report to Congress on January 1, 2016.~~The initiative would be implemented on January 1, 2011.~~

SUBTITLE B—MEDICAID

Improving Access to Preventive Services for Eligible Adults

Current Law

States are required under Medicaid to cover a package of "well-child" and preventive service benefits for the majority of eligible children under the age of 21, called the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services. For eligible adults, states are required to cover family planning services and supplies, and certain pregnancy-associated services, including prenatal and postpartum care. Otherwise, state coverage of screening and preventive

services for eligible adults is optional. Such services are defined in section 1905(a)(13) as "other diagnostic, screening, preventive, and rehabilitative services, including any medical or remedial services (provided in a facility, a home, or other setting) recommended by a physician or other licensed practitioner of the healing arts within the scope of their practice under State law, for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level;...." Under Medicaid, States are not required to cover tobacco cessation services (either drugs or counseling) for pregnant women, although most states offer some type of tobacco cessation service to their entire Medicaid population.

Under traditional Medicaid, states may impose on beneficiaries certain costs, such as enrollment fees, premiums, deductions, and cost-sharing. Under specified conditions, states may be prohibited from imposing such costs for services provided to children, or to eligible adults who are in a hospital or other institutional facility, or who are receiving emergency services, family planning services, or hospice care. States are also prohibited from imposing deductions, cost-sharing, or other charges for Medicaid covered pregnancy-related services provided to pregnant women.

Chairman's Mark

The Chairman's Mark would encourage states to improve coverage of and access to recommended preventive services and immunizations. At a minimum, states would be required to provide Medicaid coverage for comprehensive tobacco cessation services for pregnant women without cost-sharing for such services. Additionally, a state that opts to provide Medicaid coverage for all USPSTF (described in an earlier section) recommended services and immunizations recommended by the Advisory Committee on Immunization Practices (ACIP) as well as removes cost-sharing for those services would receive a one percentage point increase in the Federal share of its Federal Medical Assistance Percentage (FMAP) for those services, and for the required comprehensive tobacco cessation services for pregnant women.

Incentives for Healthy Lifestyles

Current Law

No provision.

Chairman's Mark

The Secretary of Health and Human Services would develop criteria for healthy lifestyle programs using relevant, evidence-based resources. These programs must be comprehensive and uniquely suited to address the needs of Medicaid eligible beneficiaries and have demonstrated success in helping individuals lower or control cholesterol and/or blood pressure, lose weight, quit smoking and/or manage or prevent diabetes, and may address co-morbidities, such as depression, associated with these conditions. The Secretary would set targets for measuring health status improvements. After the Secretary develops criteria, states could design a proposal and apply for funds to provide incentives to Medicaid enrollees who successfully complete healthy lifestyle programs. States are permitted to collaborate with community-based programs,

non-profit organizations, providers, and faith-based groups, among others. The state is required to establish a system to monitor beneficiary participation and validate health outcomes. The Mark authorizes $100 million in funding for these grants during a five-year period beginning on January 1, 2011.

Medicaid State Plan Option Promoting Health Homes and Integrated Care

Current Law

The Tax Relief and Health Care Act of 2006 (TRCHA, P.L. 109-432) mandated CMS to establish a Medicare medical home demonstration project. However, there is currently no such provision under the Medicaid program.

Chairman's Mark

The Chairman's Mark would create a new Medicaid state plan option under which Medicaid enrollees with at least two chronic conditions or with one chronic condition and at risk of developing another chronic condition, could designate a provider as their health home. In particular, Medicaid enrollees with at least one serious and persistent mental health condition qualify to receive services under this option.

Qualifying providers would have to meet certain standards established by the Secretary, including demonstrating that they have the systems and infrastructure in place to provide comprehensive and timely high-quality care either in-house or by contracting with a team of health professionals. The designated provider or a team of health professionals would offer the following services: comprehensive care management; care coordination and health promotion; comprehensive transitional care, including appropriate follow-up, from inpatient to other settings; patient and family support; and referral to community and social support services, if relevant and as feasible use health information technology to link such services. Teams of providers could be free-standing, virtual, or based at a hospital, community health center, community mental health center, clinic, physician's office, or physician group practice. Designated providers would be required to report to the state on all applicable quality measures in the state Medicaid program. The state would develop a mechanism to pay the health home for services rendered. When appropriate the state will consult and coordinate with the Substance Abuse and Mental Health Services Administration specifically in addressing the prevention and treatment of mental illness and substance abuse. The state plan amendment would include a plan for tracking avoidable hospital readmissions and plan for producing savings resulting from improved chronic care coordination and management. The Mark will provide an enhanced match of 90 percent FMAP for two years for states that take up this option. In addition, small planning grants may be available to help states intending to take up this option. FMAP rules would apply.

The Mark would require the Secretary to survey states and report to Congress on the nature, extent, and use of this option, particularly as it pertains to hospital admission rates, chronic disease management, and coordination of care for the chronically ill. The state option would be available beginning on January 1, 2011. After two years there would be an independent evaluation of the impact of this option on reducing hospital admissions.

Appropriations for Childhood Obesity Demonstration Project

Current Law

The Children Health Insurance Program Reauthorization Act of 2009 (CHIPRA, P.L. 111-3) established the Childhood Obesity Demonstration Project under a new subsection 1139A(e) of the Social Security Act. Appropriations of $25 million were authorized for the period of fiscal years 2009 through 2013.

Chairman's Mark

The Chairman's Mark would appropriate $25 million for the Secretary to carry out the demonstration project.

The Mark would also require the Secretary of HHS to issue guidance to states and health care providers regarding Medicaid's coverage of obesity-related services and preventive services. The Secretary would be required to increase public awareness of and education regarding coverage of obesity-related benefits such as obesity screening and counseling for both children and adults. The Secretary must report to Congress on its public awareness efforts as well as the guidance provided to states and health care providers every three years starting in 2011 and ending in 2017.

SUBTITLE C—WORKPLACE WELLNESS

Incentives for Participation in Voluntary Wellness Programs

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).

Chairman's Mark

The Mark would codify and enhance 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 Mark 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 Mark would allow 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 Mark 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 Mark 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 Mark would apply 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 Mark 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 provision 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.

TITLE III—IMPROVING THE QUALITY AND EFFICIENCY OF HEALTH CARE

SUBTITLE A—TRANSFORMING THE HEALTH CARE DELIVERY SYSTEM

PART I—LINKING PAYMENT TO QUALITY OUTCOMES IN THE MEDICARE PROGRAM

Hospital Value-Based Purchasing

Current Law

As required by the Medicare Prescription Drug, Improvement and Modernization Act (MMA, P.L.108-173), since FY2005, acute care hospitals that submit required quality data have received higher payments than those hospitals that do not submit such information under Medicare's Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU) program (often referred to as the hospital pay-for-reporting program). As subsequently modified by Section 5001(a) of the Deficit Reduction Act of 2005 (DRA, P.L. 109-171), beginning in FY2007, hospitals were required to submit data for an expanded set of quality measures to participate in

the RHQDAPU program, and nonparticipating hospitals received a reduction of 2.0 percentage points in their Medicare annual update for that fiscal year.

The Secretary has the authority to expand the set of measures that are included in the RHQDAPU program. Specifically, the Secretary can add other measures that reflect consensus among affected parties and, to the extent feasible and practicable, can include measures set forth by one or more national consensus building entities. The Secretary may replace any measures or indicators in appropriate cases, such as where all hospitals are effectively in compliance or the measures or indicators have been subsequently shown not to represent the best clinical practice.

Currently, there are 42 quality measures collected in the RHAQDPU program that impact the FY2009 payment update. In some cases, the Centers for Medicare and Medicaid Services (CMS) gathers quality information by abstracting claims data. In these instances, hospitals are not required to report data on these specific measures since the information is collected directly by CMS. Today, the RHAQDPU program collects quality data on the following conditions: acute myocardial infarction (AMI); heart failure; pneumonia; and surgical care improvement. The program also collects information on: 30-day mortality rates for AMI, heart failure and pneumonia patients; readmission rates for heart failure, AMI, and pneumonia; a nursing sensitive measure; several Agency for Health Care Research and Quality (AHRQ) Patient Safety and Inpatient Quality Indicators; and the patients' experience of care through the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey.

Procedures for making reported quality data available to the public must be established and hospitals must be granted the opportunity to review quality data prior to such information being made public. The required quality measures of process, structure, outcome, patients' perspectives on care, efficiency, and costs of care that relate to services furnished in inpatient settings in hospitals must be reported on the Internet website of CMS. Currently, individual hospital performance on specific quality measures and on certain conditions is available on Hospital Compare available on the CMS website.

DRA also required the Secretary of Health and Human Services to formulate and report on a plan to implement a value-based purchasing program for payments under the Medicare program for acute care hospitals (also referred to as IPPS or subsection(d) hospitals) beginning with FY2009. On November 17, 2007, CMS responded to this mandate by releasing the report, "Report to Congress: Plan to Implement a Medicare Hospital Value-Based Purchasing Program." This report recommends expanding the RQHDAPU program in order to financially reward hospitals differentially for performance, rather than for simply reporting quality data. Public reporting of performance would be a key component, as well.

As of 2008, nearly 95 percent of inpatient hospitals successfully participated in the RHAQDPU program, which means that the majority of IPPS hospitals complied with the quality data reporting requirements and were not subject to payment penalties that would have occurred in the case of not meeting the reporting requirements.

Chairman's Mark

Building on the success of the RHQDAPU program, the Chairman's Mark would establish a Hospital Value-Based Purchasing (VBP) program in Medicare that moves beyond pay-for-reporting on quality measures, to paying for hospitals' actual performance on these measures. This value-based purchasing program would provide value-based incentive payments to acute care IPPS hospitals that meet certain quality performance standards beginning in FY2012. The first year of the program would be a data collection/performance year. Beginning in FY2013, hospital payments would be adjusted based on performance under the VBP program. Certain hospitals would be excluded from the VBP program, including: those that fail to report quality measures under the RHQDAPU program; those that have been cited by the Secretary for deficiencies that posed immediate jeopardy to the health or safety of patients during the performance period; and hospitals for which a minimum number of patients with conditions related to the quality measures or a minimum number of quality measures do not apply.

Measures for the hospital VBP program would be selected from the measures used in the RHQDAPU program. The measures would focus on the same areas that are the focus of the RHQDAPU program: heart attack (AMI); heart failure; pneumonia; surgical care activities; ~~and~~ patient perception of care; and would include healthcare-associated infections, as measured by the prevention metrics and targets established in the Department of Health and Human Services HHS Action Plan to Prevent Healthcare-Associated Infections or any successor plan. Beginning in FY2014 and beyond, the Secretary would have the authority to expand these categories through the quality measure development and endorsement procedures laid out in the Quality Infrastructure section of this legislation. By FY2014, the Secretary would be required to expand categories to include efficiency measures. Such measures would include Medicare hospital spending per beneficiary for selected medical conditions and would be adjusted by factors including age, sex, race, severity of illness and other factors that the Secretary determines are appropriate. The Secretary would have the authority to replace a measure if it is found that all hospitals are effectively in compliance with the measure or if the measure no longer represents a best practice.

Funding for value-based incentive payments for qualifying acute care hospitals would be generated through reducing Medicare IPPS payments to the hospitals. The reductions would be used to fund an incentive pool and would be phased-in as follows: 1.0 percent in FY2013; 1.25 percent in FY2014; 1.5 percent in FY2015; 1.75 percent in FY2016; and 2.0 percent in FY 2017 and beyond. The reductions would apply to all MS-DRGs under which a hospital provides services. The Secretary would be required to ensure that all funds reduced from hospital payments to fund the VBP program in a given year be returned to hospitals in the form of value-based incentive payments in that same year (i.e. the program would be budget neutral to the Medicare program).

IPPS add-on payments such as disproportionate share hospital (DSH) payments, indirect medical education payments (IME) for teaching hospitals, low-volume add-on payments and outlier payments would not be impacted by the payment reductions. Payment adjustments or reductions under the hospital VBP program would only apply to a relevant fiscal year and would not be taken into account in calculating payments in future fiscal years.

Performance standards that reward hospitals based on either attaining a certain performance standard or making improvements on performance relative to a previous performance period would be established. Hospitals would be paid based on whichever level is higher: attainment or improvement.

Performance standards would be announced at least 60 days prior to the performance period for which they would apply. When setting the standards, the Secretary would be required to take into account the following factors: past hospital experience with the measures; historical performance standards; improvement rates; and opportunity for continued improvement.

The Secretary would establish a performance period for the VBP program that would begin and end before the beginning of the fiscal year in which value-based incentive payments are awarded. A methodology for assessing the performance of each hospital for each condition during the performance period would be developed. Results would include both condition-specific and total hospital performance scores. However, determination of whether the performance standard was met would be based on the hospital's total performance score. The Secretary would have discretion to determine how to weight various categories of measures/conditions when determining the hospital's total score.

Hospitals that meet or exceed performance standards would receive value-based incentive payments. Payment adjustments would only apply to a relevant fiscal year and not be taken into account in calculating payments in future fiscal years.

Individual hospital performance on each specific quality measure, on each condition or procedure, and on total performance would all be publicly reported. Data regarding the total number of hospitals receiving incentive payments or payment reductions under the VBP program would be published periodically. Hospitals would continue to be provided with an opportunity to review and correct information before it is publicly reported.

An appeals process would be established that allows hospitals to contest performance score calculations and the resulting value-based incentive payments. There would be no judicial or administrative review of the following items: (1) the methodology used to determine the amount of the value-based incentive payments; (2) the determination of the amount of funding available for value-based incentive payments; (3) the establishment of the hospital performance standards; (4) the quality measures that are selected for inclusion in RHQDAPU or the VBP program; (5) the methodology that is used to calculate hospital performance scores; and (6) the methodology for validating hospital performance.

The selection of measures, the development of the methodology for assigning scores and the development of the methodology for calculating payments would be transparent and public through rulemaking.

The Secretary would be required to work with hospitals, patients, researchers, policymakers and other stakeholders to modify the Hospital Compare website to make it more user-friendly.

The Secretary and the Government Accountability Office (GAO) would conduct ongoing monitoring and submit reports to Congress on the program, including any unintended consequences. GAO would be required to submit an interim report to Congress on the program no later than October 1, 2015 and a final report by July 1, 2017. The Secretary would be required to submit a report by January 1, 2016. This report would include an analysis of whether the VBP program resulted in lower Medicare spending or other financial savings to hospitals and would include recommendations on the appropriateness of the Medicare program sharing in any savings generated through the VBP program in the future.

The Secretary would be provided the necessary funding to administer the program (amount to be determined).

Three-year demonstration projects would be established to test VBP models tailored toward critical access hospitals (CAHs) and small hospitals that otherwise would not qualify to participate in the VBP program. The Secretary would be required to submit a report to Congress 18 months after completion of the project.

Physician Value-Based Purchasing

Current Law

Physician Quality Reporting Initiative. TRHCA required the establishment of a physician quality reporting system that would include an incentive payment, based on a percentage of the allowed Medicare charges for all such covered professional services, to eligible professionals who satisfactorily report data on quality measures. CMS named this program the Physician Quality Reporting Initiative (PQRI). MIPPA made this program permanent and extended the bonuses through 2010; the incentive payment was increased from 1.5 percent of total allowable charges under the physician fee schedule in 2007 and 2008 to 2 percent in 2009 and 2010.

Providers that successfully report for services provided in calendar year 2009 will receive an incentive payment of two percent of total allowable charges for the physician fee schedule. Providers may choose claims-based reporting or registry-based reporting. For claims-based reporting, providers seeking incentive payments for the entire calendar year may meet the requirement by reporting on one measures group for a sample of 30 consecutive Medicare Part B fee-for-service patients (FFS), or report for one measures group for 80 percent of applicable Medicare Part B FFS. For providers seeking to report for the six-month period beginning July 1, 2009, similar criteria apply for those that report through CMS approved registries.

Expansion of Physician Feedback Program. Both MedPAC and GAO have recently recommended providing information to physicians on their resource use. MedPAC asserts that physicians would be able to assess their practice styles, evaluate whether they tend to use more resources than their peers or what evidence-based research (if available) recommends, and revise practice styles as appropriate. MedPAC notes that in certain instances, the private sector use of feedback has led to a small downward trend in resource use. The GAO noted that certain public and private health care purchasers routinely evaluate physicians in their networks using measures

of efficiency and other factors and that the purchasers it studied linked their evaluation results to a range of incentives to encourage efficiency.

MIPPA established a physician feedback program with the intent to improve efficiency and to control costs. Under the Physician Feedback Program, the Secretary will use Medicare claims data to provide confidential reports to physicians that measure the resources involved in furnishing care to Medicare beneficiaries. The resources to be considered in this program may be measured on an episode basis, on a per capita basis, or on both an episode and a per capita basis. The GAO will conduct a study of the Physician Feedback Program, including the implementation of the Program, and will submit a report to Congress by March 1, 2011 containing the results of the study, together with recommendations for such legislation and administrative action as the Comptroller General determines appropriate.

Chairman's Mark

Physician Quality Reporting Initiative. The Chairman's Mark would establish a new PQRI option in addition to the options within the current program detailed above. Beginning with the 2011 reporting period, CMS would be required to make PQRI incentive payments available for two successive years to eligible professionals who voluntarily complete the following on a biennial (every two years) basis. The Secretary shall allow eligible professionals to qualify if they: (1) participate in a qualified American Board of Medical Specialties certification, known as Maintenance of Certification (MOC), or equivalent programs; and (2) complete a qualified MOC practice assessment. A qualified MOC practice assessment would include an initial assessment of a participant's practice, designed to demonstrate the physician's use of evidence-based medicine, and would seek to improve quality of care through follow-up assessments. The methods, measures, and data used for the MOC would be submitted by the Boards to CMS in accordance with requirements established by the Secretary in consultation with the Boards. As part of this consultation, the Secretary would ensure that methods, measures and data to be submitted allow for innovation and appropriateness by specialty.

The Chairman's Mark would further improve the PQRI program by requiring CMS to make two additional enhancements to the program. First, CMS would be required to provide timely feedback to eligible professionals on their performance with respect to satisfactorily submitting data on quality measures. Second, CMS would be required to establish an appeals process for providers who participate in the PQRI program but do not qualify for incentive payments during their performance period.

The Chairman's Mark would extend PQRI incentive payments beyond 2010. ~~Eligible professionals who successfully report in 2010 would receive a two percent bonus in 2011.~~ Eligible professionals who successfully report in 2010 would receive a one percent bonus in 2011. Eligible professionals who successfully report in 2011 would receive a 0.5 percent bonus in 2011. ~~Eligible professionals who failed to participate successfully in the program would face a 1 percent payment penalty in 2012, based on their 2011 reporting period.~~ Eligible professionals who failed to participate successfully in the program would face a 1.5 percent payment penalty in 2013, based on their 2012 reporting period. The incentive payments and adjustments in payment would be based on the allowed charges for all covered services furnished

by the eligible professional, based on the applicable percent of the fee schedule amount. ~~For 2012, the applicable percent would be calculated as 99 percent of their total allowed charges. For reporting periods 2012 and in subsequent years, the penalties for non-reporting would be two percent, calculated as 98 percent of their total allowed charges.~~ For 2013, the applicable percent would be calculated as 98.5 percent of their total allowed charges. For 2014 and in subsequent years, the penalties for non-reporting would be two percent, calculated as 98 percent of their total allowed charges. The penalty would be assessed on an annual basis and would not be cumulative.

Finally, the Mark would require CMS to develop a plan to integrate the PQRI program with the standards for meaningful use of certified electronic health records as created in the American Recovery and Reinvestment Act of 2009.

Expansion of Physician Feedback Program. The Chairman's Mark would require the Secretary, beginning in 2012, to provide reports to physicians that compare their resource use with that of other physicians or groups of physicians caring for patients with similar conditions. Resource use would be measured based on the items and services furnished or ordered by physicians or groups of physicians. Feedback reports would be based on an episode-grouper methodology established by the Secretary that would combine separate but clinically-related services into an episode of care for which the physician is accountable. The episode-grouper would be required to be developed by January 1, 2012. The Secretary would be required to make the methodology available to the public, and the Secretary would be required to seek endorsement of the episode-grouper by the entity with a contract with the Secretary under section 1890(a) of the Social Security Act.

In preparing feedback reports, the Secretary would be required to make appropriate data adjustments, including adjustments to (1) account for differences in the demographic characteristics and health status of individuals so as not to penalize those physicians who tend to serve less healthy individual who may require more intensive interventions, and (2) eliminate the effect of geographic adjustments in payment rates.

The Secretary would have the authority to exclude certain information regarding an item or service from feedback reports if the Secretary determines that there is insufficient information relating to such item or service to provide a valid assessment of utilization. The Secretary would be required to provide for education and outreach activities to physicians on the operation of, and methodologies used, under the Feedback Program. The Secretary shall coordinate the physician feedback program with other relevant value-based purchasing reforms being undertaken by CMS.

Beginning in ~~2014~~2015, payment would be reduced by five percent if an aggregation of the physician's resource use is at or above the 90th percentile of national utilization. After five years, the Secretary would have the authority to convert the 90th percentile threshold for payment reductions to a standard measure of utilization, such as deviations from the national mean.

Value-Based Modifier for Physician Payment Formula. The Secretary of Health and Human Services would be required to apply a separate, budget-neutral payment modifier to the fee-for-

service physician payment formula. This separate modifier will not be used to replace any portion of the Geographic Adjustment Factor. The separate payment modifier will, in a budget-neutral manner, pay physicians or groups of physicians differentially based upon the relative quality of care they achieve for Medicare beneficiaries relative to cost. Costs shall be based upon a composite of appropriate measures of cost that take into account justifiable differences in input practice costs, as well as the demographic characteristics and baseline health status of the Medicare beneficiaries served by physicians or groups of physicians. Quality shall be based upon a composite of appropriate, risk-based measures of quality that reflect the health outcomes and health status of Medicare beneficiaries served by physicians or groups of physicians. In establishing appropriate quality measures the Secretary would be required to seek the endorsement of the entity with a contract with the Secretary under section 1890(a) of the Social Security Act. The Secretary would also be required to take into account the special conditions of providers in rural and other underserved communities.

The Secretary would be required to publish, by January 1, 2012, the specific measures of quality and cost, the specific dates for implementation of the payment adjustment, and the proposed prospective performance period. The Secretary would be required to begin implementing the value-based payment adjustment in the 2013 rulemaking process. During the performance period, which will begin in 2014, the Secretary will provide, to the extent feasible, information to physicians about the value of care they provide. The Secretary will implement payment consequences beginning in 2015 based on the value of care delivered during the performance period. The payment modifier should be applied in a way that promotes systems-based care. By 2017, all physician payments must be subject to this payment modifier.

Medicare Inpatient Rehabilitation Facility, Long Term Acute Care Hospital and Hospice Quality Reporting

Current Law

Under current law, inpatient rehabilitation facilities (IRFs), long term care hospitals (LTCHs) and hospices are not required to report quality data to the Centers for Medicare and Medicaid Services (CMS). However, Medicare does require an IRF to submit a clinician's comprehensive assessment of each Medicare patient upon admission and again at discharge. These documented assessments must be based on the direct observation of and communication with the patient and information may be supplemented with information from other sources, including family members or other clinicians. The IRF's patient assessment instrument (PAI) form, the Uniform Data Set for Medical Rehabilitation (UDSmr), encompasses about 55 questions used to ascertain a patient's functional independence including motor skills and cognitive capacities and to establish a patient's comorbidities. A patient's assessments (from both admission and discharge) are transmitted to CMS electronically in one submission. Failure to meet the IRF-PAI transmission deadlines results in a 25 percent reduction in Medicare's payment in all but extraordinary circumstances. No comparable patient reporting requirements have been established for LTCHs and hospices.

Medicare pays for inpatient care provided by IRFs and LTCHs using different prospective payment systems (PPS). Each PPS is updated annually using a market basket (MB) index which

measures the estimated change in the price of goods and services purchased by the provider to produce a unit of output. Medicare payments to hospices are predetermined fixed amounts for each case, according to the general type of care provided to a beneficiary on a daily basis. Payments for hospice care are based on one of four prospectively determined units of payment, which correspond to four different levels of care (i.e., routine home care, continuous home care, inpatient respite care, and general inpatient care) for each day a beneficiary is under the care of the hospice. Hospice payments are updated annually based on the hospital MB index.

Chairman's Mark

The Secretary would be directed to establish quality reporting programs for IRFs, LTCHs and hospices. Under this policy, the Secretary would be required to select quality measures for IRFs, LTCHs and hospices by FY2013 and implement mandatory quality measure reporting programs for these providers by FY 2014. Failure to report quality measures would result in reduction of annual MB update by 2.0 percent. Quality measures included in these reporting programs would be selected via the quality measure development and endorsement procedures laid out in the Quality Infrastructure section of this legislation. The selected measures would cover, to the extent feasible and practicable, all dimensions of quality as well as efficiency of care. The Secretary would be able to replace any measure in appropriate cases, such as where all providers are effectively in compliance or the measure has been subsequently shown not to represent the best clinical practice.

Medicare IPPS Exempt Cancer Hospital Quality Reporting

Current Law

Eleven cancer hospitals are exempt from the Medicare inpatient prospective payment system (IPPS) used to pay inpatient hospital services provided by acute care hospitals. As part of these exemptions, these facilities are paid on a reasonable cost basis for providing inpatient services, subject to certain payment limitations and incentives. These hospitals are also held harmless under the outpatient prospective payment system (OPPS) and will not receive less from Medicare under this payment system than under the prior outpatient payment system. Under OPPS, Medicare pays for outpatient services using ambulatory payment classification (APC) groups. Currently, there are no quality reporting requirements for these hospitals.

Chairman's Mark

The Secretary would be directed to establish quality reporting programs for IPPS-exempt cancer hospitals. Under this policy, the Secretary would be required to select quality measures for IPPS-exempt cancer hospitals by FY2013 and implement mandatory quality measure reporting programs for these providers by FY 2014. IPPS exempt cancer hospitals would be required to report these quality measures as part of Medicare provider agreements. Quality measures included in these reporting programs would be selected via the quality measure development and endorsement procedures laid out in the Quality Infrastructure section of the Chairman's mark. The selected measures would cover, to the extent feasible and practicable, all dimensions of quality as well as efficiency of care. The Secretary would be able to replace any measure in

appropriate cases, such as where all providers are effectively in compliance or the measure has been subsequently shown not to represent the best clinical practice.

Medicare Home Health Agency and Skilled Nursing Facility Value-based Purchasing Implementation Plans

Current Law

As required by Section 5201(c) of the Deficit Reduction Act of 2005 (DRA, P.L. 109-171), beginning in 2007, home health agencies (HHAs) were required to submit data for a set of quality measures. HHAs that did not submit these data received a reduction of 2.0 percent in their Medicare annual update for that year. As a Medicare condition of participation, skilled nursing facilities (SNFs) are required to submit data on quality to the Secretary.

Currently, individual HHA and SNF performance on specific quality measures and on certain conditions is available on *Home Health Compare* and *Nursing Home Compare*, which are available on the CMS website.

Medicare payment demonstrations have been or are to be implemented that will test value-based purchasing for HHAs and SNFs.

Section 5201(d) of the DRA also required the Medicare Payment Advisory Commission (MedPAC) to submit a report to Congress on considerations for implementing a value-based payment system for Medicare home health services. MedPAC submitted this report to Congress in June 2007.

Chairman's Mark

The Secretary would be directed to complete and submit to Congress Medicare value-based purchasing implementation plans for HHAs and SNFs by 2011 and 2012, respectively. Each plan would include consideration of the following issues: (1) the development, selection, and modification process of measures, to the extent feasible and practicable, of all dimensions of quality and efficiency relative to the quality measure development and endorsement procedures laid out in the Quality Infrastructure section of this bill; (2) the reporting, collection, and validation of quality data; (3) a structure of proposed value-based payment adjustments, including recommendations on thresholds or improvements in quality that would substantiate a payment adjustment, the size of such payments, and the source of funding for value-based incentive payments; and (4) methods for publicly disclosing performance information on performance. In developing each plan, the Secretary would be required to consult with relevant stakeholders and take into consideration experiences with demonstrations that are relevant to value-based purchasing in each setting.

Reducing Hospital Acquired Conditions

Current Law

Medicare pays for inpatient services provided by acute care hospitals under section 1886(d) of the Social Security Act using the inpatient prospective payment system (IPPS), where each patient is classified into a Medicare severity adjusted diagnosis-related group (MS-DRG) based on diagnoses and procedures performed. Generally, except for outlier cases, a hospital receives a predetermined amount for a given MS-DRG regardless of the services provided to a patient. In some instances, Medicare patients may be assigned to a different MS-DRG with a higher payment rate based on secondary diagnoses. Inpatient services provided by acute care hospitals in Maryland are paid under a state-specific Medicare payment system under section 1814(b)(3) of the Social Security Act.

As established by the Deficit Reduction Act of 2005 (DRA, P.L. 109-171), hospitals will not receive additional Medicare payment for complications that were acquired during a patient's hospital stay. By statute, these hospital acquired conditions (HACs) are: (1) high cost, high volume, or both; (2) identified though a secondary diagnosis that will result in the assignment to a different, higher paid MS-DRG; and (3) reasonably preventable through the application of evidence-based guidelines. Starting October 1, 2007 (FY2008), CMS required hospitals to report whether certain conditions (secondary diagnoses) for Medicare patients were present at admission. Starting October 1, 2008, IPPS hospitals will not receive additional payment for secondary diagnoses resulting from hospital acquired conditions for certain select conditions.

Chairman's Mark

The Chairman's Mark would apply a new payment adjustment to hospitals ranked in the top quartile of national, risk-adjusted hospital acquired condition (HAC) rates.

Under this policy, CMS would calculate national and hospital-specific data on the HAC rates of Medicare participating subsection (d) hospitals and for hospitals paid under section 1814 (b)(3) for select conditions. Starting in FY13, the Secretary would share these data with hospitals, and the data would be publicly reported on the Hospital Compare website.

Starting on October 1, 2014, hospitals in the top quartile of national HAC rates would receive 99 percent of their otherwise applicable Medicare payments. Calculation of percentiles would be based on a prior's year performance. For example, if a hospital is subject to the payment adjustment in 2015, and then in 2016 is under the 75th percentile in terms of ranking on national HAC rates, it would not be subject to the policy in 2017. A HAC would be defined as a condition that an individual acquires during a hospital stay, as determined by the Secretary.

PART II—STRENGTHENING THE QUALITY INFRASTRUCTURE

Quality Infrastructure

Current Law

There are no provisions in current law requiring the Secretary of Health and Human Services (HHS) to develop national quality goals, strategy or infrastructure. However, the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA, P.L. 110-275) requires the Secretary to identify and have in effect a contract with a consensus-based entity, such as the National Quality Forum (NQF), to perform the following duties: (1) synthesize evidence and convene stakeholders to make recommendations, with respect to activities conducted under this Act, on an integrated national strategy and priorities for health care performance measurement in all applicable settings; (2) provide for the endorsement of standardized health care performance measures; (3) establish and implement a process to ensure that endorsed measures are updated or retired based on new evidence; (4) promote the development of electronic health records that facilitate the collection of performance measurement data; and (5) report annually to Congress. The NQF has been awarded this contract and recently released its first report, *Improving Healthcare Performance: Setting Priorities and Enhancing Measurement Capacity*, in fulfillment of this statutory requirement.

In addition, the Agency for Healthcare Research and Quality (AHRQ) has significant authorities with respect to the development of quality measures. Specifically, the Agency's mission, among other things, is to promote healthcare quality improvement by conducting and supporting research that develops and presents scientific evidence regarding all aspects of health care, including methods for measuring quality and strategies for improving quality. AHRQ also is required to provide support for public and private efforts to improve healthcare quality, including the ongoing development, testing, and dissemination of quality measures. To comply with this last requirement, the Agency has established the National Quality Measures Clearinghouse, an online resource that compiles and catalogues quality measures. AHRQ also develops annual reports to Congress on trends in healthcare quality and in healthcare disparities. Finally, AHRQ is required to coordinate all research, evaluations, and demonstrations related to health services research, quality measurement and quality improvement activities undertaken and supported by the Federal Government.

Chairman's Mark

Building on the provision set forth in MIPPA, the Chairman's Mark would provide additional resources to HHS to strengthen and improve quality measure development processes for purposes of improving quality, informing patients and purchasers and guiding payment under Federal health programs. AHRQ and the Centers for Medicare and Medicaid Services (CMS) would implement the provisions in this proposal.

National Strategy to Improve Health Care Quality. The Chairman's Mark would direct the Secretary to establish a national quality improvement strategy that includes priorities to improve the delivery of health care services, patient health outcomes, and population health through a

transparent and collaborative process. In developing these priorities, the Secretary would consider how the priorities would: address health care needs of those with high-cost chronic diseases; improve strategies and best practices to improve patient safety and reduce medical errors, preventable hospital admissions and readmissions, and health care-associated infections; have the greatest potential for improving the health outcomes, efficiency and patient-centeredness of health care; reduce health care disparities across populations and geographic areas; address gaps in quality, efficiency and outcomes measures and data aggregation techniques; identify areas in the delivery of health care services that have the potential for rapid improvement in the quality and efficiency of patient care; improve payment policy under Federal health programs to emphasize quality and efficiency; enhance the use of health care data to improve quality, efficiency, transparency, and outcomes; and other areas as determined appropriate by the Secretary.

The national strategy would also include a comprehensive strategic plan to achieve the priorities described above. At a minimum, the strategic plan would include provisions for addressing coordination among agencies within HHS; agency specific strategic plans, where appropriate, along with annual benchmarks to achieve the priorities; strategies to align incentives among public and private payers with regard to quality and patient safety efforts; and other requirements deemed appropriate by the Secretary.

In developing the national strategy and priorities, the Secretary would take into consideration recommendations submitted by a qualified consensus-based entity as set forth in MIPPA. To develop these recommendations, the qualified consensus based entity would convene a multi-stakeholder group. Stakeholders would include, but would not be limited to representatives of hospitals, physicians, post-acute providers, quality alliances, nurses and other health care practitioners, health plans, consumer representatives, life sciences industry, employers and public purchasers, labor organizations, licensing, credentialing and accrediting bodies, relevant government agency representatives, and others deemed appropriate by the Secretary. This multi-stakeholder group would operate in an open and transparent process.

The Secretary would update the national strategy not less than triennially and the first report would be due to Congress on December 31, 2010. Any update would include a review of short and long term goals as well as an analysis of progress in meeting these goals. In addition, the Secretary would make the national strategies available via a public website.

Interagency Working Group on Health Care Quality. The President would convene a working group consisting of relevant Federal departments and agencies[43] that would collaborate and consult on fulfilling the national quality improvement strategy and priorities. Not later than a

[43] Relevant Federal departments and agencies shall include: The Centers for Medicare and Medicaid Services (CMS), National Institutes of Health (NIH), Centers for Disease Control and Prevention; Food and Drug Administration (FDA), The Health Resources and Services Administration (HRSA), The Agency for Healthcare Research and Quality (AHRQ), and the Administration on Children and Families within The Department of Health and Human Services (HHS); The Department of Labor; The Department of Defense; The Department of Veterans Affairs; The Veterans Health Administration; The Department of Commerce; The Office of Personnel Management; The Office of Management and Budget; The U.S. Coast Guard; The Federal Bureau of Prisons; The National Highway Transportation and Safety Administration; and The Federal Trade Commission.

date determined appropriate by the Secretary and annually thereafter, the working group would submit a report to the Secretary, and make publicly available, a report on the progress and recommendations of the working group. This report would be taken into consideration as the Secretary develops a national quality improvement strategy and related reports to Congress as outlined in previous sections.

Quality Measure Development. The Secretary would identify, not less than triennially, gaps where no quality measures exist, or where existing quality measures need improvement, updating or expansion consistent with the national strategy and priorities. The qualified consensus-based entity set forth in MIPPA would be required to submit an annual report to the Secretary describing areas where gaps in quality measures exist and areas in which evidence is insufficient to support endorsement of quality measures related to the priority areas identified by the Secretary in the national strategy. This report would also include information on the economic and quality impact of the use of endorsed measures, where available. In identifying gaps, the Secretary would take into consideration the gaps identified by the consensus based entity.

The Secretary would then be required to develop measures that would fill identified gaps. To fulfill the section, the Secretary would contract with an entity that has demonstrated expertise and capacity in the development and evaluation of quality measures; that have procedures in place to take into the account the view of payers or providers whose performance will be assessed by the measures and the views of other parties, such as consumers and health care purchasers; have transparent policies regarding governance and conflicts of interest; and have processes in place to collaborate with the qualified consensus-based entity involved with measure endorsement as identified in MIPPA.

An entity that receives a grant under this section would use such funding to develop quality measures that: build on measures required to be reported pursuant to Title XVIII of the Social Security Act; can be collected using health information technologies, to the extent practicable; is free of charge to users of such measures; and is publicly available on an Internet website. The Secretary may use amounts available under this section to update and test, where applicable, quality measures endorsed by the qualified consensus-based entity as identified in MIPPA.

Measures developed under this section would be applicable to all age groups, where appropriate, and focus at minimum on the following areas: (1) patient outcomes and functional status; (2) coordination of care across episodes of care and care transitions; (3) meaningful use of health information technology; (4) safety, effectiveness, patient centeredness, appropriateness and timeliness of care; (5) efficiency of care; (6) equity of health services and health disparities; (7) patient experience and satisfaction; and (8) other areas deemed appropriate by the Secretary.

The legislation would authorize to appropriate $75 million to the Department of Health and Human Services for each of the fiscal years 2010 through 2014 to carry out this section on Quality Measure Development.

Consultation for Selection of Endorsed Quality Measures for Use in Reporting and Payment Programs. The Secretary would also develop a process for consultation with the qualified consensus-based entity as identified in MIPPA and the multi-stakeholder group referenced above

related to the selection of measures for use in reporting to and payment under Federal health programs. The Secretary would be required to establish a pre-rulemaking process to obtain input from the consensus-based entity and multi-stakeholder group on the selection of quality measures. Under this process, by not later than December 1st of each year, starting in 2011, the Secretary shall make public a list of measures being considered for selection with respect to Medicare reporting and payment systems. The Secretary may include in this list measures that have and have not been endorsed by the consensus-based entity. Not later than February 1st, the consensus-based entity must transmit to the Secretary its recommendations regarding the proposed measures. The qualified consensus-based entity would convene the multi-stakeholder group to provide consultation on making these recommendations. The entity would ensure an open and transparent process.

After the process outlined above is complete, the Secretary may select a measure that has not been recommended or endorsed by the consensus-based entity provided the Secretary publishes a rationale for use of the measure in the *Federal Register* and determines that an appropriate, alternative endorsed measure is not available.

Use and Review of Quality Measures. The Secretary would also set forth a process to disseminate measures and incorporate measures, where applicable, in workforce programs, training curricula, Federal health programs, and other areas deemed appropriate by the Secretary. Not less than once every three years, the Secretary would review quality measures used by the Secretary to determine whether to maintain use of such measure or phase out such measure.

Funding. For purposes of carrying out these activities, the Secretary would provide for the transfer of $50 million for each of the fiscal years of 2010 through 2014 from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund (in such proportion as the Secretary determined appropriate), to the CMS Program Management Account.

Added in the Modification or by Amendment at Markup

Health Information Technology. Free clinics would be added to the list of providers eligible for Medicare and Medicaid health information technology incentives.

PART III—ENCOURAGING DEVELOPMENT OF THE NEW PATIENT CARE MODELS

Accountable Care Organizations

Current Law

There are no existing laws that directly address the ability of organizations or systems of integrated providers to share in the efficiency gains resulting from the joint responsibility and care of Medicare beneficiaries. However, while some providers who deliver care in a vertically integrated managed care environment under Medicare are able to achieve these efficiency gains (e.g., a staff-model managed care organization), other providers face obstacles to this type of

practice and related potential sharing (e.g., fee-for-service providers who practice across a range of separate legal entities).

Experts define groups of providers (e.g. combinations of one or more hospitals, physician groups including primary care physicians and possibly specialists, and other health care providers) that are jointly responsible, through shared bonuses or penalties, for the quality and cost of health care services for a population of beneficiaries as accountable care organizations (ACOs). MedPAC has been among the proponents that have encouraged this type of gain sharing through accountable care organizations.

Medicare has some practical experience with ACO-like organizations. The Medicare Physician Group Practice (PGP) Demonstration, mandated by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, created pay-for-performance incentives for physician groups (being paid fee-for-service) to coordinate the overall care delivered to Medicare patients. The physician groups were rewarded for improving the quality and cost efficiency of health care services through increased coordination of Part A and Part B services, investment in care management programs, process redesign, and improved patient health outcomes, especially for beneficiaries with chronic illness, multiple co-morbidities and those near the end of life. CMS selected ten physician groups on a competitive basis to participate in the demonstration, favoring multi-specialty physician groups with well-developed clinical and management information systems. The ten physician groups represented 5,000 physicians and 224,000 Medicare fee-for-service beneficiaries. Groups that were able to meet quality-of-care benchmarks and reduce their total expected Medicare spending by more than two percent were allowed to share in the savings they generate to the Medicare program.

Results from the PGP demo suggest that the concept shows promise. Preliminary results from the demonstration and reports from participants suggest that the program has achieved its goals of better coordination of care for the chronically ill, careful attention to hospital discharge processes, expanded role for non-physician providers, and investments in IT. In the most recent year of the PGP demo, all participants demonstrated improvements in quality and achieved below average growth in costs. In addition, four were awarded with incentive payments for reducing costs below the two percent threshold. Accountable care organizations would go beyond the PGP model, which is based on physician groups, to include additional providers.

Chairman's Mark

The Medicare program would allow groups of providers who voluntarily meet certain statutory criteria, including quality measurements, to be recognized as ACOs and be eligible to share in the cost-savings they achieve for the Medicare program. Beginning on Jan. 1, 2012, eligible ACOs would have the opportunity to qualify for an incentive bonus.

Eligible ACOs would be defined as groups of providers and suppliers who have an established mechanism for joint decision making, such as for capital purchases. The following groups of providers and suppliers would be eligible for participation: practitioners in group practice arrangements; networks of practices; partnerships or joint-venture arrangements between hospitals and practitioners; hospitals employing practitioners; and such other groups of providers

of services and suppliers as the Secretary determines appropriate. Practitioners would be defined as physicians, regardless of specialty, nurse practitioners, physician assistants, clinical nurse specialists, and other practitioners or suppliers as the Secretary determines appropriate.

To qualify as an ACO, an organization would have to meet at least the following criteria: (1) agree to become accountable for the overall care of their Medicare fee-for-service beneficiaries; (2) agree to a minimum three-year participation; (3) have a formal legal structure that would allow the organization to receive and distribute bonuses to participating providers; (4) include the primary care physicians for at least 5,000 Medicare fee-for-service beneficiaries; (5) provide CMS with information regarding primary care and specialist physicians participating in the ACO as the Secretary deems appropriate; (6) have arrangements in place with a core group of specialist physicians; (7) have in place a leadership and management structure, including with regard to clinical and administrative systems; (8) define processes to promote evidence-based medicine, report on quality and costs measure, and coordinate care such as through the use of telehealth, remote patient monitoring, and other such enabling technologies; and (9) demonstrate to the Secretary that it meets patient-centeredness criteria determined by the Secretary, such as use of patient and caregiver assessments or the use of individualized care plans.

To earn the incentive payment the organization would have to meet certain quality thresholds. In determining the quality of care furnished by an ACO, the Secretary would be required to use measures such as: (1) clinical processes and outcomes; (2) patient and caregiver perspectives on care; and (3) utilization and costs (such as rates of ambulatory-sensitive admissions and readmissions). ACOs would be required to submit data, at the group and individual provider level, on measures the Secretary determines necessary to evaluate the quality of care furnished by the ACO. The Secretary would be required to establish performance standards for measures of the quality of care furnished by ACOs. The Secretary would be required to seek to improve the quality of care furnished by ACOs over time by specifying higher standards for purposes of assessing quality of care.

The Secretary would be authorized to incorporate reporting requirements and incentive payments and penalties related to the physician quality reporting initiative (PQRI), electronic prescribing, electronic health records, and other similar initiatives into the reporting requirements for ACOs.

CMS would assign Medicare fee-for-service beneficiaries to ACOs based on their use of Medicare items and services in preceding periods. The achievement thresholds and rewards for the ACO would be as follows. The spending baseline would be determined on an organizational level by using the most recent three years of total per beneficiary spending for those beneficiaries assigned to the ACO. The target would be set by the baseline amount plus a flat-dollar amount that is equal to the risk-adjusted average expenditure growth per beneficiary nationally. Baselines would be re-set at end of the three-year period.

ACOs with three-year average Medicare expenditures that are determined by CMS to be below their benchmark for the corresponding period would be eligible for shared savings at a rate determined appropriate by the Secretary. The Secretary would be required to set a minimum threshold of savings that would need to be achieved by an ACO before savings would be shared. The Secretary would have the authority to adjust the savings thresholds to account for the

varying sizes of participating ACOs. If the Secretary determines that an ACO has taken steps to avoid at-risk patients in order to reduce the likelihood of increasing costs, the Secretary would be authorized to impose an appropriate sanction, including terminating agreements with participating ACOs.

CMS Innovation Center

Current Law

The Social Security Amendments of 1967, as amended, provide the Secretary of HHS with broad authority to develop research and demonstration projects to test new approaches to paying providers, delivering health care services, or providing benefits to Medicare beneficiaries. Specifically, demonstrations designed to test changes in provider payment are required to increase the efficiency and economy of health care services without adversely affecting quality. Currently CMS is conducting approximately 30 Medicare demonstrations. Some of the key themes addressed in these demonstrations include coordinated care, pay for performance, HIT, and quality improvement. Although demonstrations may be initiated by both the agency and Congress, the number of congressionally mandated demonstrations has increased in recent years.

Section 646 of the MMA mandates that CMS conduct a five-year demonstration program to test ways to improve health outcomes while increasing efficiency. This demonstration, called the Medicare Health Care Quality demonstration, aims to improve patient safety, enhance quality, and reduce variation in medical practice that often in higher costs. One of the major goals of this demonstration is to see if Medicare can improve outcomes while simultaneously achieving cost savings. Improvements in care coordination are one strategy that CMS anticipates providers will attempt as they strive to improve quality but reduce costs. Two demonstration projects under this demonstration are scheduled to begin in 2009 with two others to begin soon thereafter.

Chairman's Mark

The Chairman's Mark would require the Secretary to create an Innovation Center within the Centers for Medicaid and Medicare Services (CMS). The Innovation Center will be a new office established within CMS that is authorized to test, evaluate, and expand different payment structures and methodologies which aim to foster patient-centered care, improve quality, and slow the rate of Medicare cost growth. The Mark would also make permanent the authority granted to the Secretary under Section 646 of the MMA (section 1866C of the Social Security Act).

The Center would be required to conduct an evaluation of each model tested, including an analysis of the extent to which the model results in: (1) coordination of health care services across treatment settings; (2) reduction of preventable hospitalizations; (3) prevention of hospital readmissions; (4) reduction of emergency room visits; (5) improvement in quality and health outcomes; (6) improvement in the efficiency of care; (7) reduction in the cost of health care services covered under this title; and (8) achievement of beneficiary and family-caregiver satisfaction.

In order to facilitate the timely design, implementation, and evaluation of payment models by the Center, the Mark exempts the Center from budget-neutrality requirements for an initial testing period. The Center would be given the authority to terminate or modify the design of models at any time during a testing period.

To support its work, including the Center's evaluation component, the Center would be required to consult regularly with outside experts and stakeholders, including the Medicare Payment Advisory Commission (MedPAC), health professionals with demonstrated expertise in chronic care management of older adults, and representatives of patients and caregivers.

The Secretary would be given the authority to expand the duration or the scope of any project undertaken by the Center if the Secretary determines that doing so would improve the quality of patient care and reduce the rate of growth of Medicare fee-for-service expenditures. The expected reduction in future Medicare expenditures must be certified by the CMS Office of the Actuary before an expansion could occur.

The Center would be required to test and evaluate patient-centered delivery and payment models. The Center would review models that have shown evidence of success in the Medicare population. The Center would consider models that target beneficiaries who are dually-eligible for both Medicare and Medicaid, and beneficiaries with multiple chronic conditions and at least one of the following: (1) an inability to perform 2 or more activities of daily living; and (2) a cognitive impairment, including dementia.

In addition, the Center would be required to consider for testing, at a minimum, models that achieve at least one of the following criteria:

1. Promote broad payment and practice reform in primary care, including patient-centered medical home models for high-need beneficiaries, medical homes that address women's unique health care needs, and models that transition primary care practices away from fee-for-service based reimbursement and toward comprehensive payment or salary-based payment;

2. Contract directly with groups of providers and suppliers to promote innovative care delivery models, such as through risk-based comprehensive payments or through salary-based payment;

3. Promote care coordination between health care providers that transition health care providers away from fee-for-service based reimbursement and toward salary-based payments.

4. Support care coordination for chronically-ill Medicare beneficiaries at high risk of hospitalization through a health IT-enabled network that includes a chronic disease registry, home tele-health technology, and care oversight by the beneficiary's treating physician;

5. Vary payment to physicians ordering advanced diagnostic imaging services according to the physician's adherence to appropriateness criteria for the ordering of such services, as determined in consultation with physician specialty groups and other relevant stakeholders;

6. Utilize medication therapy management services;

7. Establish community-based health teams to support small-practice medical homes by assisting the principal primary care practitioner in chronic care management activities;

8. Fund physician, nurse practitioner, or physician assistant-led home-based primary care programs with demonstrated experience in serving high-cost beneficiaries with multiple chronic illnesses and functional disabilities;

9. Establish a program to assist beneficiaries in making informed health care choices by paying providers for using patient decision-support tools that improve beneficiary and caregiver understanding of their medical treatment options;

10. Allow states to test and evaluate fully integrating care for dually eligible members, including the management and oversight of all Medicare and Medicaid funds for this population;

11. Allow states to test and evaluate systems of all-payer payment reform for medical care of residents in each participating State, including individuals dually eligible for Medicare and Medicaid;

12. Align nationally-recognized, evidence-based guidelines of cancer care with Medicare payment incentives in the areas of treatment planning and follow-up care planning for Medicare beneficiaries with cancer, including the identification of gaps in current quality measures;

13. Improve post-acute care through continuing care hospitals that offer inpatient rehabilitation, long-term care hospital, and home health or skilled nursing care during an inpatient stay and the 30 days immediately following discharge;

14. Fund home health providers who offer chronic care management services to Medicare beneficiaries in cooperation with interdisciplinary teams.

15. Promote improved quality and reduced cost by developing a collaborative of high-quality, low-cost health care institutions charged with: (1) developing, documenting and disseminating best practices and proven care methods; (2) implementing these techniques within their own institutions to demonstrate further improvements in quality and efficiency; and (3) providing assistance to other institutions on how best to employ these techniques to improve health care quality and lower costs.

16. Facilitate inpatient care, including intensive care, of hospitalized Medicare beneficiaries at their local hospital through the use of electronic monitoring by specialists, including intensivists and critical care specialists, based at integrated health systems.

17. 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.

In selecting models for testing, the Secretary shall also consider the extent to which models meet the following criteria:

1. Foster care coordination for high-cost, chronically ill Medicare beneficiaries who are at highest risk for hospitalization or readmission;

2. Place the patient, including family members and other informal caregivers, at the center of the care team;

3. Include, but are not limited to, in-person contact with beneficiaries;

4. Utilize technology, such as electronic health records and patient-based remote monitoring systems, to coordinate care over time;

5. Maintain a close relationship between care coordinators, primary care practitioners, specialist physicians, and other health care providers;~~Maintain a close relationship between care coordinators and primary care practitioners;~~

6. Rely on a team-based approach to interventions such as comprehensive care assessments, care planning, and self-management coaching.

To be approved for expansion, models would be required to demonstrate that they meet patient-centered criteria as determined by the Secretary, such as the use of patient and caregiver assessments or the use of individualized care plans.

The scope of the Innovation Center would include the Medicaid and CHIP programs, with the same requirements for testing and evaluation of patient-centered delivery and payment models that have shown evidence of success in Medicaid and CHIP populations as proposed for Medicare.

Within 18 months of enactment, the Center would be required to post on the CMS website a report on the Center's initial consideration of the models listed above, as well as a detailed plan for the continuing work of the Center.

The Chairman's Mark would appropriate $10 billion from the Part A and Part B Trust Funds to the Center over 10 years. The costs of otherwise uncovered benefits delivered under this

authority would be counted against the Center's overall funding level. In addition, the Center would be required to directly allocate a portion of such funding for the Center's evaluation activities.

Effective Date

The Innovation Center would be established by January 1, 2011.

National Pilot Program on Payment Bundling

Current Law

Medicare pays for most acute care hospital stays and post-acute care services, including inpatient rehabilitation and long term care hospitals stays, skilled nursing facility (SNF) stays, and home health care visits, under prospective payment systems (PPS) established for each type of provider. Under each PPS, a predetermined rate is paid for each unit of service, such as a hospital discharge, or a payment classification group. Payment classification groups are based on an estimate of the relative resources needed to care for a patient with a specific diagnosis and set of care needs. (The patient classification system used by hospitals, for example, is referred to as Medicare Severity diagnosis related groups, or MS-DRGs).

Generally, PPS payments include a national standardized amount adjusted by a wage index that is associated with the area where the provider is located or, for some hospitals, where it has been reclassified. Medicare law provides for annual updates of the program payments to reflect inflation and other factors. In some cases, these updates are linked to the consumer price index for all urban consumers (CPI-U) or to a provider-specific market basket (MB) index which measures the change in the price of goods and services purchased by the provider to produce a unit of output.

As Medicare beneficiaries with complex health conditions and multiple co-morbidities move between hospital stays and a range of post-acute care providers, Medicare makes separate payments to each provider for covered services. The Medicare Payment Advisory Commission (MedPAC), among others, has suggested that Medicare test new incentives and payment models to encourage providers to better coordinate across patients' episodes of care and to evaluate the full spectrum of care a patient may receive during these episodes. Specifically, in its June 2008 report, MedPAC recommended that a bundled payment system for an episode of care be explored in a pilot program. Under this voluntary program, a single provider entity would receive a bundled payment intended to cover the costs of the full range of care needed over the hospitalization episode, including 30 days post-discharge.

Chairman's Mark

The Secretary would be required to develop, test and evaluate alternative payment methodologies through a national, voluntary pilot program that is designed to provide incentives for providers to coordinate patient care across the continuum and to be jointly accountable for the entire episode of care starting in 2013. If evaluations find that the pilot program achieves

goals of improving patient outcomes, reducing costs and improving efficiency, then the Secretary would be required to submit an implementation plan to Congress on making the pilot a permanent part of the Medicare program.

Prior to the start of the pilot program, the Secretary would be required to determine which patient assessment instrument (such as the Continuity Assessment Record and Evaluation, or CARE tool), should be used to evaluate a patient's clinical condition for the purposes of determining the most clinically-appropriate site for post-acute care. The Secretary would be required to work with the Agency for Healthcare Research and Quality (AHRQ) and the qualified consensus-based entity as defined in MIPPA to develop episode of care quality measures and quality measures in compliance with the quality measurement and endorsement procedures laid out in Quality Infrastructure section of this legislation that are applicable to all post acute care (PAC) settings. Finally, the Secretary would be required to determine which Medicare statutory provisions and related regulations would be appropriate to waive in order to conduct the pilot program. The waived requirements might include the three-day inpatient hospital admission prior to Medicare's coverage of a skilled nursing facility admission, the 60 percent compliance threshold necessary to qualify as an inpatient rehabilitation facility, or the 25 average length of stay necessary to qualify as a long term care hospital. The Secretary would be able to waive other requirements such as the anti-kickback or the civil monetary penalty statute after consultation with the Inspector General.

The Secretary would select eight conditions to be included in the pilot program by considering the following factors: (1) a mix of chronic and acute conditions; (2) a mix of surgical and medical conditions; (3) conditions for which there is evidence of opportunity for providers to improve quality of care while reducing total expenditures; (3) conditions with significant variation in readmissions and post acute care spending; (4) conditions with high-volume or high post acute care spending; and (5) conditions that are deemed most amenable to bundling across spectrum of care given current practice patterns.

The pilot program may cover the following services: acute care inpatient hospitalizations; physician services delivered inside and outside of the acute care hospital setting; outpatient hospital services, including emergency department visits; services associated with acute care hospital readmissions; PAC services including home health, skilled nursing, inpatient rehabilitation, long term care hospital; and other services that the Secretary determines appropriate.

The episode of care established in the pilot program would start three days prior to a qualifying admission to the hospital and span the length of the hospital stay and 30 days following the patient discharge, unless the Secretary determines another timeframe is more appropriate for purposes of the pilot. The Secretary would develop policies to ensure the traditional fee-for-service program provides payment for PAC services in the appropriate setting for those patients who require continued PAC services after the 30th day following the discharge.

With respect to payments for the participating providers in the pilot program, the Secretary would test alternative payment methodologies, which would include bundled payments or arrangements in which providers continue to receive reimbursement under current payment

systems, but are held jointly accountable for the quality and cost of care provided to Medicare patients. Payments would be adjusted for patient severity of illness and other patient characteristics, including having a major diagnosis of substance abuse or mental illness, resources needed to provide care as well as adjustments for differences in hospital average hourly wages, physician work, practice expense, malpractice expense, and geographic adjustment factors. The pilot program's payment methodology would also take into account the provision of services such as care coordination, medication reconciliation, discharge planning and transitional care services and other patient-centered activities as defined appropriate by the Secretary.

The pilot program's bundled payment would be made to a Medicare provider or other entity comprised of multiple providers to cover the costs of acute care inpatient and outpatient hospital services, physician services and post-acute care. The comprehensive bundled payment would include the costs of any rehospitalizations that occur during the covered period. The bundled payment for each of the eight selected conditions would be based on the average hospital, physician, and post-acute care payments made over the hospitalization period for patient.

Any Medicare provider, including hospitals, physician groups, or post-acute entities interested in assuming responsibility for the bundled payment would be able to apply to participate in the pilot program. Any entity assuming responsibility for the bundled Medicare payment would be required to have an arrangement with an acute hospital for initiation of bundled services. All services provided under the bundle would be required to be provided or directed by Medicare-participating providers. Eligible entities would receive the bundled payment for each patient served, regardless of whether patient receives certain levels of physician or post acute care.

In those instances a condition selected for the pilot program is also subject to Medicare's readmissions policy, hospitals participating in the pilot would be exempt from readmissions penalty for that condition. The bundled payment to a pilot participant would cover any preventable readmissions within the covered period. In the case where a patient with a selected condition is readmitted for a preventable readmission at a different hospital than the initial hospitalization, the Secretary would reimburse the subsequent hospital its base operating and capital MS-DRG payment amounts and the physicians at the subsequent hospital the amount that would otherwise be made if this policy did not apply. The Secretary would then adjust the bundled payment to recoup these same amounts. This payment correction would not apply to patient readmissions associated with trauma-related, and burn-related diagnoses, and other areas as outlined in the readmissions policy in another section of this legislation and as determined by the Secretary.

The Secretary would be directed to establish quality measures related to care provided across all providers participating in the pilot. These quality measures would be risk-adjusted and would include: episode of care measures; measures of improved functional status; other patient outcomes deemed appropriate by the Secretary; rates of readmission; rates of preventable readmissions as defined in the readmissions policy; rates of return to the community; rates of admission to the ER after hospitalization (as distinctly separate from readmission rates); efficiency measures; measures of patient-centeredness of care; patient perception of care

measures; measures to monitor and detect the under provision of necessary care; and other measures deemed appropriate by the Secretary

The Secretary would be given the authority to delete, revise, and add quality measures as deemed appropriate related to the care being provided to patients within the pilot program. All providers who participate in pilot would be required to report to the Secretary on quality measures during each year of the program. At the discretion of the Secretary, to the extent practicable, these measures would be required to be reported through an electronic health record in a manner prescribed by the Secretary.

The Secretary would be required to conduct an independent evaluation of the pilot program and submit reports to Congress no later than two and three years after date of the implementation of the pilot program. The evaluation would include an examination of the extent of performance improvement related to quality measures, health outcomes, access to care and financial outcomes.

The Secretary would consult with representatives of small and rural hospitals, including critical access hospitals (CAHs), to determine appropriate and effective methods for hospitals to participate in the pilot program or in a similar pilot program. The Secretary would consider innovative methods of implementing bundling in these hospitals, including the challenges associated with the small volume of services provided to Medicare beneficiaries by these hospitals and potential lack of access to certain post-acute services in some communities. Not later than two years after the date of enactment of this Act, the Secretary would submit to Congress a report on the results of this consultation including recommendations with the respect to the appropriate application of bundling to small and rural hospitals, including CAHs.

If the Secretary finds that the pilot program results in significant improvements in quality and outcomes and reductions in cost, then the Secretary would be required to submit an implementation plan to Congress in FY2016 with recommendations regarding making the pilot a permanent part of the Medicare program in FY2018. If the Secretary finds that the pilot program did not result in significant improvements in quality and outcomes or reductions in cost, the Secretary would be required to submit a report to Congress in FY2016 providing recommendations on how the pilot could have been improved to address these shortcomings. In the event the Secretary determines that the pilot program results in significant improvements in quality and outcomes and reductions in cost, the Secretary may extend the pilot program for those who participated in the pilot for a duration deemed appropriate by the Secretary. This extension will allow current participants to remain in the program absent any further action by Congress to further expand the program.

Reducing Avoidable Hospital Readmissions

Current Law

Medicare pays for most acute care hospital stays using a prospectively determined payment for each discharge under section 1886 (d) of the Social Security Act. Payment also depends on the relative resource use associated with a patient classification group, referred to as the Medicare

Severity diagnosis related groups (MS-DRGs), to which the patient is assigned based on an estimate of the relative resources needed to care for a patient with a specific diagnosis and set of care needs. Inpatient services provided by acute care hospitals in Maryland are paid under a state-specific Medicare payment system under section 1814(b)(3) of the Social Security Act.

The Medicare program currently has payment policies in place related to how the Medicare program must reimburse hospitals in cases where Medicare beneficiaries are transferred between two hospitals through the course of their acute care episodes. Under the current transfer payment policy, the sending acute care hospital (the hospital that transfers the patient to another acute care hospital) is paid on a per diem basis at a level that can be no greater than the otherwise applicable full MS-DRG payment amount if the transfer meets certain conditions. The final discharging acute care hospital (the hospital that receives the patient) receives the full MS-DRG payment amount. Payment changes resulting from such transfers are implemented via Medicare's claims processing systems.

The Balanced Budget Act of 1997 (BBA, P.L. 105-33) directed the Secretary to apply the acute care transfer policy to a broader set of circumstances. Specifically, the BBA directed the Secretary to select ten MS-DRGs with high volumes of discharges to post-acute care or disproportionate use of post-acute services and pay these cases as transfers beginning in FY 1999. Post-acute care includes long term care hospitals, inpatient rehabilitation facilities or distinct part units, psychiatric hospitals or units, skilled nursing facilities, and clinically related home health care provided within three days after the date of discharge. After FY 2000, the Secretary was authorized to expand this policy to additional MS-DRGs.

According to the Medicare Payment Advisory Commission's (MedPAC) *June 2007 Report to Congress*, analysis of 2005 Medicare data showed that 6.2 percent of hospitalizations of Medicare beneficiaries resulted in readmission within 7 days and 17.6 percent of hospitalizations resulted in readmission within 30 days. The 17.6 percent of hospital readmission accounts for $15 billion in Medicare spending. These readmission rates reflect the total number of readmissions, including those that may not have been related to the initial diagnosis and may not have been preventable. MedPAC, the Centers for Medicare and Medicaid Services (CMS), and others have expressed concern that providers do not have financial incentives to reduce potentially preventable readmissions. In addition, MedPAC, in its June 2008 report, recommended that Medicare's payments to hospitals with relatively high readmission rates for select conditions be reduced.

Chairman's Mark

CMS would calculate national and hospital-specific data on the readmission rates of Medicare participating subsection (d) hospitals and for hospitals paid under section 1814 (b)(3) for eight conditions that the Secretary selects based on spending and readmission rates. Starting in FY 2012, the Secretary would share these data with hospitals, and the data would be publicly reported on the Hospital Compare website. Starting in FY 2013, hospitals with readmission rates above a certain threshold would have payments for the original hospitalization reduced by 20 percent if a patient with a selected condition is re-hospitalized with a preventable readmission

within seven days and by ten percent if a patient with a selected condition is re-hospitalized with a preventable readmission within 15 days.

Preventable readmissions would be defined as all readmissions that could have been reasonably prevented, as determined by the Secretary. Certain readmissions that would be excluded from the definition as follows: (1) readmissions associated with metastatic malignancies, trauma, and burns; (2) planned readmissions; (3) readmissions for patients with discharge status of "left against medical advice;" and (4) patients who are transferred to another short-term acute care hospital.

According to a methodology that would be determined by the Secretary, which may include using condition-specific measures endorsed by the National Quality Forum, CMS would calculate a national preventable readmissions benchmark by condition. Each condition would be based on a weighted average of all DRGs related to each condition. CMS would also calculate a hospital-specific preventable readmissions rate by calculating preventable readmissions rates for each of the above conditions that a hospital treats. Calculations would be risk adjusted for patient's severity of illness, other patient characteristics, including having a major diagnosis of substance abuse or mental illness, and differences in case types.

Hospitals with readmissions above the 75th percentile (based on 30 day rates) for selected conditions would be subject to readmissions payment policy related to the selected conditions. Calculation of percentiles would be based on prior year's performance. For example, if a hospital is subject to the policy in 2009, and then in 2010 is under the 75th percentile, it would not be subject to the policy in 2011. A hospital above the 75th percentile would incur the 20 percent penalty for the original admission only after it is determined that a preventable readmission occurred within seven days of discharge from the original admission. A ten percent penalty for the original admission would be imposed only after it is determined that a preventable readmission occurred within 15 days of discharge from the original admission. CMS would be required to implement these edits through its claims processing systems so that a readmission to a hospital different than the hospital of the original admission would result in the application of the policy to the original hospital.

Three years after implementation of the readmissions policy, the Secretary would have the authority to expand the policy to other conditions. Additional conditions would be selected based on: (1) high spending on readmissions or high rates of readmissions; and (2) other criteria as determined by the Secretary.

Transitional Care Program to Reduce Preventable Readmissions

Current Law

No provision.

Chairman's Mark

The Chairman's Mark would establish a three-year Medicare pilot program, called the Community Care Transitions Program. Beginning in 2011, the Secretary would fund eligible hospitals and community-based partnership organizations to provide patient-centered, evidence-based care transition services to Medicare beneficiaries at the highest risk of preventable re-hospitalization. Eligible hospitals would be those identified by the Secretary as having high readmission rates, such as above the 75th percentile for selected conditions. The Secretary would give priority to eligible hospitals that disproportionally serve medically underserved populations, as well as small community hospitals and rural hospitals. A hospital in collaboration with partnership organizations must identify at least one evidence-based care transition intervention to be utilized as the model of service delivery for targeted high-risk beneficiaries. Examples of core intervention elements for care transition services could include:

1. Initiating care transition services for targeted high-risk beneficiaries no later than 24 hours prior to the beneficiary being discharged from the participating hospital;

2. Assessment and active engagement with patient and caregiver focusing on coaching, self-management support when appropriate, and providing information specific to the patient's health, functional, social, and environmental conditions;

3. Comprehensive medication review and management, including patient self-management when appropriate;

4. Assisting patient and caregiver to engage in productive interactions with post-acute and outpatient providers in a timely manner; and

5. Arrangement of timely follow-up in order to educate patient and/or caregiver about health symptoms that indicate a worsening condition and how to respond.

Targeted high-risk beneficiaries would be individuals identified by the Secretary as being at highest risk for readmission or for a poor transition from a hospital to a post-hospital site of care. The identification by the Secretary would be based on achieving a minimum hierarchical condition category score (specified by the Secretary) in order to target eligibility for benefits to individuals with multiple chronic conditions and other risk factors, such as cognitive impairment, depression, or a history of multiple hospitalizations.

The program's funding level would be set at $500 million over three years. The Secretary would have the authority to continue or expand the scope and duration of the program if the Secretary determined that expansion would improve quality of care and the CMS Office of the Actuary certified that expansion would reduce projected Medicare spending.

Extension of Gainsharing Demonstration

Current Law

Section 5007 of the Deficit Reduction Act of 2005 (DRA, P.L.109-171) authorizes a gainsharing demonstration to evaluate arrangements between hospitals and physicians designed to improve the quality and the efficiency of care provided to beneficiaries. In the absence of this DRA authority, gainsharing arrangements are restricted by the Civil Monetary Penalty law. CMS is currently operating two projects, each consisting of one hospital in New York and West Virginia. Although authorized to begin on January 1, 2007, the project began on October 1, 2008 and will end as mandated on December 31, 2009. The Secretary was required to submit a report on quality improvement and achieved savings as a result of the demonstration no later than December 1, 2008. The final report on these issues was due on May 1, 2010. The project was appropriated $6 million in FY2006 to be available for expenditure through FY2010.

Chairman's Mark

The authority to conduct the gainsharing demonstration would be extended until September 30, 2011. The due date of the quality improvement and achieved savings report would be extended from December 1, 2008, to March 31, 2011. The final report would be due September 30, 2012, instead of May 1, 2010. An additional $1.6 million would be appropriated in FY2010. All appropriations would be available for expenditure through FY2014.

Added in the Modification or by Amendment at Markup

Home-based Chronic Care Management Program. The Mark 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. Interdisciplinary teams of health care professionals caring for patients with multiple chronic conditions in their residences would be eligible for shared-savings if they achieve quality outcomes, patient satisfaction and cost savings. The Secretary shall limit the number of practices selected for participation under the pilot so that no more than 10,000 applicable beneficiaries are expected to participate. Applicable beneficiaries are beneficiaries who are not enrolled in Medicare Advantage, PACE programs, medical homes, ACOs, or other shared savings programs. Practice would be required to have a minimum of 200 beneficiaries; however practices can join into larger groups to meet this requirement. The Secretary shall establish target spending levels for practices in such a manner as to account for normal variation in expenditures for items and services covered under parts A and B based upon the size of the practice, characteristics of the enrolled individuals, and such other factors as the Secretary determines appropriate.

PART IV—STRENGTHENING PRIMARY CARE AND OTHER WORKFORCE IMPROVEMENTS

Primary Care/General Surgery Bonus

Current Law

Medicare uses a fee schedule to reimburse physicians for the services they provide. In certain circumstances, physicians receive an additional payment to encourage targeted activities. These bonuses, typically a percentage increase above the Medicare fee schedule amounts, can be awarded for a number of activities including demonstrating quality achievements, participating in electronic prescribing, or practicing in underserved areas.

Section 1833(m) of the Social Security Act provides bonus payments for physicians who furnish medical care services in geographic areas that are designated by the Health Resources and Services Administration (HRSA) as primary medical care health professional shortage areas (HPSAs) under section 332 (a)(1)(A) of the Public Health Service (PHS) Act. In addition, for claims with dates of service on or after July 1, 2004, psychiatrists furnishing services in mental health HPSAs are also eligible to receive bonus payments.

The bonus payment equals ten percent of what would otherwise be paid under the fee schedule. HPSAs may be designated as having a shortage of primary medical care, dental or mental health providers. They may be urban or rural areas, population groups or medical or other public facilities.

Chairman's Mark

The Chairman's Mark would establish a new ten percent bonus on select evaluation & management codes under the Medicare fee schedule for five years, beginning January 1, 2011. The groups of codes to which this bonus would apply would be office visits, home visits, nursing facility visits, and domiciliary, rest home (e.g. boarding home), or custodial care services.

The bonus would be available to primary care practitioners who: (1) have a specialty designation of family medicine, internal medicine, geriatric medicine, or pediatric medicine (or are an advanced practice nurse or physician assistant); and (2) furnish 60 percent of their services in the select codes. Services provided to both established patients and new patients would qualify. Qualifying practitioners providing care in a HPSA would also receive the 10 percent bonus on hospital visit codes that are typical of primary care medicine (as determined by the Secretary), though only ten percent of these visits would count toward the 60 percent threshold.

In addition, general surgeons providing care in a HPSA would also be eligible for a ten percent bonus on major procedure codes for five years, beginning January 1, 2011.

Half (50 percent) of the cost of the bonuses would be offset through an across-the-board reduction to all other codes, except for physicians who primarily provide services in a HPSA zip code.

Redistribution of Unused GME slots to Increase Access to Primary Care and Generalist Physicians

Current Law

With certain exceptions, the Balanced Budget Act of 1997 (BBA, P.L. 105-33) limited the number of allopathic and osteopathic residents that Medicare would reimburse a teaching hospital at the level reported in its cost report ending on or before December 31, 1996. The limit does not include dental or podiatry residents. The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA, P.L. 108-173) authorized the redistribution of up to 75 percent of each teaching hospital's unused resident positions to hospitals seeking to increase their medical residency training programs. Any adjustments made to teaching hospitals' resident limits would be permanent. Rural teaching hospitals with less than 250 beds were exempt from the redistribution of any of their unfilled positions. Under the redistribution program, teaching hospitals were allowed to request up to an additional 25 full time equivalent (FTE) positions for direct graduate medical education (DGME) and indirect medical education (IME) payments. Hospitals were required to demonstrate the likelihood that the redistributed positions would be filled within three cost reporting periods beginning July 1, 2005. MMA required that the unused slots be redistributed according to specific priorities: rural hospitals, urban hospitals located in areas with a population of one million or less, specialty training programs that are the only specialty program in a state, and all other hospitals. The redistribution was effective for portions of cost reporting periods starting July 1, 2005. The redistributed resident slots have different IME and DGME payment formulas from those used to reimburse hospitals' previous residents.

Chairman's Mark

Similar to the proposal set forth in the MMA, the Chairman's Mark would establish a policy to redistribute currently unused residency training slots as a way to encourage increased training, particularly in the areas of primary care and general surgery. In this provision, the Centers for Medicare and Medicaid Services (CMS) would calculate the number of unused resident slots over the last three fiscal years. Unused slots would be defined as the difference between total available resident slots and a hospital's actual FTE of residents. Based on this calculation, 80 percent of unused slots would be included in a pool for redistribution. Rural teaching hospitals with less than 250 beds would be exempt from the redistribution of any of their unfilled positions. Certain other hospitals who participated in a voluntary reduction plan under Section 1886 (h)(6) would also be exempt from the redistribution policy if they demonstrate that they have a specified plan in place for filling the unused residency positions within two years of enactment of this legislation.

The Secretary would be required to increase the otherwise applicable resident limit for each qualifying hospital that submits a timely application by such number determined by the Secretary. The aggregate number of increases in resident limits would be equal to the estimated aggregate reduction in resident limits. A hospital that receives an increase in its otherwise applicable resident limit would be required to ensure that (1) the number of FTE residents in a primary care residency as determined by the Secretary is not less than the average number of FTE residents in a primary care residency during the three most recent cost reporting periods

ending prior to the date of enactment; and (2) that not less than 75 percent of the positions attributable to such an increase are in a primary care or general surgery residency. A hospital that does not meet this requirement would have its otherwise applicable resident limit reduced by the amount of the increase authorized under this provision. Those positions would be subsequently distributed according to the priorities established in this provision.

When determining the increase in a hospital's otherwise applicable resident limit, the Secretary would take into account the demonstrated likelihood that: (1) a hospital would fill the positions within the first three cost reporting periods beginning on or after July 1, 2010; (2) a hospital would take part in an innovative delivery model that promotes quality and care coordination, such as payment bundling; and (3) a hospital would have an accredited rural training track residency program. The Secretary would distribute the increase in the otherwise applicable resident limit based on the following factors: (1) to hospitals located in states with resident to population ratios in the lowest quartile; (2) to hospitals located in a state that is among the top 10 states in terms of the ratio of the total population living in a health professional shortage area (HPSA) determined by the U.S. Department of Health and Human Services as of the date of enactment compared to total population of the state based on the most recent state population projections by the U.S. Census Bureau~~to hospitals located in a state that is among the top 25 states in terms of the ratio of the total population living in a health professional shortage area (HPSA) determined by the U.S. Department of Health and Human Services compared to total population of the state based on the most recent state population projections by the U.S. Census Bureau~~; and (3) to hospitals located in rural areas.

From the pool of redistributed slots referenced above 70 percent of such slots shall be reserved for states meeting the first criteria.

Slots not re-assigned within one year after the Secretary allows for application under the modified criteria may be assigned according to the other criteria established within the Mark. Hospitals would not be permitted to apply for more than 75 additional FTE residency positions under this provision, unless the number of residency positions exceed the number of approved applications for such positions. The increase in resident positions would be distributed no later than two years after the date of enactment.

The per resident amounts (PRAs) for the resident positions distributed under this provision would equal the hospitals PRAs for primary and non-primary care positions for the purposes of calculating direct graduate medical payments. The indirect medical education adjustment for these resident positions distributed under this provision would be reimbursed at the full IME adjustment factor. ~~The indirect medical education adjustment for the resident positions distributed under this provision would reduce the formula multiplier in the IME adjustment factor by 50 percent.~~

Promoting Greater Flexibility for Residency Training Programs

Current Law

Medicare currently reimburses the direct costs of graduate medical education (DGME) for approved residency training programs without regard for the setting where the residents' activities relating to patient care are performed as long as the hospital incurs all, or substantially all, of the costs for the training program in that setting. Through regulation, CMS has defined all, or substantially all costs, as 90 percent of resident stipends and fringe benefits and costs associated with a supervising physician. However, as presently administered, a hospital that jointly operates a residency program with another hospital cannot include the time spent by residents working at a non-hospital site if it incurs, all or substantially all of the costs for only a portion of the residents in that program at the non-hospital site.

Chairman's Mark

In order to promote training in outpatient settings and to ensure the availability of residency programs in rural and underserved areas, this policy would provide increased flexibility in laws and regulations governing graduate medical education funding in the Medicare program. Specifically, effective for cost reporting periods beginning on or after July 1, 2010, all time spent by a resident would count toward Medicare direct graduate education payment, without regard to the setting where the activities are performed, if the hospital continues, or in the case of a jointly operated residency program, the involved entities continue to incur the costs of the stipends and the fringe benefits of the resident during the time the resident spends in the setting.

Effective for discharges on or after July 1, 2010, all the time spent by a resident in patient care activities in a nonhospital setting would be counted towards Medicare indirect medical education payment if the hospital continues, or in the case of a jointly operating residency training program, the entities continue to incur the costs of the stipends and fringe benefits of the resident during the time spent in that setting.

An eligible training site would be an ambulatory or outpatient training site. A jointly operated residency training program means an approved medical residency training program that is jointly operated by one or more hospitals or by one or more eligible training sites under a written agreement which specifies a method for an equitable distribution of time spent by the resident in activities relating to patient care.

Each hospital or eligible training site participating in the operation of a jointly operated residency training program would submit the written agreement to the Secretary. In the case of a jointly operated residency training program, the direct graduate medical education and the indirect medical education payments would not exceed the aggregate payments that would have been made to the hospitals and the eligible training sites if the training program had been independently operated.

Rules for Counting Resident Time for Didactic and Scholarly Activities and Other Activities

Current Law

Medicare pays teaching hospitals the costs of approved medical residency training programs through two mechanisms: an indirect medical education (IME) adjustment within the inpatient prospective payment system (IPPS) and direct graduate medical education (DGME) payments made outside of IPPS. Certain non-patient care activities that are part of an approved training program are not allowable for DGME or IME payment purposes. With respect to training that occurs in hospital settings, Medicare would not include the time that residents spend in non-patient care activities, including didactic activities, when calculating IME payments. With respect to training that occurs in nonhospital settings, Medicare would not count the time that residents spend in non-patient care activities, including didactic activities, when calculating DGME or IME payments.

Chairman's Mark

When calculating DGME payments, Medicare would count the time that residents in approved training programs spend in certain non-patient care activities in a nonhospital setting that is primarily engaged in furnishing patient care. Reimbursable non-patient care activities would include didactic conferences and seminars but would not include research that is not associated with the treatment or diagnosis of a particular patient. In addition, Medicare would count all the vacation, sick leave and other approved leave spent by resident in an approved training program as long as the leave time does not extend the program's duration.

When calculating IME payments, Medicare would adopt the same rules about counting residents' leave time. Medicare would also include all the time spent by residents in approved training programs on certain non-patient care activities (including didactic conferences but not certain research) that occurs in an acute care hospital or in a provider-based hospital outpatient department.

These provisions would be effective as of dates determined appropriate by the Secretary.

Preservation of Resident Cap Positions from Closed and Acquired Hospitals

Current law

The Centers for Medicare and Medicaid Services (CMS) has established certain regulations governing Medicare's provider enrollment requirements that determine under which circumstances providers can bill the Medicare program including those involved in change of ownership transactions. Very generally, in order to acquire a teaching hospital's resident cap under a change of ownership transaction, the acquiring entity must retain the original provider number. However, the acquiring entity would also assume all liabilities associated with that provider number.

Starting August 29, 2005 (the day after Hurricane Katrina), hospitals were permitted to form emergency affiliation agreements if located in Federally declared disaster areas starting the first day of a Section 1135 emergency period. Under 42 Code of Federal Regulations (CFR) 413.79, a home hospital located in such an area that experiences at least a 20 percent decline in inpatient occupancy can temporarily transfer its resident cap to a host hospital.

Chairman's Mark

The Secretary would promulgate regulations to establish a process where the residency allotments in a hospital with an approved medical residency program that closes could be used to increase the otherwise applicable residency limit for other hospitals. The increase in residency positions would be distributed in the following priority order. First priority would be given to hospitals located in the same or contiguous core-based statistical area as the hospital that closed; second priority would be given to hospitals located in the same State as the hospital that closed; third priority would be given to hospitals located in the same region of the country as the hospital that closed; and fourth priority, to be used only if the residents are not distributed under the other priorities, would be the priorities established for the distribution of additional residency positions established previously in this legislation. The residency positions would be distributed to those hospitals that demonstrate a likelihood of filling the position within three years.

A special rule for acquired hospitals would be established. Specifically, when a hospital is acquired through any mechanism by another entity with approval of a bankruptcy court during a period determined by the Secretary, but not less than within three years, the applicable resident limit of the acquired hospital would be the limit of the acquired hospital as of the date immediately before the acquisition without regard to whether the acquiring entity accepts assignment of the Medicare provider number of the hospital that was acquired. The acquiring entity would be required to continue operation of the hospital that was acquired and to furnish services, medical residency programs, and the volume of patients similar to those of the hospital that was acquired during such period. These provisions would not affect any temporary adjustment to a hospital's FTE resident cap established under 42 CFR 413.79 as in effect on the date of enactment.

The provisions would not be implemented in a manner that would require reopening of any settled hospital cost report where there is not a jurisdictionally proper appeal pending on Medicare's IME and DGME payments as of the date of enactment.

Proposal on Development of a National Workforce Strategy

Current Law

In the Department of Health and Human Services, the Centers for Medicare and Medicaid Services (CMS) and the Health Resources and Services Administration (HRSA) play key roles in supporting workforce development and training.

In CMS, the Medicare program provides an important funding source for graduate medical education (GME) through two distinct payments made to teaching hospitals. Medicare makes

direct graduate medical education (DGME) payments to compensate teaching hospitals for costs directly related to residency programs, such as residents' stipends and benefits and the costs associated with supervisory physicians. These payments are made based on the number of residents and the hospital's proportion of Medicare inpatient caseload. Medicare also makes indirect medical education (IME) payments to compensate hospitals for costs indirectly associated with medical education, such as higher patient costs and other costs associated with teaching hospitals. These payments are based on a hospital's intern/resident to bed (IRB) ratio along with a national adjustment factor. Also, most states make Medicaid payments to help cover the costs of training new physicians in teaching hospitals and other teaching programs. Payments for GME in the Medicaid program are made at the state's option.

HRSA administers a number of health care workforce programs authorized by Title VII and Title VIII of the Public Health Service Act. HRSA is also the primary Federal agency that collects health care workforce data and is responsible for tracking national trends. HRSA is comprised of six bureaus: The Bureau of Primary Health Care, The Bureau of Clinician Recruitment and Service, The Bureau of Health Professions, The Maternal and Child Health Bureau, The HIV/AIDS Bureau, The Healthcare Systems Bureau. The Bureau of Clinician Recruitment and Service and The Bureau of Health Professions focus on all levels of medical education, including undergraduate education, undergraduate medical education, and graduate medical education. HRSA is also responsible for certifying communities as Health Professional Shortage Areas (HPSAs), which take into account factors such as the prevailing rate of poverty and infant mortality; the number of physicians per 1,000 residents; and travel distances to the nearest available care. HPSA designations determine eligibility for a number of Federal workforce programs, including the National Health Service Corps, Nursing Education Loan Repayment Program and Rural Health Clinic Certification. In addition, HRSA is supported by four health profession committees that advise the agency on various workforce issues. These committees include the National Advisory Committee on Nursing Education and Practice; the Advisory Committee on Interdisciplinary and Community Based Linkages; the Advisory Committee on Training in Primary Care Medicine and Dentistry; and the Council on Graduate Medical Education.

Chairman's Mark

Several studies and policy experts have called for a renewed effort to develop a comprehensive and coordinated national strategy to address workforce shortages and encourage training in key focus areas that support delivery system reform goals, such as improving care coordination, health provider use of health information technology and increasing access to primary care services. Some recommendations have promoted, at minimum, a need to provide additional resources to support the workforce-related activities of CMS and HRSA and to encourage increased collaboration among these agencies. Others have called for the establishment of a national workforce commission that would be tasked with advising Congress and the Secretary on health care workforce policy and recommendations.

To achieve these goals, the Secretary would create a Workforce Advisory Committee. The Committee would be comprised of external stakeholders and representatives of health professionals, schools of higher education for health care professionals, public health experts,

health insurers, business, labor, state or local workforce investment boards, and any other health professional organization or practice the Secretary determines appropriate.

These stakeholders would develop and present a national workforce strategy to the Secretary and the Congress that will set the nation on a path toward recruiting, training and retaining a health workforce that meets the nation's current and future health care needs. In developing this strategy, the Committee would consult closely with relevant Federal agencies such as HRSA and the Veterans Administration to avoid duplication of effort and to review government wide Federal workforce policies. The Committee would also consult with state and local entities. The Committee would present biannual reports to Congress, relevant Federal agencies, and the public outlining its findings and policy recommendations. Specifically, the committee will examine the current and projected health care workforce supply; the current and projected demand for health professionals; the health care workforce education training capacity; the implications of new and existing Federal policies which will affect the health care workforce; and finally the health care workforce needs of specific populations, including minorities, rural and urban populations, and medically underserved populations.

In addition, the committee would report on specific high-priority topics including efforts to integrate the health care workforce into a reformed delivery system, the implications for the health care workforce as a result of greater utilization of health information technology, nursing workforce capacity, mental and behavioral health care workforce capacity, and the geographic distribution of health care providers.

Demonstration Project to Address Health Professions Workforce Needs

Current Law

No provision.

Chairman's Mark

The Chairman's Mark establishes demonstration grants to address needs in the health professions workforce. It would establish a demonstration grant program through competitive grants to provide aid and supportive services to low-income individuals with the opportunity to obtain education and training for occupations in the health care field that pay well and are expected to experience labor shortages or be in high demand. These grants would be made by the Secretary of Health and Human Services, in consultation with the Secretary of Labor, to states, Indian tribes, tribal organizations, institutions of higher education, local workforce investment boards under the Workforce Investment Act, or community-based organizations. At least three grants must be awarded to an Indian tribe, Tribal organization, or Tribal College or University. Grantees must consult with the state agency administering the Temporary Assistance for Needy Families (TANF) block grant, and, if the grantee is not a local workforce investment board, consult with local and state workforce investment boards.

The demonstration grant is to serve low-income persons, including recipients of assistance under state Temporary Assistance for Needy Families (TANF) programs. The demonstration program shall provide eligible individuals, if appropriate, with financial aid; child care, case management;

and supportive services. Financial aid received shall not be considered income, and shall be disregarded in determining eligibility for TANF, Medicaid, the Supplemental Nutrition Assistance Program (SNAP), Low Income Home Energy Assistance Program, and any program administered by the Department of Housing and Urban Development.

Grantees must submit interim reports and a final report to the Secretary of HHS on their activities, which will assess the projects' effectiveness in improving outcomes for participants and address health professions workforce needs in the project areas. The Secretary of HHS must evaluate the demonstration project. The evaluation will identify successful activities for creating and sustaining a health professions workforce that has accessible entry meets, meets high standards for education, training, certification and professional development; and provides increased wages, health care coverage, and other benefits for the workers. The Secretary of HHS shall submit interim and final reports on the demonstration to Congress.

The Chairman's Mark also establishes a demonstration program to competitively award grants to up to six states for three years to develop core training competencies and certification programs for personal and home care aides.

In selecting states to participate, the Secretary will establish criteria to ensure geographic and demographic diversity. In addition, a state must offer medical assistance for personal care services under its Medicaid state plan, not reduce the number of hours of training from pre-demonstration levels or below levels required by state or federal law; and recruit a minimum number of health and long term care providers to participate in the project. Participating states must demonstrate that their existing training standards are different from other states and different from the competencies described in the demonstration.

The demonstration will determine the efficacy of developing core training competencies in the following areas: the role of the personal or home care aid; consumer rights, ethics, and confidentiality; communication, cultural, and linguistic competence and sensitivity, problem solving, behavior management, and relationship skills; personal care skills; health care support; nutritional support; infection control; safety and emergency training; training specific to an individual consumer's needs; and self-care. The project will also evaluate the methods used to implement these competencies including: length of training; appropriate student to trainer ratio; time spent in the classroom compared to on-site; trainer qualifications; content for hands-on training and written certification exam; and continuing education requirements.

The Secretary of Health and Human Services will develop an experimental or control group testing protocol, in consultation with an independent evaluation contactor, to evaluate the impact of core training competencies on: job satisfaction; mastery of job skills; beneficiary and family satisfaction with services; and on existing training infrastructure and resources of the States. The evaluation must also address whether a minimum number of hours of initial training should be required for personal or home care aides. The Secretary will make an interim report to Congress within two years after enactment and a final report within a year of completion of the demonstration project.

The Chairman's Mark appropriates $85 million per year for five years (FY2010-FY2014) for these demonstrations, with no more than $5 million per year for three years (FY 2010-FY2012) allowed for the personal and home care aid demonstration.

Extension of Family-to-Family Health Information Centers

Current Law

The Deficit Reduction Act of 2005 (DRA, P.L. 109-171) provided dedicated funding for the development and support of family-to-family health information centers. The centers assist families of children with disabilities or special health care needs make informed choices about health care to promote good treatment decisions, cost effectiveness, and improved health outcomes for such children; provide information regarding the health care needs of children with disabilities or special health care needs; identify successful health delivery models for such children; develop models of collaboration between families of such children and health professionals; provide training and guidance with regard to the care of such children; and conduct outreach activities to families of such children, health care providers, schools, and other appropriate entities and individuals. Family-to-family health information centers are staffed by members of families with expertise in Federal, State and private health systems and health professionals. In Fiscal Year 2009, family-to-family health information centers are funded at $5 million. No funds are appropriated for years after FY2009.

Chairman's Mark

The Chairman's Mark would extend funding for family-to-family health information centers at $5 million for FY2010 through FY2012.

Added in the Modification or by Amendment at Markup

***Teaching Health Centers*.** The Mark would seek to increase training and improve access to primary care services. Qualified teaching health centers would be eligible for payments for direct graduate medical education expenses and other indirect expenses associated with operating approved graduate medical residency training programs. These programs will be in addition to existing Medicare-supported residency slots and must meet criteria for accreditation (as set forth by either the Accreditation Council for Graduate Medical Education or the American Osteopathic Association). The Secretary would determine the basis of payment and funding calculations for both the direct and indirect payments and would promulgate regulations under existing rulemaking requirements to establish this program.

A teaching health center would mean a facility which is community based, ambulatory patient care center and operates a primary care residency program. These could include Federally Qualified Health Centers, Community Mental Health Centers, community health centers, health care for the homeless centers, rural health centers, migrant health centers, Native American health centers operated by the Indian Health Service, Indian tribes and tribal organizations, and Title X clinics. A primary care residency program would mean a medical residency program in

family medicine, internal medicine, pediatrics, medicine-pediatrics, obstetrics and gynecology, psychiatry and geriatrics.

A total of $230 million will transferred from the Medicare Part A trust fund for FY2011 to FY2015 using a formula for calculating the direct graduate medical education expenses and the indirect expenses associated with operating approved graduate medical residency training programs established by this Section.

The Mark would also create a new Section 749, Teaching Health Centers Development Grants, to be included in the Public Health Service Act to establish newly accredited or to expand primary care medical residency programs meeting certain criteria. These grants would be awarded for up to 2 years and would not exceed more than $500,000. Certain amounts would be authorized to be appropriated: $25 million in FY2010; $50 million in FY2011; $50 million for FY2012 and such subsequent sums as may be necessary to carry out this section. No more than $5 million annually would be used for technical assistance program grants.

Advance Practice Nurse Training. The Mark adds an appropriation of $50 million per year for FY2012 through FY2015 to establish a graduate nurse education demonstration program in Medicare. Eligible hospitals would receive Medicare reimbursement for the educational costs, clinical instruction costs, and other direct and indirect costs of an eligible hospital attributable to the training of advanced practice nurses with the skills necessary to provide primary and preventive care, transitional care, chronic care management, and other nursing services appropriate for the Medicare-eligible population.

Eligible participants must have an affiliation with one or more accredited schools of nursing (as defined in section 801 of the Public Health Service Act) and partner with two or more non-hospital community-based care settings where at least half of all clinical training occurs. Such an affiliation must include an agreement with the schools of nursing and non-hospital community-based settings to pay for their share of the costs of educational activities. The Secretary may waive the community-based setting requirement for clinical training of advanced practice registered nurses, such as certified registered nurse anesthetists and certified nurse-midwives, in rural and medically underserved areas.

Costs under this paragraph are limited to costs attributable to an increase in the enrollment and the number of advanced practice nurse graduates in each training program over the comparable average number from 2006 to 2010 (as determined by the Secretary) but shall not be offset or take into account tuition, fees, or State or local government appropriations. In implementing this provision, CMS must ensure that demonstration cost shall not exceed the appropriation.

For purposes of this provision, the term “advanced practice nurse” shall include a clinical nurse specialist, nurse practitioner, certified registered nurse anesthetist, and certified nurse midwife.

SUBTITLE B—IMPROVING MEDICARE FOR PATIENTS AND PROVIDERS

PART I—ENSURING BENEFICIARY ACCESS TO PHYSICIAN CARE AND OTHER SERVICES

Sustainable Growth Rate

Current Law

Medicare payments for services of physicians and certain non-physician practitioners are made on the basis of a fee schedule. The fee schedule assigns relative values to services that reflect physician work (i.e., time, skill, and intensity it takes to provide the service), practice expenses, and malpractice costs. The relative values are adjusted for geographic variation in costs. The adjusted relative values are then converted into a dollar payment amounts by a conversion factor. The law specifies a formula, commonly referred to as the sustainable growth rate formula (SGR), for calculating the annual update to the conversion factors and the resultant fees. Section 101 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA, P.L. 110-173) increased the update to the conversion factor for Medicare physician payment by 0.5 precent compared with 2007 rates for the first six months of 2008. The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA, P.L. 110-275) extended the 0.5 percent increase in the physician fee schedule that was set to expire on June 30, 2008, through the end of 2008 and set the update to the conversion factor to 1.1 percent for 2009. The conversion factor for 2010 and subsequent years will be computed as if this modification had never applied, so unless further legislation is passed, the update formula will require a 21 percent reduction in physician fees beginning January 1, 2010 and by additional amounts annually for at least several years thereafter.

Chairman's Mark

The annual update to the conversion factor used in the determination of the Medicare fee schedule would be a 0.5 percent increase in 2010. The conversion factor for 2011 and subsequent years would be computed as if the increase in 2010 had never applied.

Extension of Floor on Medicare Work Geographic Adjustment

Current Law

The Medicare fee schedule is adjusted geographically for three factors to reflect differences in the cost of resources needed to produce physician services: physician work, practice expense, and medical malpractice insurance. The geographic adjustments are indices – known as Geographic Practice Cost Indices (GPCIs) – that reflect how each area compares to the national average in a "market basket" of goods. A value of 1.00 represents an average across all areas. A series of bills set a temporary floor value of 1.00 on the physician work index beginning January 2004; most recently, Section 134 of the MIPPA extended the application of this floor when calculating Medicare physician reimbursement through December, 2009. The other geographic indices (for practice expense and medical malpractice) were not modified by these acts.

Chairman's Mark

The Chairman's Mark would extend the 1.00 floor for the geographic index for physician work for an additional two years through December, 2012.

The Chairman's Mark would also 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 Mark 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.

Misvalued Relative Value Units (RVUs)

Current Law

The Medicare physician fee schedule is based on assigning relative weights to each of the approximately 7,500 physician service codes used to bill Medicare. The relative value for a service compares the relative work involved in performing one service with the work involved in

providing other physicians' services. The scale used to compare the value of one service with another is known as a resource-based relative value scale (RBRVS).

The Center for Medicare and Medicaid Services (CMS), which is responsible for maintaining and updating the fee schedule, continually modifies and refines the methodology for estimating relative value units (RVUs). CMS relies on advice and recommendations from the American Medical Association/Specialty Society Relative Value Scale Update Committee (RUC) in its assessments. In general, as currently implemented, increases in RVUs for a service or number of services lowers the resultant fees for other physician services. One consequence has been that the payments for evaluation and management codes, whose RVUs typically are not increased over time, have fallen relative to other codes whose RVUs have increased and as a consequence of new technologies that have been introduced into coverage with relatively high RVUs. CMS is required to review the RVUs no less than every five years.

In determining adjustments to the relative value units (RVUs) used as the basis for calculating Medicare physician reimbursement under the fee schedule, the Secretary has authority to adjust the number of RVUs for any service code to take into account changes in medical practice, coding changes, new data on relative value components, or the addition of new procedures. The Secretary is required publish an explanation of the basis for such adjustments.

These adjustments are subject to a budget neutrality condition. With the exception of certain expenditures that are exempt by statute, the adjustments may not cause the amount of expenditures made under the Medicare physician fee schedule to differ from year to year by more than $20,000,000 from the expenditures that would have been incurred without such an adjustment.

Chairman's Mark

The Secretary would be required to periodically identify physician services as being potentially misvalued, and make appropriate adjustments to the relative values of such services under the Medicare physician fee schedule. For purposes of identifying potentially misvalued services, the Secretary shall examine codes for which there has been the fastest growth; codes that have experienced substantial changes in practice expenses; codes for new technologies or services after the relative values are initially established for such codes; multiple codes that are frequently billed in conjunction with furnishing a single service; codes with low relative values, particularly those that are often billed multiple times for a single treatment; codes which have not been subject to review since the implementation of the RBRVS; and such other codes determined to be appropriate by the Secretary. Adjustments to misvalued procedures would be subject to budget neutrality requirements.

Therapy Caps

Current Law

Current law places two annual per beneficiary payment limits for all outpatient therapy services provided by non-hospital providers. For 2009, the annual limit on the allowed amount for

outpatient physical therapy and speech-language pathology combined is $1,840, and there is a separate limit for occupational therapy of $1,840. The Secretary was required to implement an exceptions process for 2006, 2007, and the first half of 2008 for cases in which the provision of additional therapy services was determined to be medically necessary. Section 141 of the MIPPA extended the exceptions process for therapy caps through December 31, 2009.

Chairman's Mark

The Chairman's Mark would extend the exceptions process for therapy caps for two years, through December 31, 2011.

Extension of Treatment of Certain Physician Pathology Services under Medicare

Current Law

The Medicare Modernization Act of 2003 (MMA, P.L. 108-173) permitted independent laboratories to receive direct payments for the technical component for certain pathology services. MIPPA extended the provision until January 1, 2010.

Chairman's Mark

The Chairman's Mark would extend the provision until January 1, 2012.

Extension of Increased Payments for Ambulance Services under Medicare

Current Law

The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA, P.L. 110-275) provided that the Medicare rate for ground ambulance services otherwise established for the year would be increased an additional three percent for rural ambulance services and two percent for other areas for the period July 1, 2008 through December 31, 2009. Areas designated as rural on December 31, 2006 are treated as rural for purposes of payments for air ambulance services during this period.

Chairman's Mark

The Chairman's Mark would extend the provision until January 1, 2012.

Extension of Long Term Care Hospital Provisions

Current Law

Long-term care hospitals (LTCHs) are designed to provide extended medical and rehabilitative care for patients who are clinically complex and have multiple acute or chronic conditions. LTCHs that are distinct part units of other hospitals are not explicitly permitted by the Medicare statute. Over time, however, the LTCH industry has evolved to include co-located hospitals-

within-hospitals (HwHs) or satellite facilities in addition to traditional freestanding facilities. CMS has implemented additional organizational requirements on these LTCHs, in an attempt to ensure that these are separate entities. Certain LTCHs (grandfathered HwHs) have been exempted from the requirements. Starting October 1, 2004, CMS established limits on the number of discharged Medicare patients that an HwHs and satellite LTCHs (except grandfathered LTCHs) can admit and be paid as independent LTCHs; after that threshold has been reached, generally, the LTCH will receive a substantially lower payment for subsequent patient admissions who have been discharge from the host hospital. Starting July 1, 2007, CMS extended this payment policy to other types of LTCHs, including grandfathered entities. Among other LTCH changes, the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA, P.L. 110-173), as modified by the American Recovery and Reinvestment Act of 2009 (ARRA, P.L. 111-5), provided for a three-year moratorium on the application of this payment policy for certain LTCHs.

Effective for the first cost reporting period beginning on or after October 1, 2002, LTCHs are paid according to a prospective payment system (PPS), subject to a five-year transition period. Under this PPS, Medicare pays a LTCH a predetermined amount per discharge, depending upon the patient's assignment into one of the Medicare-severity long term diagnosis related groups (MS-LTC-DRGs). The LTCH patient classification system, MS-LTC-DRGs, is based on Medicare severity diagnosis related groups (MS-DRGs) used to in the inpatient prospective payment system (IPPS) used to pay acute care hospitals. By statute, total payments under LTCH-PPS must be equal to the amount that would have been paid if the PPS had not been implemented in the initial year of implementation. CMS proposed to review LTCH payments and make a one-time prospective adjustment to the LTCH PPS to correct for any errors in the original budget neutrality calculations. MMSEA established a three-year moratorium on that one-time budget neutrality adjustment starting December 29, 2007 (the enactment date of MMSEA).

The LTCH-PPS includes certain case level adjustments for short stay and interrupted stay cases. CMS adopted a very short-stay outlier payment policy starting July 1, 2007 to reduce payments for patients who have lengths of stay that are less than or equal to one standard deviation from the geometric ALOS of the same MS-DRG under the IPPS. This very short stay outlier policy is subject to the three-year moratorium established by MMSEA.

Finally, MMSEA, as modified by ARRA, also established a three-year moratorium on the establishment of new LTCHS, including HwHs and satellite facilities, and on the increase of hospital beds in existing LTCHs.

Chairman's Mark

The Chairman's Mark would extend the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA, P.L. 110-173), Section 114(c) and (d) by two years.

Extension of Payment Adjustment for Medicare Mental Health Services

Current Law

The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA, P.L. 110-275) increased payments for certain Medicare mental health services by five percent.

Chairman's Mark

The Chairman's Mark would extend the provision until January 1, 2012.

Permitting Physician Assistants to Order Post-Hospital Extended Care Services

Current Law

In a skilled nursing facility (SNF), Medicare law allows physicians, as well as nurse practitioners and clinical nurse specialists who do not have a direct or indirect employment relationship with a SNF, but who are working in collaboration with a physician, to certify the need for post-hospital extended care services for purposes of Medicare payment. Section 20.2.1 of Chapter 8 of the Medicare Benefit Policy Manual defines post-hospital extended care services as services provided as an extension of care for a condition for which the individual received inpatient hospital services. Extended care services are considered "post-hospital" if they are initiated within 30 days after discharge from a hospital stay that included at least three consecutive days of medically necessary inpatient hospital care.

Chairman's Mark

The Chairman's Mark would allow a physician assistant who does not have a direct or indirect employment relationship with a SNF, but who is working in collaboration with a physician, to certify the need for post-hospital extended care services for Medicare payment purposes.

This provision would apply to items and services furnished on or after January 1, 2010.

Recognizing Attending Physician Assistants as Attending Physicians to Serve Hospice Patients

Current Law

Under the Medicare program, hospice services may only be provided to terminally ill individuals under a written plan of care established and periodically reviewed by the individual's attending physician and the medical director (and by the interdisciplinary group of the hospice program). For purposes of a hospice written plan of care, Medicare defines an attending physician as a physician or nurse practitioner who may be employed by a hospice program and who the individual identifies as having the most significant role in the determination and delivery of medical care to the individual at the time the individual makes an election to receive hospice care.

For an individual to be eligible for Medicare-covered hospice services, the individual's attending physician (not including a nurse practitioner) and the medical director (or physician member of the interdisciplinary group of the hospice program) must each certify in writing that the individual is terminally ill at the beginning of the first 90-day period of hospice.

Chairman's Mark

For purposes of a hospice written plan of care, the provision would include a physician assistant in the definition of an attending physician. The provision would continue to exclude physician assistants from the authority to certify an individual as terminally ill.

This provision would apply to items and services furnished on or after January 1, 2010.

Medicare Diabetes Self-Management Training

Current Law

Medicare covers diabetes self-management training (DMST) under certain conditions to help a beneficiary learn how to successfully manage their diabetes. The training must be prescribed by a physician or qualified non-physician practitioner. When Congress passed the DMST benefit in 1997, it did not include Certified Diabetes Educators (CDEs) as providers. However, most CDEs worked in hospital outpatient clinics where diabetes education and care is generally provided.

Chairman's Mark

The Chairman's Mark would provide for the recognition of state- licensed or registered health care professionals who are certified diabetes educators as Medicare providers of diabetes outpatient self-management training services. CDEs would still provide DSMT services according to physician referral, but they would be able to provide such services in appropriate, non-hospital locations to meet current needs.

Medicare Improvement Fund

Current Law

Section 188 of MIPPA established the Medicare Improvement Fund (MIF), available to the Secretary to make improvements under the original fee-for-service program under Parts A and B for Medicare beneficiaries. Under current law, $22.29 billion is available for services furnished during FY2014.

Chairman's Mark

The Chairman's Mark would eliminate the funding in the MIF.

Medicare Part B Special Enrollment Period for Disabled TRICARE Beneficiaries

Current Law

TRICARE is the health care plan under the Department of Defense (DoD) that covers members of the uniformed services, their families and survivors. TRICARE coverage was extended to Medicare-eligible military retirees, their Medicare-eligible spouses and dependent children and Medicare- eligible widow/widowers by the Floyd D. Spence National Defense Authorization Act of 2001 (P.L. 106-398). This law authorized a program known as TRICARE For Life (TFL) which acts as a secondary payer to Medicare and provides supplemental coverage to TRICARE-eligible beneficiaries who are entitled to Medicare Part A based on age, disability or end stage renal disease (ESRD). In order to participate in TFL, these TRICARE-eligible beneficiaries must enroll in and pay premiums for Medicare Part B.

Under current law (10 U.S.C. 1086(d)), TRICARE-eligible beneficiaries who are entitled to Medicare Part A based on age, disability or ESRD, but decline Part B, lose eligibility for TRICARE benefits. Veterans' advocacy groups have reported that many beneficiaries are not aware that their TRICARE coverage is dependent upon Part B enrollment. Individuals who choose not to initially enroll in Medicare Part B upon becoming eligible may elect to do so later during a January 1 through March 31 annual enrollment period. However, Medicare Part B coverage is effective July 1 of the year during which enrollment occurs and the Medicare Part B late enrollment penalty, (ten percent for each 12 month period in which the individual could have been enrolled but did not) would apply. In addition to the late-enrollment penalty, late-enrollers are liable for all medical expenses incurred during the period they are not enrolled in Part B.

Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA, P.L. 108-173) provided enrollment incentives to TRICARE beneficiaries who were entitled to Medicare Part A, but were not enrolled in Medicare Part B during their initial eligibility period. Further, the law directed the Secretary to provide a Part B special enrollment period for TRICARE beneficiaries who had not enrolled in Part B as of the date of MMA's enactment—December 8, 2003. The law mandated that this special enrollment period begin as soon as possible after MMA's enactment and end on December 31, 2004. In addition the MMA waived premium surcharges for TRICARE beneficiaries who enrolled in Medicare Part B from 2001 through 2004.

Chairman's Mark

The Chairman's Mark creates a twelve-month special enrollment period (SEP) for military retirees, their spouses (including widows/widowers) and dependent children, who are otherwise eligible for TRICARE and entitled to Medicare Part A based on disability or ESRD, but who have declined Part B. This twelve-month special enrollment period (SEP) would be available to an individual once in their lifetime and begin on the day after the last day of the initial enrollment period. If the individual was notified of retroactive Medicare Part A and Part B entitlement, the twelve-month period would begin with the month in which the individual was notified of Medicare Part B entitlement. For this population, the Part B coverage period would begin on the first day of the month in which the individual enrolls during the SEP. The

individual would also have the option of choosing Part B coverage retroactive to the first month after the initial enrollment period. The late enrollment penalty would not apply to individuals who enroll during the SEP. The Secretary of Defense would be required to identify and notify individuals of their eligibility for the SEP; the Secretary of Health and Human Services and the Commissioner for Social Security would support these efforts. The provision would become effective on the date of enactment.

Added in the Modification or by Amendment at Markup

Federally Qualified Health Centers. The Mark directs the Secretary of Health and Human Services to establish a prospective payment system (PPS) for Medicare-covered services furnished by Federally Qualified Health Centers (FQHCs). The PPS 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 Secretary. Additionally, the Mark would add remaining Medicare-covered preventive services to the list of services eligible for reimbursement when furnished by an FQHC.

The PPS payment rate would be extended to health plans and health insurers participating in the state exchanges. Insurers participating in the state exchanges would be required to provide payment for services furnished to enrollees by FQHCs must pay these providers at the PPS rate described above.

Guidelines to Ensure Emergency Room Access. The Mark directs the Secretary 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 would be directed to:

(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 (EMTALA);
(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 would terminate upon submission of the report in (4).

Medicare Payment for Biosimilar Products. The Mark allows a Part B biosimilar product approved by the Food and Drug Administration and assigned a separate billing code to be reimbursed at the ASP of the biosimilar plus six percent of the ASP of the reference product.

Access to Critical Lab Tests. The Mark would provide that for a two-year period, in cases when a laboratory test is ordered less than 14 days after a beneficiary leaves a hospital, the laboratory furnishing the test could bill for tests that meet 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.

Public Meeting and Report to Congress on Payment for New Clinical Lab Tests.
The Mark directs the Secretary of Health and Human Services to convene a public meeting on payment systems for new clinical laboratory diagnostic tests and to submit a report to Congress, summarizing the meeting and providing recommendations for legislative and administrative actions to reform the reimbursement mechanisms for new clinical laboratory diagnostics.

PART II—RURAL PROTECTIONS

Extend Medicare Rural Hospital Flexibility Program

Current Law

The Balanced Budget Act of 1997 established the Medicare Rural Hospital Flexibility Program, which created the critical access hospital (CAH) designation under Medicare and authorized a grant program (FLEX grants) that is administered by the Health Resources and Services Administration (HRSA). Under this program, Flex grants may be awarded to States to develop and implement rural health care plans and rural health networks, to designate critical access hospitals, to upgrade data systems and to improve the provision of rural emergency medical services.

The Medicare Rural Hospital Flexibility Program also authorized up to $50,000 for the Small Rural Hospital Improvement (SHIP) Grant Program. This program provides funding to small rural hospitals to provide assistance with any or all of the following: (1) to pay for costs related to the implementation of Medicare's prospective payment systems; (2) to comply with provisions of Health Insurance Portability and Accountability Act; and (3) to reduce medical errors and support quality improvement. To be eligible for these grants, a hospital must have less than 50 beds and be located in a rural area and may include critical access hospitals (CAHs).

As established by MIPPA, the Secretary may also award grants to States to increase the delivery of mental health services or other health services deemed necessary to meet the needs of veterans and other residents of rural areas, including rural census tracks. There are certain limitations imposed on the use of grant funds for administrative expenses, both at the state and Federal level. The FLEX grant program is authorized at $55 million for each fiscal year from 2009 and 2010 and the new rural mental health and other services grants would be authorized at $55 million for each of fiscal years 2009 and 2010.

Chairman's Mark

The FLEX grant program would be extended two years until 2012. The proposed change would allow SHIP funding to also be used to support small rural hospitals' participation in the delivery system reform programs outlined in this legislation, such as value-based purchasing programs, accountable care organizations, bundling and other programs deemed appropriate by the Secretary.

Extend Hospital Outpatient Department Hold Harmless for Small Rural Hospitals; Extend and Expand Hospital Outpatient Department Hold Harmless for Sole Community Hospitals

Current Law

Small rural hospitals (with no more than 100 beds) that are not sole community hospitals (SCHs) can receive additional Medicare payments if their outpatient payments under the prospective

payment system are less than under the prior reimbursement system. For calendar year (CY) 2006, these hospitals would receive 95 percent of the difference between payments under the prospective payment system and those that would have been made under the prior reimbursement system. The hospitals would receive 90 percent of the difference in CY2007 and 85 percent of the difference in CY2008 and CY2009. Sole community hospitals with not more than 100 beds would receive 85 percent of the payment difference for covered HOPD services furnished on or after January 1, 2009, and before January 1, 2010.

Chairman's Mark

The provision would establish that small rural hospitals would receive 85 percent of the payment difference in CY2010 and CY2011. SCHs with not more than 100 would receive 85 percent of the payment difference in CY2010 and CY2011. SCH with more than 100 beds would receive 85 percent of the payment difference in CY2010 and CY2011.

Extend Reasonable Cost Reimbursement for Laboratory Services in Small Rural Hospitals

Current Law

Generally, hospitals that provide clinical diagnostic laboratory services under Part B are reimbursed using a fee schedule. Hospitals with under 50 beds in qualified rural areas (certain rural areas with low population densities) receive 100 percent of reasonable cost reimbursement for the clinical diagnostic laboratories covered under Part B that are provided as outpatient hospital services. Reasonable cost reimbursement for laboratory services provided by these hospitals ended July 1, 2008.

Chairman's Mark

Reasonable cost reimbursement for clinical diagnostic laboratory service for qualifying rural hospitals with under 50 beds would be reinstated from July 1, 2010 and extended for two years, ending July 1, 2012.

Extend Rural Community Hospital Demonstration Program

Current Law

As required by Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA, PL 108-173), the Centers for Medicare and Medicaid Services (CMS) is conducting a five-year Rural Community Hospital Demonstration Program to test the feasibility and advisability of reasonable cost reimbursement for small rural hospitals (those with fewer than 51 beds). Currently, there are 10 hospitals participating in the program.

Chairman's Mark

This provision would extend the demonstration program for an additional two years, expand the maximum number of participating hospitals to 30 and expand eligible sites to rural areas in all states until January 1, 2012.

Extend Medicare Dependent Hospital Program and Study on Applying the MDH program to Urban Hospitals

Current Law

Medicare dependent hospitals (MDHs) are small rural hospitals with a high proportion of patients who are Medicare beneficiaries. Specifically, the hospitals have at least 60 percent of acute inpatient days or discharges attributable to Medicare in FY1987 or in two of the three most recently audited cost reporting periods. As specified in regulation, they cannot be a sole community hospital and must have 100 or fewer beds. MDHs receive special treatment, including higher payments, under Medicare's inpatient prospective payment system. The sunset date for the MDH classification has been periodically extended by legislation. As established by the Deficit Reduction Act of 2005 (DRA, P.L. 109-171), the MDH classification would expire September 30, 2011.

Chairman's Mark

The MDH classification would be extended two years, until September 30, 2013.

The Secretary of HHS must 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 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 Secretary must submit a report to Congress no later than 9 months from the date of enactment. The report should describe the findings and conclusions as well as recommendations for legislation and administrative action.

Temporary Improvements to the Medicare Inpatient Hospital Payment Adjustment for Low-Volume Hospitals

Current Law

Under Medicare's inpatient prospective payment system (IPPS), certain low-volume hospitals receive a payment adjustment to account for their higher costs per discharge. A low-volume hospital is defined as an acute care hospital that is located more than 25 road miles from another comparable hospital and that has less than 800 total discharges during the fiscal year. Under

current law, the Secretary is required to determine an appropriate percentage increase for these low-volume hospitals based on the empirical relationship between the standardized cost-per-case for such hospitals and their total discharges to account for the additional incremental costs (if any) that are associated with such number of discharges. The low-volume adjustment is limited to no more than 25 percent. Accordingly, under regulations, qualifying hospitals (those located more than 25 road miles from another comparable hospital) with less than 200 total discharges receive a 25 percent payment increase for every Medicare discharge.

Chairman's Mark

A temporary adjustment that would increase payment in FY2011 and FY2012 for certain low-volume hospitals would be created. A low volume hospital could be located more than 15 road miles from another comparable hospital and have 1,500 ~~2,000~~ discharges of individuals entitled to or enrolled for Medicare Part A benefits. The Secretary would determine the applicable percentage increase using a continuous linear sliding scale ranging from 25 percent for low-volume hospitals with 200 or fewer discharges of individuals with Medicare Part A benefits ~~below a certain threshold~~ to no adjustment for hospitals with greater than 1,500 ~~2,000~~ discharges of individuals with Medicare Part A benefits.

Revisions to the Demonstration Project on Community Health Integration Models in Certain Rural Counties

Current Law

The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA, P.L. 110-275, section 123), authorized a demonstration project to allow eligible entities to develop and test new models for the delivery of health care services in eligible counties for the purpose of improving access to, and better integrating delivery of, acute care, extended care, and other essential health care services to Medicare beneficiaries.

Eligibility to participate in the demonstration project under this section is limited to eligible entities that include a Rural Hospital Flexibility Program grantee under section 1820(g) of the Social Security Act (42 U.S.C. 1395i–4(g)) and entities located in a State in which at least 65 percent of the counties in the State are counties that have six or less residents per square mile. Based on these criteria, the Secretary is provided authority to select up to four states to participate in this demonstration program, and within those states, up to six counties. For a county to be eligible to participate, it must contain a critical access hospital (CAH) that also furnishes certain post-acute services as of date of enactment and skilled nursing facility services must be available in the qualifying county.

The demonstration project under this section shall be conducted for a three-year period beginning on October 1, 2009 and shall be done in a budget neutral manner.

Chairman's Mark

The Chairman's Mark would strike the limitation on the number of eligible counties that may participate in the demonstration project within the qualifying states. The proposed change would also delete references to rural health clinic services and replace these with a requirement that physician services may also be included within the scope of the demonstration project.

MedPAC Study on Adequacy of Medicare Payments for Health Care Providers Serving Rural Areas

Current law

No provision.

Chairman's Mark

The Chairman's Mark would require MedPAC to review payment adequacy for rural health care providers serving the Medicare program and provide a report to Congress by January 1, 2011.

In this report, MedPAC shall provide an analysis of the rural payment adjustments outlined in this section and an analysis of beneficiaries' access to care in rural communities, adequacy of Medicare payments to rural providers and quality of care. Based on this analysis, MedPAC shall provide recommendations on appropriate modifications to the rural payment adjustments outlined in this section.

Added in the Modification or by Amendment at Markup

Technical Correction related to Critical Access Hospitals (CAHs). Clarifies that CAHs are eligible to receive 101 percent of reasonable costs for providing outpatient services regardless of billing method and for providing qualifying ambulance services.

Reimbursement for DXA Services. The provision reinstates reimbursement for dual energy x-ray absorptiometry (DXA) services to 70 percent of the 2006 payment rates for 2010 and 2011. It would also authorize the Institute of Medicine to study the effect of Medicare reimbursement reductions for DXA on beneficiary access to bone density tests.

Super Rural Ambulance Payments. The provision extends until January 1, 2012 the bonus payments under Medicare to ambulance service providers which serve the most rural quartile of counties ("super rural" areas as originally defined in Section 414(c) of the Medicare Modernization Act (MMA))

PART III—MEDICARE PART D IMPROVEMENTS

Improving Coverage in the Part D Coverage Gap

Current Law

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA, P.L. 108-173) included a defined standard benefit structure under the Part D prescription drug benefit. In 2009, the standard benefit includes a $295 deductible and 25 percent coinsurance until the enrollee reaches the initial coverage limit ($2,700 in total covered drug spending). After the initial coverage limit, there is a gap in coverage, or "donut hole" in which the beneficiary is responsible for 100 percent of drug costs. Beneficiaries must spend $3,454.75 out-of-pocket before they reach the catastrophic benefit. Once they reach catastrophic coverage, they are responsible for 5 percent of drug costs. The plan pays 15 percent and the Medicare program pays 80 percent for the remainder of the benefit year.

Current law allows Part D plan sponsors to offer benefit packages that differ from the standard benefit, as long as they are actuarially equivalent. Most plans offer actuarially equivalent benefit packages in lieu of the standard benefit design. Current law also allows plans to offer "enhanced" benefit packages that provide more generous coverage (typically, enhanced benefit packages have higher premiums). Most enhanced packages have a reduced or $0 deductible and/or reduced cost-sharing in the initial coverage period. However, fewer plans choose to offer benefits during the coverage gap. Most plans that offer gap coverage only provide benefits for generic drugs and not brand-name drugs, and many times the coverage is limited to a subset of the generic drugs listed on plan formularies. Thus, if a beneficiary wants to purchase a plan that has both generic and brand-name coverage in the gap, they are not able to do so because insurers do not offer plans with those types of benefits. Insurers do not offer broad gap coverage because it is voluntary and tends to attract sicker, more expensive beneficiaries with higher drug spending that would require them to set higher premiums overall.

Chairman's Mark

The Chairman's Mark would establish a discount program for beneficiaries who enroll in Part D and have drug spending that falls into the coverage gap. The Mark would provide for manufacturer discounts on brand-name drugs that are covered under Part D and are on plan formularies or treated as being on plan formularies through exceptions and appeals processes. The discount would be available during the entire coverage gap—that is, at the point when total prescription costs of a beneficiary exceeds the initial coverage limit ($2,700 in 2009) and reaches the catastrophic coverage limit ($6,153 in 2009) each year. Once the prescription costs of a beneficiary exceed the catastrophic limit, the discount would end and the catastrophic portion of the drug benefit would apply as under current law. The discount program would apply to Medicare beneficiaries who enroll in Part D, do not qualify for the low-income subsidy, are not enrolled in an employee–sponsored retiree drug plan, and do not have annual income that exceeds the Part B income thresholds as determined under current law ($85,00 for singles and $170,000 for couples in 2009).

Specifically, beginning July 1, 2010, eligible beneficiaries would automatically receive a 50 percent discount off the negotiated price for brand-name prescription drugs that are covered under Part D and covered by their plan's formulary or are treated as being on plan formularies through exceptions and appeals processes. For purposes of the discount, the negotiated price would be the same as defined in CFR 423.100, which is the price that plans pay to pharmacies minus the amount of price concessions (i.e., rebates and discounts) that plans pass on to beneficiaries. Dispensing fees would be excluded from the negotiated price and the discount. That means beneficiaries who receive the discount would continue to pay pharmacy dispensing fees as under current law. The discount would apply to sole-source and multiple source brand-name drugs.

The Chairman's Mark would also allow 100 percent of the negotiated price of discounted drugs (excluding dispensing fees) to count toward the annual out-of-pocket threshold that is used to define the coverage gap each year. This threshold is generally referred to as "true out-of-pocket" spending. In other words, the full negotiated price of discounted drugs would count as incurred costs of beneficiaries for purposes of Section 1860D-(2)(b)(4)(B) of the Social Security Act. The Chairman's Mark includes this provision so that the size of the coverage gap would not widen and beneficiaries with high prescription drug costs would not be held back from reaching the catastrophic benefit as a result of the discount program.

The Chairman's Mark stipulates that drugs sold and marketed in the U.S. by a manufacturer would not be covered under Part D unless the manufacturer agrees to participate in the discount program described above. Manufacturers would be required to sign an agreement with the Secretary of Health and Human Services (HHS) in order to participate in the program and have their drugs covered under Part D. These conditions of coverage do not apply if the Secretary has made a determination that the availability of the drug would be essential to the health of beneficiaries or if the Secretary has determined that there are extenuating circumstances in the period between July 1, 2010 and September 30, 2010.

The agreement would require manufacturers to discount drug prices at the pharmacy or through a mail order service. The Secretary would be allowed to provide for the discount after the point-of-sale for a temporary period until the necessary data systems are in place to implement the discount at the point-of-sale. Manufacturers would be required to collect and have available appropriate data as determined by the Secretary to ensure that they can demonstrate compliance with the discount program. This information would not be authorized to be disclosed by the Secretary in a form that reveals the price concessions for applicable drugs by such manufacturers. Agreements would be effective for an initial period of not less than one year and would be automatically renewed for a period of not less than one year unless terminated. The Secretary would be authorized to terminate an agreement with 30 days notice for violation of the requirements of the agreements or for other good cause shown. The Secretary would be required to provide, upon request, a hearing concerning such a termination, but such hearing would not delay the effective date of the termination. Manufacturers would be allowed to terminate an agreement for any reason. Such termination would not be effective until the end of the benefit year. Manufacturers would not be allowed to re-enter an agreement with the Secretary until one calendar quarter has elapsed unless the Secretary finds good cause.

The Chairman's Mark would allow the Secretary of HHS to contract with a third party to administer the drug discount. The Secretary would contract with a third-party contractor to administer the drug discount program and establish performance requirements and data standards for the third-party contractor to coordinate benefits with Medicare prescription drug plans.

The Chairman's Mark would also require manufacturers who participate in the Part D drug discount program to be audited for compliance with the discount program by the third-party administrator. Manufacturers that do not comply with the discount would be subject to fines assessed by the Secretary. Fines would be commensurate with the amount manufacturers would pay if they had adhered to the discount program, along with an additional penalty equal to 25 percent of the discount amount. The Chairman's Mark would also allow for a reasonable notice and dispute resolution mechanism before penalties could be assessed. The Secretary could prohibit a manufacturer's drugs from being covered under Title XVIII for repeated non-compliance.

Improving the Determination of Part D Low-Income Benchmarks

Current Law

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA, P.L. 108-173) created an outpatient prescription drug benefit in Medicare. Medicare beneficiaries who have limited income and resources may qualify for financial assistance to help pay for their prescription drug costs under the benefit. Those who qualify for the low-income subsidy (LIS) receive "extra help" paying for their monthly premiums, yearly deductibles, co-payments, and costs in the coverage gap. For example, the federal government pays up to 100 percent of the Part D premiums for LIS beneficiaries who enroll in LIS-eligible plans.

A plan qualifies as an LIS-eligible plan if it offers standard coverage (or an equivalent) with a premium equal to or lower than a benchmark amount calculated for each region. The regional low-income benchmark amount, determined annually, is the weighted average of premiums in each of the 34 prescription drug plan (PDP) regions for standard prescription drug coverage, or the actuarial value of standard prescription drug coverage for plans that offer supplemental, or enhanced, coverage options. For Medicare Advantage prescription drug plans (MA-PD), the portion of the premium attributable to standard prescription drug benefits is used.

Under the Medicare Advantage (MA) program, private health plans bid to offer Medicare coverage to beneficiaries. The Secretary bases payment for an MA plan on the relationship between its bid and a statutorily defined benchmark. The MA benchmark represents the maximum amount the federal government would pay a plan for providing Medicare benefits. If a plan's bid is less than the benchmark, its payment equals its bid plus a rebate of 75 percent of the difference between the benchmark and the bid. The rebate must be used to provide additional benefits to enrollees, reduce Medicare cost-sharing, or reduce a beneficiary's monthly Part B or Part D premiums.

MA plans offering prescription drug coverage must submit a separate bid for the Part D portion of the benefit. Payment for the portion of the premium attributable to standard prescription drug

benefits is calculated in the same way as it is for stand-alone PDPs; however the MA plan may choose to apply some of its MA rebate payments to lower the Part D premium. If an MA plan uses rebate payments to reduce its Part D premium, the reduced premium amount, not the actual amount attributable to standard drug coverage, is factored into the regional low-income benchmark. This has the effect of lowering the LIS benchmark and therefore reducing the number of plans that are can serve LIS beneficiaries at fully subsidized or $0 premium.

Chairman's Mark

The Chairman's Mark would require the Secretary to exclude Medicare Advantage rebates and bonus payments from the MA-PDP premium amount when calculating the regional LIS benchmark amounts. This provision would take effect in 2011. It would have the effect of increasing the number of plans that can serve LIS beneficiaries at fully subsidized or $0 premiums.

Voluntary De Minimus Policy for Low-Income Subsidy Plans

Current Law

No provision.

Chairman's Mark

The Chairman's Mark would authorize a policy, beginning in 2011, through which plans that bid a nominal amount above the regional low-income subsidy (LIS) benchmark amount can choose to absorb the cost of the small difference between their bid and the LIS benchmark in order to qualify as a LIS-eligible plan. The Secretary would be given discretion to auto-enroll LIS beneficiaries into these plans in order to maintain an adequate LIS plan choices. The de minimus threshold amount would be established by the Secretary. This provision would help maintain plans that wish to serve LIS beneficiaries at fully subsidized or $0 premiums.

Special Rule for Widows and Widowers Regarding Eligibility for Low-Income Assistance

Current Law

To qualify for financial assistance under the Part D low-income subsidy (LIS) program, Medicare beneficiaries must have resources no greater than the income and resource limits established by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA, P.L.108-173). Individuals may qualify for the full subsidy in two ways: (1) if they are eligible for Medicaid or one of the Medicare Savings Programs (Qualified Medicare Beneficiary (QMB), Specified Low Income Medicare Beneficiary (SLMB), or Qualifying Individual (QI)), or are recipients of Supplemental Security Income (SSI) benefits, they are deemed automatically eligible; or (2) if they apply for the benefit through their State Medicaid agency or through the Social Security Administration (SSA) and are determined to have an annual income below 135 percent of the federal poverty level (FPL) and have resources below a certain limit (in 2009, $8,100 for an individual or $12,910 if married). Beneficiaries may qualify for a partial subsidy if

they apply and are determined to have an annual income below 150 percent of FPL and their resources do not exceed a certain limit (in 2009, $12,510 for individuals or $25,010 if married). When determining whether a beneficiary qualifies for the low-income subsidy, $1,500 in resources per person is excluded from consideration if the beneficiary indicates that he/she expects to use resources for burial expenses.

If beneficiaries experience changes in their personal or financial circumstances during the year, they may be responsible for different levels of cost sharing or may no longer qualify for the low-income subsidy for the next plan year. Each year, the Secretary conducts a redeeming process to determine whether those who automatically qualified for the full subsidy in a given year continue to meet the criteria for eligibility in the following year. For those who have qualified for the full or partial subsidy through the application process, the agency that made the determination decision (SSA or an individual state) is responsible for monitoring a recipient's eligibility. For example, for cases in which eligibility has been established through an application with SSA, a report of a subsidy-changing event, such as marriage, divorce, or death of a spouse, will trigger a redetermination of subsidy eligibility during the calendar year. This can result in changes to the individual's deductible, premium and cost sharing subsidy, or even termination of his or her LIS eligibility status. In the case of the death of a spouse, it is possible that the surviving spouse, as the sole owner of the previously combined resources, may exceed the resource limit for an individual and may no longer qualify for the LIS program. Some widows/widowers receive burial benefits that exceed $1,500 that could make them ineligible for the LIS program.

Chairman's Mark

The Chairman's Mark would require that, beginning in 2011, the surviving spouse of an LIS-eligible couple undergo a redetermination of his or her eligibility status no earlier than one year from the next redetermination that would have occurred after the death of a spouse. Subsequently, the LIS widow/widower would be determined or redetermined, as appropriate, for LIS on the same basis as other LIS-eligible beneficiaries.

Facilitation of Reassignments of Beneficiaries in Low-Income Subsidy Plans

Current Law

According to the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA, P.L. 108-173), low-income subsidy (LIS) beneficiaries who are enrolled in plans with premiums below the low-income regional benchmark amount receive assistance with premiums and cost sharing. In general, beneficiaries who qualify for the full LIS subsidy, are still enrolled in the Medicare Prescription Drug Plan in which Medicare enrolled them and are enrolled in LIS-eligible plans whose plan bids exceed the regional benchmark amount for the next benefit year are randomly reassigned by the Secretary of HHS to new plans whose bids are at or below the regional benchmark amount in order to ensure that these beneficiaries continue to receive a subsidy of plan premiums. It is possible that some covered drug(s) a beneficiary is currently taking will not be covered by the new plan.

Chairman's Mark

The Chairman's Mark would require plans whose bids exceed the regional benchmark amount and whose LIS beneficiaries are reassigned to other plans by CMS to transmit recent drug utilization data to the beneficiary's new plan within thirty days of notification of the reassignment. Within thirty days of receiving the drug utilization information, plans that are reassigned LIS beneficiaries would be required to provide these beneficiaries with information about formulary differences between the old and new plan with respect to their drug regimen, as well as a description of the new plan's appeals process, grievance mechanisms and coverage determination/redetermination process. The Secretary would be required to develop a standard format for plans to provide this information to beneficiaries.

Funding Outreach and Education of Low-Income Programs

Current Law

The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA, P.L. 110-275) provided $25 million for fiscal years 2008 and 2009 for beneficiary outreach and education activities related to low-income programs related to the Medicare through State Health Insurance Programs (SHIPs), Area Agencies on Aging (AOAs), Aging and Disability Resource Centers (ADRCs), and the Administration on Aging.

SHIPs are state-based programs that provide Medicare beneficiaries with local, personalized assistance with Medicare benefits and other health insurance programs. MIPPA provided $7.5 million for grants to the states for SHIPs. Two-thirds is allocated based on the share of persons in each state with incomes below 150 percent of poverty and who have not enrolled in the Part D low-income subsidy program. One-third is allocated among states based on the share of Part D eligible beneficiaries residing in rural areas.

MIPPA also required the Secretary of HHS to provide $7.5 million to the Administration on Aging to make grants to Area Agencies on Aging. Additionally, MIPPA provided $5 million to the Administration on Aging to make grants to Aging and Disability Resource Centers under the Aging and Disability Resource Center grant program. Finally, MIPPA provided $5 million to the Administration on Aging to make a grant or enter into a contract with an entity to, among other things, maintain and update web-based decision support tools and integrated systems designed to inform older individuals about the full range of benefits for which the individuals may be eligible under federal and state programs, and to develop and maintain an information clearinghouse on best practices and the most cost effective methods for finding such individuals.

Chairman's Mark

The Chairman's Mark would extend MIPPA Section 119 and provide $45 million for outreach and education activities related to Medicare low-income assistance programs, including the Part D low-income subsidy (LIS) program and the Medicare Savings Program (MSP). Funds would be allocated to State Health Insurance Programs, the Administration on Aging for Area Agencies on Aging, Aging Disability Resource Centers and for the contract for the National Center for

Benefits Outreach and Enrollment in the same proportion as under MIPPA. Funds would be available for obligation through 2012. The Secretary would have authority to enlist the support of these entities to conduct outreach activities aimed at preventing disease and promoting wellness as an additional use of these funds.

Strengthening Formularies with Respect to Certain Categories or Classes of Drugs

Current Law

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA, P.L. 108-173) requires Part D plans to operate formularies that cover drugs within each therapeutic category and class of covered Part D drugs, although not necessarily all drugs within such categories and classes. The Secretary of HHS published a regulation (42 CFR Section 423.120) requires Part D plans to have at least two drugs within each therapeutic category and class.

However, a higher standard of coverage has been established for six specific classes. Through sub-regulatory guidance, the Secretary protected access to certain classes of drugs by requiring Part D plans to cover all, or substantially all, of the drugs in the following six drug classes: immunosuppressant, antidepressant, antipsychotic, anticonvulsant, antiretroviral, and anti-neoplastic.

Section 176 of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA, P.L. 110-275) codified that, beginning in plan year 2010, the Secretary would identify the classes and categories of drugs that should be protected, or covered entirely by Part D plans, to ensure that beneficiaries have access to certain therapies and to a wide variety of therapy options for certain conditions. MIPPA included several clinical criteria that the Secretary would have to use in order to identify protected classes of drugs. MIPPA also added a requirement that the Secretary promulgate regulations to identify the protected classes and make any subsequent changes to the classes through regulation.

Chairman's Mark

The Chairman's Mark would remove the criteria, specified in Section 176 of MIPPA, that would have been used by the Secretary to identify protected classes of drugs. The Mark would give the Secretary authority to identify classes of clinical concern as defined by the Secretary. The Mark would codify the current six classes of clinical concern as they are currently specified through sub-regulatory guidance until the Secretary issues a rule regarding classes of clinical concern to be protected on plan formularies.

Reducing the Part D Premium Subsidy for High-Income Beneficiaries

Current Law

According to the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, (MMA, P.L.108-173), Part D beneficiary premiums account for 25.5 percent of expected total Part D premium costs for standard coverage. Medicare pays the remaining 74.5 percent of Part

D premium costs. The Medicare portion or subsidy amount of average Part D premiums is determined annually and paid directly to plans on a monthly basis for each beneficiary they enroll. However, beneficiaries pay different monthly premiums depending on the plan they select and whether or not they are entitled to low-income premium subsidies. If a beneficiary chooses a plan with lower than average premiums, then their share of their plan's premium will be lower than the 25.5 percent set nationally. Beneficiary premiums under Part D are not subject to income thresholds or means testing.

Beginning in 2007, as required by the MMA, high-income beneficiaries are required to pay higher premiums for Part B benefits. Beneficiaries with modified adjusted gross income that exceeds a threshold amount are charged additional premiums based on a sliding scale that ranges from 35 percent to 80 percent of the value of Part B. In 2009, threshold levels started at $85,000 for an individual tax return and $170,000 for a joint return (based on 2007 returns). The threshold amounts are specified in the law, and are adjusted annually for inflation using the Consumer Price Index. The income thresholds are tied to specific premium shares. In 2008, approximately 5 percent of Part B enrollees paid the higher premiums.

Chairman's Mark

The Chairman's Mark would reduce, beginning in 2011, the Medicare premium subsidy amount for beneficiaries whose modified adjusted gross income (MAGI) exceeded the thresholds used under Part B. That is, $85,000 for an individual and $170,000 per couple in 2009. The reduction in the Part D premium subsidy amount would be implemented in a manner that is similar to the current income-related reductions in Part B premium subsidies. Instead of setting the Medicare premium subsidy at 74.5 percent of total Part D premiums, the Chairman's Mark would decrease the Medicare premium subsidy to reflect the percentages used to decrease the Part B premium subsidy under current law. For individual MAGIs in 2007, the income-related share of total Part B costs were as follows: 35 percent for incomes between $80,000 and $100,000, 50 percent for incomes between $100,000 and $150,000, 65 percent for incomes between $150,000 and $200,000, and 80 percent for income greater than $200,000. Income thresholds for couples filing jointly are twice these dollar amounts. These income thresholds are per 2007 tax returns and have been inflated by the Consumer Price Index (CPI) for 2008 and 2009.

The Chairman's Mark would also inflate the income thresholds by the CPI, except for the period between 2010 and 2019 when the income thresholds would not be updated.

In addition, the Chairman's Mark would expand the current authority for IRS to disclose income information to SSA for purposes of adjusting the Part B subsidy to include the Part D subsidy adjustments and related appeals.

Simplifying Part D Plan Information

Current Law

According to the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, (MMA, P.L.108-173), Part D plans can design two general types of benefit packages: standard

(or actuarially equivalent alternatives) and supplemental. The supplemental, or enhanced, benefit must be of higher actuarial value than the standard benefit. Enhanced plans may offer lower or $0 deductible, reduced cost sharing, an increased initial coverage limit, coverage of some drugs excluded from Part D and/or some coverage of drugs during the coverage gap. Plans must also offer a standard option in a region in order to offer enhanced benefit options.

Beneficiaries and persons assisting them can use the "Medicare Prescription Drug Plan Finder" on the Medicare.gov website to help them find and compare Part D plans in their area. The plan finder provides information on monthly premium and annual deductible amounts, whether there is coverage in the gap and estimated annual costs to the beneficiary. However, the plan finder does not indicate whether the benefits offered by a particular plan are standard, a standard alternative or enhanced. Additionally, marketing and enrollment materials provided by the plans may or may not include this information.

Chairman's Mark

The Chairman's Mark would require the Secretary to establish, beginning with 2011, two or more categories of prescription drug plans offered by Part D sponsors based on ranges of the actuarial values of the prescription drug benefits provided under the plans. The Secretary would also be required to develop standardized nomenclature, definitions, and language to describe and present the benefit categories on the Part D plan finder and in other relevant beneficiary communications. For example, the Secretary could establish three categories of benefit levels—Bronze, Silver, and Gold. Plans would be required to indicate the benefit category of each plan in the name of the product. The Secretary would also be required to ensure that there are meaningful differences between the benefit categories.

Limitation on Removal or Change of Coverage of Covered Part D Drugs Under a Formulary Under a Prescription Drug Plan or a MA-PD

Current Law

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003, (MMA, P.L.108-173) permits Part D plans to manage drug utilization and costs through formularies, or lists of drugs that a plan chooses to cover and the terms under which they are covered. The formulary must be developed by a Pharmacy and Therapeutics Committee, in which the majority of members are physicians and/or practicing pharmacists. A plan's formulary must include at least two drugs in each category or class used to treat the same medical condition. Drug plans are also allowed to apply various utilization management (UM) restrictions to drugs on their formularies. These restrictions may include assignment of drugs to tiers that correspond to different levels of cost sharing; prior authorization, in which the beneficiary must obtain a plan's approval before it will cover a particular drug; and step therapy, in which a beneficiary must first try a generic or less expensive drug; and quantity limits.

Under current law, Part D plans may not change the therapeutic categories and classes in a formulary other than at the beginning of each plan year, except the Secretary may take into account new therapeutic uses and newly approved covered drugs. The law further stipulates that

any removal of a covered drug from a formulary and any change in the preferred or tiered cost sharing status of such a drug shall take effect only after appropriate notice is made available to the Secretary, affected enrollees, physicians, pharmacies, and pharmacists.

The Secretary of HHS published regulations (42 CFR Section 423.120) that also requires that, except under certain circumstances, for example when a covered drug has been deemed unsafe by the Food and Drug Administration (FDA) or removed from the market by its manufacturer, a Part D sponsor may not remove a covered drug from a plan formulary or make any change in the preferred or tiered cost sharing status of a covered drug on a plan's formulary between the beginning of the open enrollment period and 60 days after the beginning of the contract year associated with that open enrollment period. After March 1 of a given plan year, Part D sponsors may make maintenance changes to their formularies, such as replacing brand name drugs with new generic drugs or modifying formularies as a result of new information on drug safety or effectiveness. Part D sponsors can also currently make non-maintenance changes if they are approved by the Secretary.

According to guidance from the Secretary, if Part D sponsors remove drugs from their formularies, move covered drugs to a less preferred tier status, or add utilization management requirements, these changes must be approved in advance. Sponsors may make such changes only if enrollees currently taking the affected drug are exempt from the formulary change for the remainder of the contract year.

Regulation also allows Part D sponsors to expand formularies by adding drugs, reducing copayments or coinsurance by placing a drug on a lower cost sharing tier, or removing utilization management requirements at any time during the year.

Chairman's Mark

The Chairman's Mark would not allow Part D sponsors, beginning in 2011, to remove a covered drug from a plan formulary, apply a cost or utilization management tool that imposes a restriction or limitation on the coverage of such a drug (such as through the application of a preferred status, usage restriction, step therapy, prior authorization, or quantity limitation), or increase the cost sharing of such a drug (such as through the placement of a drug on a tier that would result in higher cost sharing for a beneficiary) other than the date on which Part D sponsors may begin marketing their plans with respect to the immediately succeeding plan year.

The Mark would allow for exceptions if the change is in regard to a brand name drug for which a generic drug was approved during the plan year, or if the change is in regard to a safety issue determined by the plan's Pharmacy and Therapeutic Committee or by the FDA. During the annual open enrollment period, Part D sponsors would be required to provide each enrollee a notice of any change in the formulary or other restrictions or limitations on coverage of a drug for the upcoming plan year.

Added in the Modification or by Amendment at Markup

Medicare Part D Copayment Equity. Cost sharing under Part D for full-benefit, dual eligible beneficiaries receiving care under a home and community based services under sections 1915, 1932 or 1115 waivers would be equal to the cost sharing for those who otherwise receive institutional care. This provision would be effective January 1, 2011.

AIDS Drug Assistance Programs and Indian Health Service. The Mark would allow drugs provided to patients by AIDS Drug Assistance Programs (ADAPs) or the Indian Health Service (IHS) to count toward the annual out-of-pocket threshold. The provision would be effective January 1, 2011

Generic "First Fill". Sponsors of prescription drug plans and Medicare Advantage prescription drug plans under Medicare Part D would be allowed to waive copayments for first fills of generic drugs as an incentive for beneficiaries to try a generic formulation of a drug. This provision would be effective January 1, 2011.

Long-Term Care Pharmacy. The Mark would require Medicare Part D prescription drug and Medicare Advantage prescription drug plans to employ utilization management techniques, such as weekly, daily or automated dose dispensing to reduce the quantity dispensed per fill when dispensing medications to beneficiaries who reside in long-term care facilities in order to reduce waste associated with 30-day fills.

Pharmacy Benefit Manager Transparency. The Mark would require pharmaceutical benefit managers (PBM) to share information with the Secretary of HHS and with plans the PBMs contract with through Medicare Part D or the exchanges. Plans will only be given access to 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 not mandates that these rebates are passed through, only that they be reported to plans.

The Mark would apply the same penalties that currently apply to the Secretary for disclosure of information under the Medicaid rebate statute.

Office of the Inspector General. The Mark would require the Office of the Inspector General to report annually on the inclusion of drugs commonly used by dual eligibles on Part D plan formularies.

The Inspector General would also be required to conduct a study comparing prescription drug prices paid by Medicare Part D insurers to those negotiated by state Medicaid plans for the top 200 drugs determined by both volume and expenditures. The prices should include all rebates

and discounts the Medicaid and Part D plans receive. In conducting the study, the Inspector General is given the authority to collect all necessary information related to pricing necessary to produce comparisons of the Medicare and Medicaid drug benefits. The Inspector General shall assess—

(A) the financial impact of any price discrepancies on the federal government; and
(B) the financial impact of any price discrepancies on beneficiaries.

The report would not disclose information that is deemed proprietary or likely to negatively impact a Medicaid program or Part D plan's ability to negotiate drug prices. The report shall be submitted to Congress no later than October 1, 2011.

HHS Ongoing Study on Coverage for Dual Eligibles. The Mark would require the Secretary to monitor and track how many full benefit dual eligibles enroll in a plan under Part D and receive retroactive drug coverage, the number of months of retroactive coverage provided, and the amount of reimbursements paid to individuals during the retroactive period. The Secretary would also report annually on total annual expenditures for dual eligibles made under titles XVIII and XIX as well as an analysis of health outcomes and the extent to which these beneficiaries are able to access their benefits under both titles.

SUBTITLE C—MEDICARE ADVANTAGE

Medicare Advantage Payment

Current Law

Under the Medicare Advantage (MA) program, beneficiaries have the option to receive Medicare benefits through private health insurance plans. MA plans are paid a monthly per-capita amount to provide all Medicare-covered benefits (except hospice) to beneficiaries who enroll in their plan.

Section 1853 of the Social Security Act requires the Secretary each year to calculate monthly benchmark amounts for MA plans for each county of the country (and the territories). These benchmark amounts are administered prices—that is, they are set by statutory formula and used to determine how MA plans are paid under Medicare. Current law also requires MA plans to submit bids to the Secretary on an annual basis that represent their average monthly revenue requirements for providing Medicare-covered benefits per enrollee for the following year. The monthly bid amounts reflect plans' estimated costs of delivering Medicare benefits per enrollee, as well as their administrative costs, such as profits and expenses for sales, marketing, and care management activities. MA plans also submit separate monthly bids for benefits that they offer under Part D.

MA benchmarks are calculated differently for local plans and regional plans. The local benchmark is based solely on statutory county-level rates. The regional benchmark consists of two components: statutory county-level rates and a weighted average of regional plan bids. The

latter component introduces an element of price competition among regional plans by basing a portion of the benchmark amount on bids submitted by the plans.

Medicare payments to MA plans are determined by comparing their bids to the administered prices or benchmark rates. If an MA plan bid is equal to or above the benchmark, its payment is the benchmark, and it must charge an enrollee premium equal to the difference between its bid and the benchmark. If an MA plan bid is below the benchmark, its payment is its bid. MA plans that bid below the MA benchmarks are also paid a "rebate" amount in addition to their bid. Specifically, MA plans that bid below the benchmarks are paid 75 percent of the difference between their bids and the benchmarks. Thus, the Medicare payment to MA plans that bid below the statutory benchmark is equal to each plan's bid plus 75 percent of the difference between each bid and the benchmark rate.

The "rebate" paid to MA plans must be used to provide benefits that are not covered by Medicare. These extra benefits can take the form of lower Medicare cost sharing under Parts A, B or D, reduced or eliminated monthly Part B premium, or added benefits and services beyond those covered by statute. Rebate payments to MA plans vary widely across the country. Areas with high statutory benchmark rates—mainly areas with the highest levels of per capita Medicare spending—tend to have the highest rebates paid to MA plans. Consequently, MA plans in high cost areas can offer significantly more extra benefits than MA plans in areas with average or low per capita Medicare costs. Under current law, the average rebate amount is about $100 per month, or $1,200 per year. Rebate payments enable MA plans to compete on extra benefits rather than on the price or quality of care they offer.

In general, the MA benchmarks in each local area (county) are updated annually by the national per capita growth rate in Medicare expenditures, otherwise known as the national MA per capita growth percentage. In certain years (known as *rebasing years*), MA benchmarks are reset as the greater of the prior years' rate updated by the national MA per capita growth percentage or 100 percent of local fee-for-service (FFS) costs, with adjustments.

Determination of a plan's service area differs for local and regional MA plans. Local plans chose the counties they wish to serve. Regional plans must agree to serve an entire region defined by the Secretary, and may choose to serve more than one region. MA regions are made up of states or groups of states.

Current payments to MA plans (bids plus rebate payments) are risk adjusted. The Centers for Medicare and Medicaid Services (CMS) uses characteristics, such as age, sex, disability status and prior health history to estimate the relative risk of each beneficiary enrolled in a plan. MA plans are paid their bids plus rebate payments adjusted by their enrollees' risk scores. If MA plans enroll beneficiaries with higher costs, their payments are adjusted upward to account for the costs of covering sicker enrollees. If MA plans enroll beneficiaries with lower costs, their payments are adjusted downward to account for the lower cost of covering healthier enrollees.

Other than risk adjusting payments, the statute does not contain explicit financial incentives for MA plans to manage or coordinate care for high cost, chronically ill beneficiaries.

Section 1854 of the Social Security Act gives the Secretary broad authority to set guidelines and review the actuarial soundness of the monthly bid amounts submitted by MA plans. The statute requires that the Secretary only accept bid amounts or proportions that reasonably reflect the revenue requirements of benefits provided under the plan. Current law also allows the Secretary to negotiate with plans regarding the bid amounts and supplemental benefits, which is similar to the authority provided to the Director of the Office of Personnel Management with respect to the Federal Employee Health Benefits Program (FEHBP). There is one exception: the Secretary is not allowed to review the actuarial bases of the bid amounts or use negotiation authority with respect to private fee-for-service plans.

The Medicare Prescription Drug, Improvement and Modernization Act (MMA, P.L 108-173) required all MA organizations to have a quality improvement program. As part of this program, plans must collect, analyze, and report data that measure health outcomes and other indicators of performance. The quality measures reported by MA plans are summarized by CMS into a composite quality score for each plan. MA plan quality scores are published annually by CMS. MA plans are also required to annually assess the impact and effectiveness of their quality improvement programs and take timely action to correct any systemic problems that come to their attention.

Chairman's Mark

The Chairman's Mark would base the calculation of MA benchmarks on actual plan costs as reflected in plan bids rather than statutorily set rates. Using plan bids to set MA benchmarks would encourage plans to compete more directly on the basis of price and quality rather than on the level of extra benefits offered to enrollees. It also provides cost savings to Medicare because in nearly all areas of the country plan bids are lower than the current benchmark rates.

MA Benchmarks and Rebates. Beginning in 2011, the Chairman's Mark would transition MA benchmarks to reflect plan bids. In 2011, the national MA per capita growth percentage would be reduced by three percentage points. Starting in 2012, local MA benchmarks would be blended with plan bids. Specifically, local MA benchmarks would be based on 33 percent of the enrollment weighted average of plan bids for each payment area and 67 percent of the current law MA benchmarks. In 2013, a greater share of the benchmark rates would reflect actual plan bids. Specifically, 67 percent of the benchmark rates would be based on the enrollment weighted average of plan bids for each payment area, while the remaining 33 percent would be based on the current law MA benchmarks. The Mark would require that the Secretary use the enrollment figures from the most recent month from which data is available.

In 2014, the local MA benchmarks would be based on the actual plan bids from the prior year. That is, the 2014 MA benchmarks would be equal to 100 percent of the enrollment weighted average of the 2013 plan bids increased by the national MA growth percentage for 2014. Beginning in 2015, the MA local benchmarks would be determined by the enrollment weighted average of all MA bids in each payment area. In the case of a payment area where only a single plan is offered, the weight would be equal to one. In the case of a payment area where no MA plans were offered in a prior year and multiple plans bid in the following year, the Secretary would use a simple average to calculate the MA benchmark in that area. An upper bound would

be established in each area so that local benchmarks could not exceed the levels that would have existed under current law. Bids from all local MA plans (except regional plans, PACE plans and 1876 cost plans) would be used to set the MA benchmarks.

Regional plan benchmarks would continue to be calculated as a weighted blend of the regional bids and local MA benchmarks. However, the statutory portion would be based on the new MA benchmarks instead of statutory rates.

In 2011, 2012, and 2013, local and regional MA plans would still receive 75 percent of the difference between their bids and the benchmark rates as a rebate payment. Beginning in 2014, MA plans that bid below the new benchmark rates would receive a rebate amount equal to 100 percent of the difference between their bids and the new benchmarks (rather than 75 percent of the difference as under current law). Just as required under current law, local and regional MA plans that bid equal to or above the new benchmark rates would be paid the benchmark amount and must charge an enrollee premium equal to the difference between their bids and the benchmarks.

The Chairman's Mark would also risk adjust total payments to plans as under current law. Also, MA plans would be required to use 100 percent of any rebate amount to provide additional benefits to their enrollees. Plans would still be allowed to offer supplemental benefits for which they would charge beneficiaries an added premium, as under current law.

Under the Chairman's Mark, PACE plans would be exempt from changes to the MA benchmarks beginning with the transition to competitive bidding in 2012.

Bidding Rules. The Chairman's Mark would require bid information submitted by MA plans to be certified by a member of the American Academy of Actuaries (MAAA). The Secretary would continue to use current statutory authority to review and negotiate plan bids and set guidelines with respect to the actuarial standards that bids must meet. Beginning in 2012, the Secretary would establish bidding rules that plans would follow in order to protect the integrity and fairness of the bidding process as bids are used to set benchmarks amounts. The Mark would also require the Secretary to deny bids that do not meet the actuarial standards and guidelines or abide by the rules established with respect to the competitive bid process. The Secretary would be required to report plan actuaries who repeatedly do not comply with bidding rules and standards to the Actuarial Standards Board for Counseling and Discipline.

Payment Areas. The Chairman's Mark would require the Secretary to establish new MA payment areas for urban areas for plan years beginning in 2012. In urban areas, payment areas would be based on the definition of Metropolitan Statistical Areas (MSA) as determined by the Office of Management and Budget. The Secretary would be required to divide MSAs that cover more than one state, and would be allowed to adjust MSA-based payment areas to reflect patterns of actual health care use. The Secretary would be required to base the adjustments on recent analyses of the patterns of care. The Mark would require the Secretary to combine one or more rural counties in a state into a single service area beginning in 2015. The Mark would require that these new payment areas reflect recent research on actual patterns of care.

The Chairman's Mark would provide additional authority to the Secretary to make limited exceptions to payment area requirements for plans that have historical licensing agreements that preclude the offering of benefits throughout an entire payment area or that have historical limitations in their structural capacity to offer benefits throughout an entire payment area.

Under the Chairman's Mark, bidding and service areas would be the same as payment areas beginning in 2012. MA plans would be allowed to choose which payment areas they would like to serve, but they must bid and serve the entire payment area.

Bonus Payments. The Chairman's Mark would establish two new bonus payments for local and regional MA plans. When added together, the two bonus payments would equal a maximum of five percent of the national U.S. Per Capita Costs of Medicare (USPCC) on a per member per month basis. These bonus payments would be available to all MA plans, beginning in 2014, regardless of plan type or service area. Unlike rebate payments, bonus payments would be available to plans that meet certain performance criteria and would not depend on benchmark rates.

The Mark would create a new bonus payment for care coordination and management activities that are conducted by MA plans. Up to two percent of the USPCC would be available to MA plans that demonstrate to the Secretary that they conduct activities in four of eight areas. A plan would be eligible to earn ½ percent of the USPCC for each of the following separate areas in which they conduct activities:

1. Care management programs that target individuals with one or more chronic conditions, identify gaps in care, and facilitate improved care by using additional resources like nurses, nurse practitioners, and physician assistants.

2. Programs that focus on patient education and self-management of health conditions, including interventions that help manage chronic conditions, reduce declines in health status and foster patient/provider collaboration.

3. Transitional care interventions that focus on care provided around a hospital inpatient episode, including programs that target post-discharge patient care in order to reduce unnecessary health complications and re-admissions.

4. Patient safety programs, including provisions for hospital-based patient safety programs in their contracts with hospitals.

5. Financial policies that promote systematic coordination of care by primary care physicians across the full spectrum of specialties and sites of care, such as medical homes, capitation arrangements or pay-for-performance programs.

6. Medication therapy management programs that focus on poly-pharmacy and medication reconciliation, periodic review of drug regimens, and integration of medical and pharmacy care for chronically-ill, high-cost beneficiaries.

7. Health information technology programs, including electronic health records, clinical decision support and other tools to facilitate data collection and ensure patient-centered, appropriate care.

8. Programs that address identify and ameliorate health care disparities among principal at-risk subpopulations

The Secretary would be authorized to add care management and coordination programs as appropriate. The Mark would also allow for plans to implement programs in ways that are appropriate for urban and rural areas.

The Mark would create a second bonus for prior year achievement or improvement in plan quality performance. Performance would be measured based on a ranking system that measures clinical quality and enrollee satisfaction at the contract or plan level as feasible. MA plans would be eligible to receive two percent of the USPCC if they achieve a three-star rating on a five-star ranking system or four ~~two~~ percent of the USPCC if they achieve between four-and five-stars on a five-star ranking system. Plans that do not achieve at least a three-star rating would be eligible for a one percent quality bonus if their ratings improve over a prior year. If the Secretary does not use a five-star ranking system to measure quality under the MA program, bonus payments would continue to be available to plans at levels that reflect similar levels of achievement and improvement as the five-star ranking system. In making quality bonus payments to plans, the Secretary would use the most recent plan rankings available.

The Mark would make accommodations for the quality bonus for new and low-enrollment plans for limited time frames. New MA plans would be eligible for a two percent bonus for the first two years of operation if they meet certain criteria for structural measures of quality and network adequacy as defined by the Secretary. The criteria would be set with the goal of not creating an unfair advantage or disadvantage for new plans over other existing MA plans in the same service area. In the third year of operation, new plans would be evaluated in the same manner as other plans with comparable enrollment.

For plans with low enrollment, the Secretary would be required to use the regional or local mean for any quality measure that precludes a plan with insufficient data from being evaluated for quality performance using a five-star ranking system. The Secretary would have authority to create alternative mechanisms of measuring quality for purposes of the quality bonus for plans with persistently low enrollment.

The Mark would risk adjust both the care coordination and quality bonus payments to reflect the demographics and actual health status of each enrollee, just as the bid and rebate payments are risk adjusted under the Chairman's Mark and current law. Also, MA plans would be required to use 100 percent of bonus payment amounts to cover the costs of additional benefits offered to their enrollees. Plans would still be allowed to offer supplemental benefits for which they charge beneficiaries an added premium, as under current law.

~~***Efficiency Bonus.*** The Chairman's Mark would create an efficiency bonus for local and regional MA plans that bid significantly below per capita fee-for-service (FFS) costs. The Mark would~~

~~make the efficiency bonus available in addition to rebates (that are paid to plans when their bids fall below new benchmarks) and bonuses for providing care coordination and meeting quality thresholds. Specifically, MA plans that bid more than 85 percent below the average per capita fee-for-service (FFS) Medicare cost in each payment area would be able to retain 10 percent of the difference between their bids and 85 percent of the average FFS amount. Only plans that bid below FFS would be eligible for this bonus.~~

~~Under the Mark, efficiency bonus payments would be risk adjusted in the same manner as MA payments and rebates. In addition, the Mark would require MA plans to use 100 percent of their efficiency bonus to cover the costs of additional benefits offered to their enrollees. Plans would still be allowed to offer supplemental benefits for which they charge beneficiaries an added premium, as under current law.~~

Grandfather Policy. The Mark would allow MA plans to grandfather the extra benefits for their current enrollees in certain areas of the country where average plan bids are at or below 75 percent of local fee-for-service costs. Plans would be able to grandfather enrollees beginning in 2012. The amount of extra benefits would be reduced by 5 percent each year beginning in 2013. Plans that retain or "grandfather" their current enrollees would also be required to submit bids under competitive bidding in those areas. Bids for covered Medicare benefits under competitive bidding and for grandfathered enrollees would be the same. The difference would be the extra benefits. Performance bonus payments under competitive bidding would not be available to enrollees in grandfathered plans. Bids and extra benefits for grandfathered enrollees would be risk adjusted, as under competitive bidding, except extra benefits for grandfathered plans would also be adjusted for differences in utilization that could result from differences in extra benefits.

Transitional benefits. The Secretary would be required 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 two 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 through 2019.

CMS Actuary Certification. The Mark would strike the MA provisions of the Chairman's Mark related to competitive benchmarks and bonus payments if the Chief Actuary of CMS certifies that beneficiaries currently participating in MA would lose Medicare-covered benefits when the provisions of the Chairman's Mark are implemented. The Chief Actuary of CMS would be required to make this certification three months after the enactment of this legislation.

Benefit Protection and Simplification

Current Law

Under the Medicare Advantage (MA) program, the cost sharing (i.e., coinsurance, copayments, and deductibles) that an enrollee must pay for covered health benefits is determined on a plan-by-plan basis. Cost sharing for any service offered by an MA plan may be greater than or less than cost sharing for the same service under the traditional Medicare program. However, the total value of cost sharing required by an MA plan is constrained by the estimated actuarial value of total cost sharing under original Medicare.

Payments to MA plans are based on the relation between the bid and the benchmark, as explained above. If a plan's bid is below the benchmark, the plan is paid its bid plus 75 percent of the difference in the form of a rebate. The rebate must be used to provide additional benefits to enrollees. MA plans have broad authority to determine how they use their rebates to cover the costs of additional benefits. They can reduce Medicare cost sharing expenses under Parts A, B or D. They can also reduce a beneficiary's monthly Part B premium or prescription drug premium. They may also use rebates to pay for benefits that are not covered by traditional Medicare. MA plans also have full discretion to determine how to apportion their rebates among these additional benefits. For this reason, the type and composition of additional benefits that are paid for by rebates varies widely among plans.

Regardless of whether a plan bids above or below the benchmark, a plan may choose to provide benefits not covered under original Medicare and charge a supplemental premium.

Chairman's Mark

The Chairman's Mark would include several protections for beneficiary with respect to the cost sharing amounts charged by MA plans. The Mark would also make additional benefits that are offered by MA plans and paid for by rebates and bonus payments more consistent across plans.

Beginning in 2011, the Mark would prohibit MA plans from charging cost sharing that is greater than the cost sharing under the original Medicare program for certain services for which beneficiaries need the highest level of predictability and transparency, such as chemotherapy treatment, renal dialysis and skilled nursing care. The Secretary would be given authority to identify additional services for which this provision would apply. The Mark would continue to allow MA plans to charge cost sharing for Medicare-covered services where there is no cost sharing under the traditional program.

The Chairman's Mark would also modify how plans can use their rebates and bonuses for additional benefits beginning with 2012. MA plans would have to apply the full amount of rebates and bonuses to cover the cost of additional benefits in the following priority order:

First, plans would use the most significant share to meaningfully reduce Part A, B, and D cost sharing relative to the traditional FFS program. Cost sharing would include copayments, co-insurance, deductibles, as well as out-of-pocket caps on total beneficiary spending. The

Secretary could provide guidance on what constitutes meaningful cost sharing reductions, but could not set the amounts for each plan. The Chairman's Mark would remove authority of MA plans to reduce or eliminate the Part B premium as an additional benefit. In addition, any out-of-pocket spending limits that plans offer would be required to apply to all Part A and B benefits. In other words, MA plans would not be able to exclude certain services, like chemotherapy drugs, from out-of-pocket spending limits.

Second, plans would use the next share to add preventive and wellness benefits, such as preventive care visits, smoking cessation programs, and free flu shots.

Third, plans would be able to use the remainder to add non-covered benefits, such as eye examinations and dental coverage.

In addition, the Chairman's Mark would simplify information about additional benefits that are offered by MA plans. Beginning in 2011, the Secretary would be required to categorize MA plans in each payment area into two or more distinct categories according to the share that rebates, bonuses and supplemental premiums are of each plan's bid. Any marketing materials used must reflect the plan's category. For example, the Secretary may decide to create three categories of plans: Bronze, Silver and Gold. These categories are intended to help beneficiaries compare and distinguish the additional benefits that MA plans offer above traditional Medicare.

Uniform Exceptions and Appeals. The Mark would require sponsors of prescription drug plans and Medicare Advantage prescription drug plans to develop a uniform exceptions and appeals process by 2012.

Medicare Complaint System. The Mark would require the Secretary to develop and maintain a complaint tracking system capable of (1) tracking complaints made by a Medicare Advantage eligible individual or a Part D eligible individual through resolution and (2) producing reports.

Simplification of Annual Beneficiary Election Periods

Current Law

According to the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA, P.L. 108-173), Medicare beneficiaries may enroll in or change their enrollment in Medicare Advantage (MA) and Part D plans from November 15 to December 31 each year in the annual coordinated election period. These changes become effective on January 1 of the next year. During a continuous enrollment and disenrollment period in the first three months of the new benefit year beneficiaries can enroll in an MA plan, and individuals enrolled in an MA plan can either switch to a different MA plan or return to original Medicare. However, during the three-month period, beneficiaries cannot change their drug coverage elections.

In a December 2008 report, the Government Accountability Office (GAO) found that about 15 percent of beneficiaries who chose to switch plans in the Part D annual coordinated election period for the 2008 benefit year were not fully enrolled in their new plan by January 1, primarily because of the volume of applications submitted late in the period. GAO recommended that

Congress consider authorizing the Secretary of HHS to amend the current coordinated election period to include a sufficient processing interval to fully enroll beneficiaries prior to the effective date of their new coverage.

Chairman's Mark

The Chairman's Mark would shift the annual enrollment period dates for Medicare Advantage and Part D to October 15 to December 7. The change would be effective beginning in 2011. The Mark would also eliminate the annual open enrollment period (January 1 through March 31) for MA plans. These changes are intended to simplify the time frames under which beneficiaries would need to make enrollment decisions.

The Mark would also create a 45-day period (January 1 – February 15) beginning in 2011 in which beneficiaries who enroll in Medicare Advantage or prescription drug plans during the annual enrollment period could disenroll and return to traditional fee-for-service.

Extension for Specialized MA Plans for Special Need Individuals

Current Law

Under the Medicare Modernization Act of 2003 (MMA, P. L. 108-173), Congress created a new type of Medicare Advantage coordinated care plan focused on individuals with special needs. Special needs plans (SNPs) are allowed to target enrollment to one or more types of individuals identified by Congress as: 1) institutionalized; 2) dually eligible for Medicare and Medicaid; and/or 3) individuals with severe or disabling chronic conditions.

Congress has since passed additional legislation affecting SNPs. The original SNP authority established by MMA was to expire in December 31, 2008. Passage of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA, P.L. 110-173) authorized the SNP program through December 31, 2009, but also established a moratorium on the creation of SNPs after January 1, 2008. More recently, the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA, P.L. 110-275), lifted the moratorium and authorized the SNP program through December 31, 2010. In addition to legislative changes affecting SNPs, CMS has issued regulatory guidance for the legislative changes. Most recently, the Centers for Medicare and Medicaid Services (CMS) issued a Final Rule in the January 12, 2009 *Federal Register*.

The number of SNPs has increased dramatically since 2004, the first year of operation. In 2004, CMS approved 11 SNPs, but by January 2008, CMS had approved 787 SNPs, including 442 dual-eligible SNPs, 256 chronic care SNPs, and 89 institutional SNPs. In September 2008, there were 1.2 million beneficiaries in SNPs.

Under MIPPA, the SNP program was authorized through December 31, 2010. MIPPA also required that new SNP enrollment be limited to individuals that meet the criteria for which the SNP is designated: dual-eligible, chronic care, and institutional care. Further, MIPPA required that dual eligible SNPs contract with state Medicaid agencies to provide medical assistance services in order to serve new areas. Such contracts with states may include long-term care

services. However, there is no requirement for state Medicaid agencies to contract with SNPs in order to serve new areas.

MIPPA also modified the definition of a chronic care SNP to focus on beneficiaries who are at the greatest risk for hospitalizations and who may have the greatest need for care coordination. MIPPA also required that all SNPs have models of care that are appropriate to their populations and that include personalized care plans for each beneficiary that they enroll.

MIPPA required SNPs to collect, analyze, and report data related to their model of care. These data are required to be reported for each plan sponsored by an organization. CMS provided additional guidance in an interim final rule that requires data that demonstrates compliance with 10 quality indicators. CMS coordinated with the National Committee on Quality Assurance to develop quality measures for SNPs. However, there is no statutory requirement that SNP participate in the NCQA quality measurement requirement or be approved by NCQA.

Current law covering SNPs does not address requirements for the transition to other appropriate MA plans or FFS Medicare if beneficiaries fail to meet the target definition for the types of SNP plans in which they are enrolled. Further, the Secretary does not have the authority to adjust payment levels for dual-eligible SNP plans. Under PACE program authority, CMS may negotiate frailty adjustments for PACE organizations that treat a greater number of frail enrollees.

There is no requirement for the Secretary of HHS to assess how well the risk adjustment model used for SNPs is functioning and to make recommendations for changes.

Chairman's Mark

The Chairman's Mark would extend SNP authority through December 31, 2013. In addition, by January 1, 2013, SNPs would need to have beneficiaries enrolled in their plans that meet the definitions for each type of SNP.

The Chairman's Mark would also require the Secretary to transition beneficiaries enrolled in SNPs to other MA plans or original Medicare if they do not meet the definitions established for such plans by 2013. The Secretary would be allowed to make exceptions to the transition requirements for dual-eligible beneficiaries who lost their Medicaid status in order to give them time to reapply for Medicaid benefits.

The Chairman's Mark would require all dual-eligible SNPs to have established contracts with state Medicaid programs by January 1, 2013, in order to operate and serve dual-eligible beneficiaries.

The Mark would make all changes related to payment, rebates and bonuses, as well as payment and service areas apply to SNPs in the same manner as they apply to MA plans through 2013. SNPs would continue to submit bids in same manner as MA plans. Their bids would also be used to determine the new MA benchmarks from 2012 through 2013, as described in the previous section. All SNPs would be eligible for rebates and new bonus payments in the same

manner and degree as other MA plans. As under current guidelines, dual-eligible SNPs would not be allowed to charge premiums if their bids exceed the new benchmarks.

The Chairman's Mark would create a new payment adjustment for fully-integrated dual-eligible SNPs. Specifically, it would give the Secretary authority to provide a frailty adjustment for fully-integrated dual-eligible SNPs that have similar average levels of frail beneficiaries as PACE plans as defined by the Secretary. However, the Secretary would only be able to adjust payments to dual-eligible SNPs that fully integrate benefits covered under Titles 18 and 19 of the Social Security Act. In order to qualify, dual-eligible SNPs would need to integrate Medicare and Medicaid benefits and payments through an MA contract with the Secretary and a contract with their state Medicaid agency that includes the provision of long-term care.

The Chairman's Mark would also give the Secretary discretion to require SNPs to be certified or otherwise approved by NCQA in order to participate in the Medicare Advantage program. Finally, beginning in 2011, the Secretary would use a risk score for new enrollees in SNPs that reflects the known underlying risk profile and chronic health status of each enrollee. The new risk score would be budget-neutral and applied in lieu of the default risk score for new enrollees of non-SNP MA plans.

For 2011 and periodically thereafter, the Secretary would evaluate and revise the methodology used to risk adjust MA plan payments in order to as accurately as possible account for higher medical and care coordination costs associated with frailty, persons with multiple, co-morbid chronic conditions, enrollees with a mental illness diagnosis and also to account for costs that may be associated with higher concentrations of beneficiaries with these conditions. The Secretary would publish a description of its evaluations and any modifications with the announcement of final payment rates.

The Mark would also require special needs plans (SNPs) to be certified by the National Committee for Quality Assurance (NCQA) beginning in 2012 in order to serve targeted populations. The Secretary would have discretion to design the certification requirements in conjunction with NCQA.

Extension of Reasonable Cost Contracts

Current Law

Reasonable cost plans are Medicare Advantage (MA) plans that are reimbursed by Medicare for the actual cost of providing services to enrollees. Cost plans were created in the Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982. The Balanced Budget Act of 1997 included a provision to phase-out the reasonable cost contracts, however, the phase-out has been delayed over the years through Congressional action. These plans are allowed to operate indefinitely, unless two other plans of the same type (i.e., either 2 local or 2 regional plans) offered by different organizations operate for the entire year in the cost contract's service area. After January 1, 2010, the Secretary may not extend or renew a reasonable cost contract for a service area if: (a) during the entire previous year there were either two or more MA regional plans or

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two or more MA local plans in the service area offered by different MA organizations; and (b) these regional or local plans meet minimum enrollment requirements.

Chairman's Mark

The Chairman's Mark would extend for three years—from January 1, 2010, to January 1, 2013—the length of time reasonable cost plans may continue operating regardless of any other MA plans serving the area.

MA Private Fee-for-Service Plans

Current Law

Current law allows different types of private plans to participate in the MA program, including coordinated care plans (CCPs, such as health maintenance organizations (HMOs) and preferred provider organizations (PPOs)), and private fee-for-service plans (PFFS). CCPs are required to meet medical access requirements by forming networks of contracted providers. Private fee-for-service plans (PFFS) can meet access requirements either by establishing payment rates for providers that are not less than rates paid under original Medicare or by developing contracts and agreements with a sufficient number and range of providers within a category to provide covered services under the terms of the plan. Beginning in 2011, the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA, P.L. 110-275) requires PFFS plans sponsored by employers or unions to establish contracted networks of providers to meet access requirements. PFFS plans that are not sponsored by employers are required to establish contracted networks of providers in areas defined as areas having at least two plans with networks (such as HMOs or PPOs). In areas without at least two network-based plans, PFFS plans retain the ability to establish access requirements through establishing payment rates that are not less than those under original Medicare.

The Secretary has the authority to waive or modify requirements that hinder the design of, the offering of, or the enrollment in employer or union sponsored MA plans. The CMS Medicare Managed Care Manual for Employer/Union Sponsored Group Health Plans specifies the circumstances under which the Secretary would exercise authority to waive some service-area network requirements for employer-sponsored coordinated care plans.

Chairman's Mark

The Chairman's Mark would clarify that in defining areas in which PFFS plans (not sponsored by employers) must establish contracted networks of providers, a network area would be defined as an area served by two or more MA *organizations*. The Chairman's Mark would also allow the Secretary to grant employer-based PFFS plans a waiver from the network requirements in a manner similar to the Secretary's authority to waive or modify other MA requirements for employer-based coordinated care plans.

Erickson Demonstrations

Current Law

Erickson Advantage is a Medicare Advantage demonstration project administered by Evercare and available exclusively to Erickson Retirement Community residents. In general, Medicare Advantage plans are required to serve an area no smaller than a county, which prevents plans from targeting smaller areas of healthier, low-cost enrollees. The Erickson Advantage plan received a waiver of this requirement to be able to restrict enrollment to community residents.

Chairman's Mark

The Chairman's Mark would allow Erickson demonstrations to be a type of MA Special Need Plan, beginning in 2011, if they serve beneficiaries who reside in continuous care environments, have sufficient number of on-site primary care providers as determined by the Secretary, supply transportation benefits to other providers, and were in existence under a demonstration for at least one year.

Medigap

Current Law

Many Medicare beneficiaries have individually purchased health insurance policies, commonly referred to as "Medigap" policies. Beneficiaries with Medigap insurance typically have coverage for Medicare's deductibles and coinsurance; they may also have coverage for some items and services not covered by Medicare. Individuals generally select from one of a set of standardized plans (Plan "A" through Plan "L", though not all plans are offered in all states.) The law incorporates by reference, as part of the statutory requirements, certain minimum standards established by the National Association of Insurance Commissioners (NAIC) and provides for modification where appropriate to reflect program changes. Policy issuers are required to offer at least policies with benefit packages "A", and if they are to offer others, they must offer at least "C" or "F".

Beginning in 2010, two new packages may be offered -- Plan "M" and Plan "N." Plan "M" includes 50 percent coverage of the Part A deductible, and no coverage of the Part B deductible. Plan "N" includes 100 percent coverage of the Part A deductible but no coverage for the Part B deductible. In addition, coverage for the Part B coinsurance is limited to up to $20 for an office visit and up to $50 for an emergency room visit.

Chairman's Mark

The Chairman's Mark would request that NAIC create new model plans for C and F that include nominal cost sharing to encourage the use of appropriate Part B physician services. The nominal cost sharing must be based on evidence either published or from integrated delivery systems, of how cost sharing affects utilization of appropriate physician care. The new models C and F would be available in 2015.

SUBTITLE D—IMPROVING PAYMENT ACCURACY

Home Health Payment Changes

Current Law

Home health agencies (HHAs) are paid under a prospective payment system (PPS) that provides payments based on 60-day episodes of care for beneficiaries, subject to several adjustments. The home health (HH) base payment amount is increased annually by an update factor that is determined, in part, by the projected increase in the HH market basket (MB) index (a measure of changes in the costs of goods and services purchased by HHAs to provide HH services). HHAs that submit quality data to the Secretary receive a full MB increase, while HHAs that do not submit quality data receive a reduced update equivalent to the MB minus two percentage points. For CY 2009, the HH MB update is 2.9 percent. The base payment amount is adjusted for differences in the care needs of patients (case mix) using "HH resource groups" (HHRGs) and outlier adjustments (to account for extraordinarily costly patients), among other adjustments. Presently, there is no difference between urban and rural base payment amounts.

In CY2008, refinements to the Medicare HH PPS included, among other changes, a reduction in the payment rate for four years (to continue through CY2011) to adjust for increases in case mix that are related to changes in coding instead of increased patient severity of illness. These increases occurred between CY2000 and CY2005.

In its March 2009 Report *to Congress: Medicare Payment Policy*, MedPAC reported that most HHAs continued to be paid above costs. Accounting for the payment refinements in CY2008 and the MB update under current law, MedPAC estimates that HHAs would have margins of 12.2 percent in CY2009. In this report, MedPAC recommends that the CY2010 HH payment update be eliminated in CY2010. MedPAC also recommends that the planned coding reductions for CY2011 be advanced to CY2010 and HH payments be rebased in CY2011 to more closely reflect the cost of visits and other services delivered in the average HH episode.

Chairman's Mark

Updating Home Health Payments through Rebasing

Starting in CY2013, the Secretary would be directed to rebase payments to reflect the number and mix of HH services, level of intensity of services, and the average cost of providing care. In doing so, the Secretary would be required to take into account: (1) differences between hospital-based and freestanding HH providers; (2) differences in for-profit and non-profit providers; and (3) differences in resource costs between urban and rural HH providers. The Secretary would evaluate costs based on data from the most recently available audited cost, including either 2009 or 2010, if available. In addition, the Secretary would be directed to phase in the new reimbursement system according to the following schedule: in CY2013, 25 percent of current payment rates would be rebased and 75 percent would be based on amounts calculated under the prior payment system; in CY2014, 50 percent would be rebased and 50 percent would be based

on the prior payment system; in CY2015, 75 percent would be rebased and 25 percent would be based on the prior payment system; and in CY2016, 100 percent of the payments would be rebased.

As part of the rebasing proposal, the Secretary would be directed to ensure adjustments in home health spending as a result of this policy will be no greater than 3.5 percent per year during the four year transition relative to home health payment levels at the date of enactment of this legislation.

MedPAC would be directed to report to Congress in CY2014 and CY2016 on the implementation of the new system, with particular emphasis on how rebasing changes impact: access to care for beneficiaries, quality outcomes, supply of HH providers; and any differential financial impacts on rural, urban, non-profit and for-profit providers.

Provider-Specific Cap on Home Health Outlier Payments

Starting in CY2011, the Secretary would be directed to establish a provider-specific annual cap of ten percent of revenues that a HH agency may be reimbursed in a given year from outlier payments. Provider-specific outlier payments would be calculated using provider cost reports. To ensure that providers would not be paid in excess of the ten percent cap, CMS would be directed to update its claims processing system to ensure the outlier cap is not exceeded.

Reinstatement of Rural Home Health Payment Adjustment

Between CY2010 to CY2015, the Secretary would be directed to provide for a three percent add-on payment for HH providers serving rural areas.

Study Regarding the Development of Home Health Payment Reforms to Ensure Access to Care and Quality Services

1. The Secretary shall conduct a study to evaluate the costs and quality of care among efficient home health providers relative to their peers in providing ongoing access to care and in treating beneficiaries with varying severity levels of illness and develop recommendations on ways to reform home health payments and case mix adjustments based on this analysis.

2. In conducting the study, the Secretary shall consider whether certain factors should be used to measure patient severity of illness and access to care. Factors to consider in this analysis may include, but are not limited to, population density and relative patient access to care; variations in service costs for providing care to Medicare-Medicaid dual eligible beneficiaries; presence of severe and/or chronic diseases as evidenced by multiple, discontinuous home health episodes; poverty status as evidenced by the receipt of a Supplemental Security Income; absence of caregivers; language barriers; atypical transportation costs; and security costs.

3. The study may include recommendations on:

    a. Methods to revise the home health payment system to more accurately account for the costs related to patient severity of illness or to improving beneficiary access to care, including payment adjustments for services that may be under or over-valued; necessary changes to reflect the resource use relative to providing home health care to low-income beneficiaries or beneficiaries living in medically underserved areas; ways the outlier payment may be improved to more accurately reflect the cost of treating beneficiaries with high severity levels of illness; the role of quality of care incentives and penalties in driving provider and patient behavior; and improvements in the application of a wage index;

    b. An assessment of the validity and reliability of responses on the OASIS instrument with particular emphasis on questions that relate to higher PPS payment and higher outcome scores under "Home Care Compare;

    c. Additional research or payment modifications that may be necessary to set home health rates based on costs of high-quality and efficient home health providers or to improve beneficiary access to care; and

    d. Other areas deemed appropriate by the Secretary.

4. In conducting the study, the Secretary shall seek input from stakeholders representing home health providers and beneficiaries. The Secretary shall also seek input from the Medicare Payment Advisory Commission, the HHS Inspector General and the Government Accountability Office in its development and design of the study.

5. The Secretary shall issue a report on its findings and recommendations to the Congress by no later than March 1, 2011. The report shall include a timetable for the potential implementation of the recommendations and a statement as to which recommendations require a change in statute and those that can be implemented under the regulatory authority of the Secretary.

6. In addition, no later than January 1, 2012, based on the findings of this report and if the Secretary deems appropriate, the Secretary shall establish a temporary Medicare payment adjustment targeted toward ensuring access to care for beneficiaries with high severity of illness or to improve access to care for low-income or underserved beneficiaries. This temporary Medicare add-on payment may be no greater than three percent of the base PPS payment amount for any covered home health service furnished to an eligible beneficiary based on the findings of this report. Payments made under this section shall not exceed $500 million in total from 2011-2019.

Hospice Payment Reforms

Current Law

Medicare covers hospice care for terminally ill beneficiaries instead of most other Medicare services related to the curative treatment of their illness. Using an interdisciplinary team, Medicare's hospice benefit provides care that specializes in the relief of the pain and symptoms associated with a terminal illness and the provision of supportive and counseling services to patients and their families during the final stages of a patient's illness and death. For a person to be considered terminally ill and eligible for Medicare's hospice benefit, the beneficiary's attending physician and the medical director of the hospice (or physician member of the hospice team) must certify that the individual has a life expectancy of six months or less. Beneficiaries electing hospice are covered for two 90-day periods, followed by an unlimited number of 60-day periods. The medical director or physician member of the hospice team must recertify at the beginning of each period that the beneficiary is terminally ill. Services must be provided under a written plan of care established and periodically reviewed by the individual's attending physician and the medical director of the hospice.

Medicare payments to hospices are predetermined fixed amounts for each case, according to the general type of care provided to a beneficiary on a daily basis. Such payments are intended to pay for the costs of care for a hospice beneficiary, on average. Payments for hospice care are based on one of four prospectively determined units of payment, which correspond to four different levels of care (i.e., routine home care, continuous home care, inpatient respite care, and general inpatient care) for each day a beneficiary is under the care of the hospice. Payment would thus vary by the length of the patient's period in the hospice program as well as by the characteristics of the services (intensity and site) furnished to the beneficiary. Hospices bill separately for additional physician services not covered under the payment categories described above.

The hospice cost report data collected by CMS contain provider-reported cost and statistical data for free-standing hospice providers. The dataset is normally updated quarterly and is available on the last day of the month following the quarter's end.

Chairman's Mark

Payment Reforms. The Secretary would be required to collect additional data and information in order to revise payments for hospice care after consulting with hospice providers and the Medicare Payment Advisory Commission. The Secretary would be required to collect the additional data and information on cost reports, claims and other mechanisms as the Secretary determines to be appropriate. Collection of the additional data and information would be required to begin by 2011. The types of additional data and information that would be collected would include, but would not be limited to: (1) the type of practitioner providing the visit; (2) the length and content of the visit; (3) charge and payment information; (4) number of days attributable to Medicare beneficiaries and dually eligible beneficiaries; (5) days of hospice care by type of service and costs and payment attributable to each type of service; and (6) charitable contributions and other revenue.

The Secretary would be required to implement changes to the payment methodology for hospice care as appropriate based on the additional data and information collected. These changes may include per diem payments to hospices that reflect changes in resource intensity in providing hospice services during the course of the entire episode or additional payments (end-of-episode payment) reflecting resource intensity of services provided at the end of episode if the patient is not transferred to another hospice or revokes election of the hospice benefit. These changes would be implemented in FY2013 through rulemaking and would be budget neutral.

Accountability. The Secretary would impose certain requirements on hospice providers as follows: (1) that a hospice physician or advanced practice nurse visit the patient to determine continued eligibility prior to the 180th day recertification and each subsequent recertification, and attest that such visits took place; and (2) that all stays in excess of 180 days be medically reviewed by CMS or its contractors for hospices for which stays exceeding 180 days make up a certain level of their total cases, as determined appropriate by the Secretary.

Medicare Hospice Concurrent Care (HCC) Demonstration. The Mark would require the Secretary to conduct a three-year demonstration program that would allow patients who are eligible for hospice care to also receive all other Medicare covered services during the same period of time. The Secretary would establish 26 sites across the country in both urban and rural areas to examine improvement in patient care, quality of life, and cost-effectiveness that results from the demonstration project. An independent evaluation of this delivery model would be conducted with reports submitted to the Secretary and Congress. This demonstration would be required to be budget neutral.

Medicare DSH Changes

Current Law

The Medicare disproportionate share hospital (DSH) adjustment was implemented in 1986 on the premise that low-income patients are more costly to treat and those hospitals serving a large number of such patients would be likely to have higher costs for their Medicare patients than would otherwise similar institutions. Over time, as the formulas for Medicare's DSH adjustment have been changed, the justification for the higher payments has evolved and the adjustment is viewed as a subsidy for uncompensated care provided by the hospital.

Medicare's DSH payments are distributed through a hospital-specific percentage increase to its prospective payment rate. In most instances, the size of a hospital's DSH adjustment would depend upon the number of patient days provided to poor Medicare patients or Medicaid patients. However, small urban hospitals and many rural hospitals have their DSH adjustment capped at 12 percent.

In its March 2007 Report to Congress, MedPAC found that about three-quarters of the Medicare DSH payments (accounting for about $5.5 billion in FY2004) was not empirically justified in terms of higher patient care costs. Also, Medicare's DSH payments were poorly targeted to hospitals' shares of uncompensated care. MedPAC recommended that an existing hospital cost

reporting form (worksheet S-10 used to collect information on the hospital's charity care practices and the amount of uncompensated care provided each year) be revised to correct existing data reporting problems.

Chairman's Mark

Starting no later than 2015 and continuing on an annual basis, the Secretary would make disproportionate share payments equal to 25 percent of the disproportionate share payments that would otherwise be made, a payment that represents the empirically justified amount as determined by the Medicare Payment Advisory Commission in its March 2007 Report to Congress. The empirically justified funding amount is intended to reimburse hospitals for the additional costs of treating low-income beneficiaries.

In addition to this amount, an additional payment would be made to reflect hospitals' continued uncompensated care costs. Funding for this additional payment would come from the difference between the empirically justified amount for DSH payments and the amount that would be paid for DSH payments under current law. For every given percentage point reduction in the uninsured in each period evaluated, the percent of funding available for this amount to hospitals would be reduced by a proportional amount.

Given a lag in accurate data to measure the change in the level of insurance in 2015, the Secretary will be directed to calculate insurance coverage levels relative to the projected impact of the coverage expansion in 2015, 2016, and 2017 compared to the last year before coverage expansion (2012). Starting in 2018, the Secretary will use the most recent Census Bureau data for purposes of the adjustment.

Plan to Reform Medicare Hospital Wage Index

Current Law

A hospital wage index is used to adjust the standardized amount to account for the local wage variation or cost of labor in the hospital's area. CMS defines hospital labor market areas using definitions of statistical areas established by the Office of Management and Budget (OMB). The wage index is intended to measure the average wage level for hospital workers in each urban area (a modified core based statistical area or CBSA) or rural area (comprised of counties that have not been assigned to any CBSA) relative to the national average wage level. Some states where every county is included in an urban area have no rural wage index.

Hospitals submit data on their hours, wages, and labor-related costs annually in their Medicare cost report. There is a four-year lag in the data used to calculate the wage index; the FY2008 wage index was calculated using data submitted by hospitals for cost reporting periods beginning in FY2004. Generally, CMS calculates an area's average hourly wage using the data on compensation and hours submitted by every hospital in the area. Starting in FY2005, CMS has adjusted this data to account for the relative skill mix of the hospitals in the area. This occupationally mix adjusted average hourly wage is then divided by the same measure calculated using data from all hospitals in the nation to establish the area's adjusted wage index.

The Tax Relief and Health Care Act of 2006 (TRHCA, P.L. 109-432) required that MedPAC submit a report to Congress on wage index revisions, including recommendations on alternatives by June 30, 2007. The Secretary was directed to consider MedPAC's recommendations and include in the fiscal year 2009 inpatient prospective payment proposed rule one or more proposals to revise the wage index. TRHCA also requires that CMS consider specific issues of Congressional concern such as eliminating exceptions, minimizing variation in the wage index across county borders and using the hospital wage index in different settings. MedPAC issued its mandated report by June 2007. CMS did consider the report's recommendations in its FY2009 rulemaking process and has hired an independent consulting firm to further evaluate the impact of making the recommended changes.

Chairman's Mark

By December 31, 2011, the Secretary would be required to provide a plan to Congress on how to comprehensively reform the Medicare wage index system. This plan would be required to take into account the goals set forth in the MedPAC June 2007 report including establishing a new hospital compensation index system that: (1) uses Bureau of Labor Statistics data, or other data or methodologies, to calculate relative wages for each geographic area involved; (2) minimizes wage index adjustments between and within CBSA and statewide rural areas; (3) includes methods to minimize the volatility of wage index adjustments that result from implementation of policy, while maintaining budget neutrality in applying such adjustments; (4) analyzes the effect that implementation of the proposal would have on health care providers and on each region of the country; (5) addresses issues related to occupational mix, such as staffing practices and ratios, and any evidence on the effect on quality of care or patient safety as a result of implementation of policy in this section; and (6) provides for a transition period.

The Secretary would also be required to restore the ratios used in determining geographic hospital wage index reclassification to pre-October 1, 2008 levels until the first fiscal year one year after the Secretary submits the Plan to Reform the Medicare Hospital Wage Index to Congress as required in the Mark. It also would ensure that any applications for reclassification for fiscal year 2011 and subsequent years denied on the basis of the changed ratios would be reconsidered using the pre-existing ratios, and approved, if the applicant meets the pre-existing ratios. This provision would be implemented in a budget neutral manner.

And finally, the Mark would require application of budget neutrality on a national basis in the calculation of the Medicare hospital wage index floor for each all-urban and rural state. In the case of discharges occurring on or after fiscal year 2011, for purposes of applying section 4410 of the Balanced Budget Act of 1997 (42 U.S.C. 1395ww note) and paragraph (h)(4) of section 412.64 of title 42, Code of Federal Regulations, the Secretary of Health and Human Services shall administer subsection (b) of such section 4410 and paragraph (e) of such section 412.64 in the same manner as the Secretary administered such subsection (b) and paragraph (e) for discharges occurring during fiscal year 2008 (through a uniform, national adjustment to the area wage index).

Extend Section 508 Reclassifications

Current Law

Section 508 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA, P.L. 108-173) provided $900 million for a one-time, three year geographic reclassification of certain hospital who were otherwise unable to qualify for administrative reclassification to areas with higher wage index values. These reclassifications were extended from March 31, 2006 to September 30, 2007 by the Tax Relief and Health Care Act of 2006 (TRHCA, P.L. 109-432). The Medicare, Medicaid and SCHIP Extension Act (MMSEA, P.L. 110-173) extended the reclassifications to September 30, 2008. The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA, P.L. 110-275) extended the reclassifications until September 30, 2009. These extensions were exempt from any budget neutrality requirements.

Chairman's Mark

The Section 508 reclassifications would be extended until September 30, 2011.

Advanced Diagnostic Imaging Services

Current Law

Under the Medicare fee schedule, some services have separate payments for the technical component and the professional component. For example, imaging procedures generally have two parts: the actual taking of the image (the technical component), and the interpretation of the image (the professional component). Medicare pays for each of these components separately when the technical component is furnished by one provider and the professional component by another. When both components are furnished by one provider, Medicare makes a single global payment that is equal to the sum of the payment for each of the components.

CMS's method for calculating the Medicare fee schedule reimbursement rate for advanced imaging services assumes that imaging machines are operated 25 hours per week, or 50 percent of the time that practices are open for business. Setting the equipment use factor at a lower — rather than at a higher—rate has led to higher payment for these services. Citing evidence showing that the utilization rate is 90 percent, rather than the 50 percent previously assumed, MedPAC is urging CMS to use the higher utilization rate in the calculation of fee schedule payments for advanced imaging services.

According to MedPAC and the Government Accountability Office (GAO), there are opportunities to improve the efficiency of the Medicare fee schedule. In 2005, MedPAC recommended reducing certain fees to account for efficiencies and savings from the technical preparation and supplies achieved when multiple imaging services are furnished sequentially on contiguous body parts during the same visit. Starting January 1, 2006, physicians receive the full technical component fee for the highest paid imaging service in a visit, but technical component fees for additional imaging services are reduced by 25 percent.

Chairman's Mark

The Chairman's Mark would increase the utilization rate assumption for calculating the payment for advanced imaging equipment from 50 percent to 65 percent for 2010 through 2013. The rate would be further increased to 75 percent beginning in 2014. The Secretary of HHS would be required to conduct a study by January 1, 2013 on the estimated impact of the utilization rate change on the following: (1) beneficiary access, including in rural areas; (2) utilization of advanced diagnostic imaging services; and (3) the estimated savings to the Medicare program over the period of 2010 through 2019.

In addition, the Chairman's Mark would increase the technical component payment reduction for sequential imaging services on contiguous body parts during the same visit from 25 percent to 50 percent.

Durable Medical Equipment

Current Law

Elimination of Additional Payment in 2014. Payments to durable medical equipment suppliers are based on fee schedules. The fee schedules are generally updated yearly to reflect a measure of health care inflation. MIPPA required the 2014 update to DME suppliers to be two percentage points above the otherwise scheduled update amount.

Power Wheelchairs. Wheelchairs, including power-driven wheelchairs, are covered by Medicare under the capped-rental category of the durable medical equipment (DME) benefit. Medicare pays for power-driven wheelchairs in one of two ways: either Medicare will pay the supplier a monthly rental amount during the beneficiary's period of medical need (though payments are not to exceed 13 continuous months), or the payment is made on a lump-sum basis at the time the supplier furnishes the chair if the beneficiary chooses the lump-sum payment option. If the reasonable lifetime of a power-driven wheelchair is reached, or the wheelchair is lost or irreparably damaged, Medicare will pay for a replacement. The beneficiary may elect to have the replacement purchased through either monthly rental payments not to exceed 13 months, or a lump-sum payment.

Rental payments for wheelchairs are statutorily determined as ten percent of the purchase price of the chair for each of the first three months of rental and 7.5 percent of the purchase price for each of the remaining ten months of the rental period.

Accreditation Exemption for Certain Pharmacies. MMA required the Secretary to establish and implement quality standards for suppliers of durable medical equipment, prosthetics and supplies (DMEPOS) under Part B of Medicare. MIPPA requires DMEPOS suppliers to prove their compliance with the quality standards by being accredited by October 1, 2009. MIPPA, however, exempted eligible professionals from having to comply with the accreditation requirement unless the standards and accreditation requirements being applied were specifically designed to be applied to those professionals. The statutes defines the following as eligible professionals: physicians, physical or occupational therapists, qualified speech-language

pathologists, qualified audiologists, physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, certified nurse-midwives, a clinical social workers, clinical psychologists, or registered dietitians or nutrition professionals. The Secretary was given authority to exempt additional professionals from the accreditation requirements. Pharmacists and pharmacies were not listed as exempt from the accreditation requirements.

Chairman's Mark

Elimination of Additional Payment in 2014. The Chairman's Mark would eliminate the 2014 add-on payment.

Power Wheelchairs. Starting in 2011~~2010~~, the provision would limit the option to purchase a power-driven wheelchair with a lump-sum payment only to complex, rehabilitative power wheelchairs. The lump-sum payment option would be eliminated for all other wheelchairs. The provision would also eliminate the lump-sum purchase option for replacing a wheelchair for all chairs except complex, rehabilitative power wheelchairs.

Accreditation Exemption for Certain Pharmacies. The Chairman's Mark would make pharmacies eligible for an exemption from the accreditation requirements under the following circumstances: (1) the pharmacy has had no adverse determination against it for the last 5 years due to fraud; (2) the pharmacy submits an attestation that its total Medicare DMEPOS billings are and continue to be less than a rolling three year average of five percent of total pharmacy sales; and (3) the pharmacy is willing to submit documentation to the Secretary (based on a random sample of pharmacies) that would allow the Secretary to verify the information in (2). The documentation submitted for (3) could consist of an accountant certification or filing of tax returns by the pharmacy.

The provision would also allow the Secretary to determine accreditation standards that are more appropriate for pharmacies.

Treatment of Certain Cancer Hospitals

Current Law

Eleven cancer hospitals are exempt from the inpatient prospective payment system (IPPS) used to pay inpatient hospital services provided by acute care hospitals. As part of this exemption, these facilities are paid on a reasonable cost basis, subject to certain payment limitations and incentives. These hospitals are also held harmless under the outpatient prospective payment system (OPPS) and will not receive less from Medicare under this payment system than under the prior outpatient payment system. Under OPPS, Medicare pays for outpatient services using ambulatory payment classification (APC) groups.

Chairman's Mark

The Secretary would be required to conduct a study determine if the outpatient costs incurred by PPS-exempt cancer hospitals with respect to Medicare's APCs exceed those costs incurred by

other hospitals reimbursed under OPPS. If the costs in the PPS exempt cancer hospitals are excessive, the Secretary would be required to provide for an appropriate adjustment for services furnished starting January 1, 2011 under Section 1833(t) of the Social Security Act. In making this adjustment, the Secretary would be directed to ensure no PPS-exempt cancer hospital receives OPPS payments that are lesser than their payment level as a result of this provision.

Added in the Modification or by Amendment at Markup

Nurse Midwifery Access and Reimbursement Equity. The Mark increases the Medicare payment rate for nurse-midwives for covered services from 65 percent to 100 percent of the physician fee schedule rate.

SUBTITLE E—ENSURING MEDICARE SUSTAINABILITY

Market Basket Cuts

Current Law

Currently, most fee-for-service Medicare providers receive predetermined payment amounts established under different, unique prospective payment systems. Typically, each year, the base payment amounts in the different Medicare payment systems are increased by an update factor to reflect the increase in the unit costs associated with providing health care services. Generally, Medicare's annual updates are linked to projected changes in specific market basket (MB) indices which are designed to measure the change in the price of goods and services (such as labor and utilities) that are purchased by the provider. These update factors are intended to reflect the increases associated with inflation on providers costs per service.

The Medicare Payment Advisory Commission (MedPAC) makes payment update recommendations for the different payment systems each year in its March report to Congress. In making these recommendations, MedPAC assesses adequacy of payments for efficient providers in the current year; how providers costs may change in the upcoming year; beneficiaries' access to care; changes in the capacity and supply of providers; changes in the volume of services; changes in the quality of care; providers' access to capital; and Medicare payment rates relative to provider costs' in the given year. Based on this analysis, in its March 2009 *Report to Congress: Medicare Payment Policy*, MedPAC recommended that a number of health care providers receive reduced or eliminated Medicare market basket updates in fiscal year 2010.

Chairman's Mark

The provision would reduce market basket updates for home health providers by one percent in 2011 and 2012.

The provision would also reduce market basket updates for hospice providers by 0.5 percent in 2013-2019 in addition to the productivity adjustments referenced in the next section.

For hospitals, the provision would require a market basket minus 0.25 percent reduction in 2010 and 2011 for inpatient and outpatient hospitals, inpatient psychiatric facilities, inpatient rehabilitation and long term care hospitals.

The provision would also implement an additional 0.2 percent market basket reduction for inpatient and outpatient hospitals, inpatient psychiatric facilities, inpatient rehabilitation facilities and long term care hospitals from 2012-2019 in addition to the productivity adjustments described in the next section.

Regarding the 0.2 percent and 0.5 percent payment reductions applied to hospitals and hospice providers, respectively, in addition to the productivity adjustment, if in any year from 2014-2019, the previous year's total percentage of insured population (as reflected in the share of the total, non-elderly population) is more than five percentage points below projections at time of bill enactment, then the Secretary shall "give back" this payment reduction via an adjustment to the otherwise applicable market basket increase in the current year.

Productivity

Current Law

Currently, most fee-for-service Medicare providers receive predetermined payment amounts established under different, unique prospective payment systems. Each year, the base payment amounts in the different Medicare payment systems are increased by an update factor to reflect the increase in the unit costs associated with providing health care services. Generally, Medicare's annual updates are linked to either: (1) projected changes in specific market basket (MB) indices which are designed to measure the change in the price of goods and services (such as labor and equipment) that are purchased by the provider and intended to reflect the effect of inflation on providers' costs per service; or (2) the Consumer Price Index (CPI).

Each year, these updates are implemented assuming that the quantity, quality, and mix of inputs remain constant over time. According to CBO, market basket updates overstate actual costs to providers because they do not assume increases in provider productivity that could reduce the actual cost of providing services (such as through new technology, fewer inputs, etc). Annual updates to the Medicare physician fee schedule are determined by a separate method that already incorporates adjustments for gains in physician productivity.

Chairman's Mark

The provision would provide for updates based on the MB or CPI minus full productivity estimates for all Parts A and B providers who are subject to a MB or CPI update.

Specifically, this change would implement a full productivity adjustment for inpatient and outpatient hospital services, inpatient psychiatric facilities, inpatient rehabilitation, long term care hospital services and nursing homes beginning in 2012. It would implement a full productivity adjustment for hospice providers beginning in 2013. In addition, it would implement a full productivity adjustment for home health providers beginning in 2015. ~~All other~~

~~productivity adjustments for other Part B providers would begin in 2011.~~ For providers paid through the clinical laboratory test fee schedule, the Chairman's Mark replaces the scheduled 0.5 percent payment reduction for years 2011 through 2013 with a full productivity adjustment for 2011 and subsequent years. The clinical laboratory productivity adjustment could not reduce the fee schedule update below zero. In addition to the productivity adjustment, for the years 2011 through 2015, the clinical laboratory test fee schedule would be further reduced by 1.75 percentage points. All other productivity adjustments for other Part B providers would begin in 2011. Additionally, beyond these adjustments, the Mark includes an additional reduction in the clinical laboratory test fee schedule equal to $100 million.

Temporary Adjustment to the Income-Related Premium for Part B of Medicare

Current Law

Medicare Part B finances coverage for physicians' and other outpatient services, in part through premiums paid by beneficiaries who enroll in the voluntary program. Before January 2007, the Part B premium was set at 25 percent of the program's costs per aged enrollee (enrollees who were age 65 or older) and was applied universally to all enrollees. Since then, under a provision of the Medicare Modernization Act, approximately 1.7 million higher-income beneficiaries have faced progressively greater shares of those costs—35 percent, 50 percent, 65 percent, or 80 percent, depending on income. The income categories that those shares apply to are based on enrollees' modified adjusted gross income. In 2009, the income thresholds for those premium shares are $85,000, $107,000, $160,000, and $213,000, respectively. (For married couples, the corresponding income thresholds are twice those values.) The income thresholds rise each year with changes in the consumer price index.

Chairman's Mark

The provision would freeze the current income thresholds for the period of 2011 through 2019.

Medicare Commission

Current Law

No provision.

Chairman's Mark

The Chairman's Mark would establish an independent Medicare Commission (hereafter the Commission) that would develop and submit proposals to Congress aimed at extending the solvency of Medicare, slowing Medicare cost-growth, and improving the quality of care delivered to Medicare beneficiaries. The Commission would be composed of 15 members, who would be appointed by the President and confirmed by the Senate. The Senate Majority Leader, the Speaker of the House, the Senate Minority Leader, and the House Minority Leader would each present three recommendations for appointees to the President; however, these recommendations in no way would limit the President's ultimate responsibility to present

Congress with qualified nominees. Qualifications for members of the Commission would be similar to the qualifications required for members of the Medicare Payment Advisory Commission (MedPAC). In addition to these qualifications, members of the Commission would be required to be free of any conflicts of interest and would be held to certain disclosure and accountability requirements. Members of the Commission would serve six-year, staggered terms and would continue to serve until replaced. After serving on the Commission, former members would be barred from lobbying the Commission and other relevant executive branch departments and agencies and relevant congressional committees for one year. In addition to the 15 members of the commission, the Secretary of Health and Human Services (HHS), the Administrator of the Center for Medicare and Medicaid Services (CMS), and the Administrator of the Health Resources and Services Administration (HRSA) would serve as ex-officio, non-voting members of the Commission. MedPAC would continue to exist in its current form as an advisory body to Congress.

The Commission would be tasked with presenting proposals to Congress that would reduce Medicare spending by targeted amounts compared to the trajectory of Medicare spending under current law. The scope of proposals presented to Congress should (1) to the extent feasible, target reductions to sources of excess cost growth; (2) to the extent feasible, improve the health care delivery system, including the promotion of integrated care, care coordination, prevention and wellness and quality improvement; (3) to the extent feasible, protect beneficiary access to care, including in rural and frontier areas; (4) to the extent feasible, consider the effects of provider payment ~~benefit~~ changes on beneficiaries; (5) to the extent feasible, consider the effects of proposals on any provider who has, or is projected to have, negative profit margins or payment updates; and (6) to the extent feasible, improve the quality of care delivered to Medicare beneficiaries; (7) to the extent feasible, consider the unique needs of individuals dually eligible for Medicare and Medicaid; and (8) prior to December 31, 2019 not impact providers scheduled to receive a reduction to their inflationary payment updates in excess of a reduction due to productivity in a year in which the Commission's proposals would take effect. The Commission would be prohibited from presenting proposals that would ration care, increase revenues, or otherwise change Medicare beneficiary cost-sharing (including premiums under sections 1818, 1818A, and 1839 of the Social Security Act), benefits, or eligibility standards.

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.

Beginning with the 2013 report of the Medicare Trustees, the Chairman's Mark would require the CMS Office of the Actuary (OACT) to project whether the Medicare per-capita growth rate in 2015 will exceed the average of the growth rates in the Consumer Price Index (CPI) and the Consumer Price Index for medical care (CPI-M) projected for 2015. The Medicare per-capita growth rate would be calculated as the five-year moving average of Medicare spending (Parts A, B, and D) per unduplicated enrollee, ending with the projection for the year in which the Commission's proposals would apply. This projection would be made without regard to the physician fee schedule update, and would take into account any delivery system reforms or other payment changes that have been enacted, are scheduled to be enacted, or published as a final rule but have not been implemented at the time of the analysis.

If the projected excess cost growth is estimated to be greater than the average of CPI and CPI-M, the Commission would be required to submit a proposal to Congress by January 1, 2014 that would reduce excess cost growth by 0.5 percentage points in 2015, as estimated by OACT. If excess cost growth is projected to be less than 0.5 percentage points (or the equivalent reduction in future years), then the Commission would be required to submit a proposal that eliminates excess cost growth, as certified by OACT. The Chairman's Mark would also require that the Commission's proposals are certified by OACT to not increase spending within the following ten-year budget window.

If the Commission fails to submit a proposal by the January 1st deadline that meets the requirements described above, the Secretary of HHS would be required to submit a proposal to Congress that would achieve the same reduction in excess cost growth (as certified by OACT) by no later than January 5, 2014. The Secretary's proposal would be subject to the same scope and requirements as the Commission.

The Commission would be required to submit a draft of its proposal to MedPAC and CBO by September 1, 2013. Once the proposal is submitted to Congress, MedPAC would be required to review and present its analysis of the Commission's (or Secretary's) proposal no later than February 1, 2014. By April 1, 2014, the Senate Finance Committee, along with the relevant House Committees, would be required to report out either the Commission's (or Secretary's) proposal or an amended proposal that achieves the same level of reductions in excess cost growth. Policy changes extraneous to Medicare would be prohibited and would be stricken from the proposal. If a committee fails to report a legislative package achieving the targeted level of Medicare savings by April 1st, the Commission's (or Secretary's) package would be automatically discharged from that committee.

The Chairman's Mark would require the package be brought to the floor within 15 days of being reported or discharged from a committee. In the Senate, the package would be subject to 30 hours of debate. Only budget-neutral and germane amendments would be considered in order. Once passed by both chambers, the conference report would be subject to 10 hours of debate in the Senate. If a package that meets the level of Medicare savings described above is not enacted

into law by August 15, 2014, the Chairman's Mark would require the Commission's (or Secretary's) original proposal to go into effect automatically.

The Chairman's Mark would require the Commission to make additional proposals on January 1st of 2015, 2016 and 2017, based on the procedures described above. However, the targeted level of Medicare savings would increase each year. The proposal delivered to Congress in 2015, would be required to reduce excess cost growth by 1.0 percentage point in 2016. The proposal delivered to Congress in 2016 would be required to reduce excess cost growth by 1.25 percentage points in 2017. The proposal delivered to Congress in 2017 would be required to reduce excess cost growth by 1.5 percentage points in 2018. The growth target in 2019 and beyond would be GDP per capita plus one percent.

In any year where excess cost growth is not projected, the Commission would not be required to submit a proposal to Congress with a specific savings target, nor would such proposals be eligible for fast-track consideration in Congress. However, the Commission would submit purely advisory proposals that fall under the Commission's purview. This advisory proposal would not go into effect automatically absent Congressional action.

In 2019, Congress would be required to hold a vote under fast-track procedures on whether the Commission should extend beyond 2019, but the Commission would continue unless Congress affirmatively votes to terminate it. ~~In 2019, the Chairman's Mark would require Congress to pass a joint resolution to continue further proposals and subsequent action by the Commission. This resolution would be placed on a fast-track procedure in order to ensure a vote occurs.~~

Changes implemented as a result of this provision would not be subject to administrative or judicial review.

The Chairman's Mark would grant the Commission immediate authority to advise the Secretary of HHS on priorities for health services research, particularly as they pertain to payment reforms under Medicare. In addition, the Commission would have the same level of access to federal data and research as MedPAC and CBO, and would be required to regularly consult with the Medicaid and CHIP Payment and Access Commission (MACPAC).

The Chairman's Mark would establish the Consumer Advisory Commission (CAC), which would be composed of ten consumer representatives that would advise the Medicare Commission on the impact of Medicare payment policies on consumers. Members of the CAC would be appointed by the GAO and serve three-year, staggered terms.

The Chairman's Mark would require, by July 1, 2015, the GAO to conduct a study on the effect of the Commission's proposals. Specifically, the study would provide an assessment of the effect of the Commission's proposal on Medicare beneficiary's access to providers, affordability of premiums and cost-sharing, and quality of care provided. GAO would be required to conduct similar subsequent studies.

No reductions in Medicare outlays may be utilized to offset any non-Medicare outlays.

Added in the Modification or by Amendment at Markup

MedPAC Review and Report on Medicaid and Commercial Payments to Congress. 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).

SUBTITLE F—PATIENT-CENTERED OUTCOMES RESEARCH

Patient-Centered Outcomes Research Act of 2009

Current Law

The need for credible information about which clinical strategies work best, under what circumstances and for whom has been widely recognized by clinicians, patients, researchers and policy makers. Commonly referred to as comparative effectiveness research (CER), the Institute of Medicine (IOM) defines this type of research as the "the generation and synthesis of evidence that compares the benefits and harms of alternative methods to prevent, diagnose, treat, monitor a clinical condition and improve delivery of care" with the aim of tailoring decisions to the needs of individual patients. CBO has referred to CER as "a comparison of the impact of different options that are available for treating a given medical condition for a particular set of patients." MedPAC has referred to "comparative-effectiveness" as "analysis [that] compares the clinical effectiveness of a service (drugs, devices, diagnostic and surgical procedures, diagnostic tests, and medical services) with its alternatives." The phrase "patient-centered outcomes research" has also been used as an alternate term.

Most recently, comparative effectiveness research has been addressed in current law by the Medicare Modernization Act of 2003 (MMA, P.L. 108-173) and the American Recovery and Reinvestment Act of 2009 (ARRA, P.L. 111-5). Section 1013 of the MMA authorizes the Agency for Healthcare Research and Quality (AHRQ) to conduct and support research on outcomes, comparative clinical effectiveness, and appropriateness of pharmaceuticals, devices, and health care services. The section also prohibits the Center for Medicare and Medicaid Services (CMS) from using the data to withhold coverage of a prescription drug. The ARRA provided $1.1 billion in funds to support the development and dissemination of CER. ARRA also asked the Institute of Medicine to recommend national priorities for the research to be addressed by ARRA funds.

Chairman's Mark

Patient-Centered Outcomes Research Institute (the "Institute"). The Chairman's Mark would authorize the establishment of a private, non-profit corporation that would be known as the "Patient-Centered Outcomes Research Institute." The purpose of the Institute would be to assist patients, clinicians, purchasers, and policy makers in making informed health decisions by advancing the quality and relevance of clinical evidence through research and evidence

synthesis. The research would focus on the manner in which diseases, disorders, and other health conditions can effectively and appropriately be prevented, diagnosed, treated, monitored, and managed, and would consider variations in patient subpopulations. Research conducted would compare the clinical effectiveness, risk and benefits of two or more medical treatments, services or items. The Mark would define treatment, services and items as: health care interventions, protocols for treatment, care management and delivery, procedures, medical devices, diagnostics tools, pharmaceuticals (including drugs and biological), and any strategies or items used in the treatment, management, and diagnosis of, or prevention of illness or injury, in patients.
The Institute would also disseminate their research findings. The Institute would be subject to the provisions specified below and, to the extent consistent with the Chairman's Mark, to the District of Columbia Non-Profit Corporation Act.

The Chairman's Mark would establish the duties of the Institute, which will be tax exempt for Federal tax purposes. The duties of the Institute would be to (1) identify research priorities and establish a research agenda, (2) carry out the research project agenda, (3) study and report on the feasibility of conducting research in-house, (4) collect appropriate data from CMS, (5) appoint advisory panels, (6) support patient and consumer representatives, (7) establish a methodology committee, (8) provide for a peer-review process for primary research, (9) disseminate research findings, (10) adopt priorities, standards, processes, and protocols, (11) coordinate research and resources and build capacity for research, and (12) submit annual reports to the Congress, the President, and the public.

Administration of the Institute. The Chairman's Mark would establish a Board of Governors for the Institute. The Board would be responsible for carrying out the duties of the Institute. The Board specifically would be prohibited from delegating the following duties to staff: approving and monitoring disbursements from the Patient-Centered Outcomes Research Trust Fund (PCORTF); identifying research priorities; and adopting priorities, methodological standards, peer review processes, dissemination protocols.

The Institute's Board would have 15~~21~~ members~~, including the Secretary of Health and Human Services, the Director of AHRQ, and the Director of NIH (or their respective designees). The other 18 members would be~~ appointed by the Comptroller General of the United States within six months after enactment and would include three members representing each of the following groups: patients and health care consumers; physicians, including surgeons; ~~agencies administering public health programs (including one member each representing the Centers for Medicare and Medicaid Services (CMS), a state health program (including Medicaid/CHIP or a state governor), and other Federal health programs);~~ private payers (including at least one health insurance plan and one self-insuring employer); pharmaceutical, device, and diagnostic manufacturers; and others (including one member representing each of non-profit health services research organization, quality improvement and decision support organizations, and independent health services researchers.)

The Board would have collective scientific expertise in clinical health sciences research, including epidemiology, decision sciences, health economics, and statistics. The Institute's Board members would be appointed for six years, except for the first appointments, of whom six would be appointed for six years, six for four years, and six for two years. Individuals would be

prohibited from serving more than two Board terms. Members whose term expires would serve until a successor takes office or the end of the calendar year, whichever is earlier; vacancies would not affect the functioning of the Board. The Comptroller General would designate a Chairperson and Vice-Chairperson from among the Board members to serve a three-year term.

Board members would be entitled to compensation at the per diem equivalent of the level IV Executive Schedule rate and allowed travel, subsistence, and other necessary expense compensation. The Board would employ and set the compensation for an executive director and other personnel as necessary. It would be allowed to seek assistance from personnel of appropriate departments and agencies of the Federal government, make arrangements and payments necessary for the performance of the Institute's duties, and prescribe such rules and bylaws as it deems necessary.

The Board would hold hearings and meetings at the call of the Chairperson or a majority of the members. Meetings not solely concerning matters of personnel would be advertised at least seven days in advance and open to the public. A majority of the Board members would constitute a quorum, but a lesser number of members could meet and hold hearings.

The Board would adopt certain positions and activities by majority vote; these would include the Institute's priorities, the research project agenda, methodological standards, peer review process(es), and the dissemination protocols and strategies. The Institute would be required to refer any of the above back to staff or to the methodology committee, where appropriate, for further review in the case where adoption is not granted.

Research of the Institute. The Chairman's Mark would charge the Institute with identifying national priorities for comparative clinical effectiveness research and establishing a research project agenda. The Institute would consider the need for a systematic review of existing research before providing for the conduct of new research. In setting priorities, the Institute would consider the following: disease incidence and prevalence in the U.S.; evidence gaps, in terms of clinical outcomes; practice variations; the potential for new evidence to improve health and quality of care; expenditures associated with a health care treatment strategy or health condition; patient needs, outcomes, and preferences, including quality of life; and relevance to assisting patients and clinicians in making informed health decisions.

The Institute would be required to use the following methods to provide for the conduct of research and synthesis of evidence: (1) systematic reviews and assessments of existing evidence; (2) primary research, such as randomized clinical trials, molecularly informed trials, and observational studies; and (3) any other methodologies recommended by the methodology committee and adopted by the Board. The research and evidence synthesis would only be conducted in accordance with the methodological standards adopted by the Board.

The Institute would be allowed to request and obtain data from Federal, state, and private entities, including data from clinical databases and registries, if the request is granted by the entity. The use of such data would be in accordance with requirements of the data-granting entity with respect to the release, use, confidentiality and privacy of the data. The Secretary of HHS

would make relevant CMS data available to the Institute with appropriate safeguards for privacy and confidentiality.

The Chairman's Mark would require the Institute to establish a process for peer-review of primary research, under which evidence would be reviewed to assess scientific integrity and adherence to the methodological standards adopted by the Institute. The Institute would make public a list of names of individuals contributing to any peer-review process during the preceding year or years and include the list in the Institute's annual reports.

Any peer-review process would be designed in a manner so as to avoid bias and conflicts of interest on the part of the reviewers; the reviews would be conducted by experts in the scientific field relevant to the research under review. The Institute would be allowed to utilize existing peer-review processes already utilized by entities with which the Institute contracts. This would include the option to utilize the peer-review process of appropriate medical journals, if these review processes met the Institute's own requirements for a peer-review process.

The Institute would coordinate its own activities and resources with that of other public and private agencies to ensure the most efficient use of the Institute's resources and ensure that research is not unnecessarily duplicated. The Institute would also be permitted to build capacity for comparative clinical effectiveness research and related efforts through activities such as supporting the Cochrane Collaboration and other organizations that develop and maintain a data network to collect, link, and analyze data on outcomes and effectiveness from multiple sources, including electronic health records. Such payments would be allowed up to 20 percent of the Patient-Centered Outcomes Research Trust Fund (PCORTF) amounts for a year.

The Institute would be required to review and update evidence periodically to take into account new research, evolving evidence, advances in medical technology and changes in the standard of care as they become available, as appropriate. In addition, the Institute would assess the feasibility of conducting research in-house and to report to Congress on the results of such assessment within five years of the date of enactment.

Addressing Subpopulations. The Institute would design research to take into account potential differences in outcomes among different subpopulations, such as racial and ethnic minorities, women, age, and groups of individuals with different comorbidities, genetic and molecular sub-types, or quality of life preferences. Members of such subpopulations would be included in the research as feasible and appropriate.

When appropriate, the Institute would design research that takes into account different characteristics of treatment modalities that could affect research outcomes.

Institute Contracts. The Chairman's Mark would allow the Institute to enter into contracts with Federal agencies as well as with appropriate private sector research or study-conducting entities for the management and conduct of research in accordance with the research agenda. To contract with Federal agencies, such as the Agency for Healthcare Research and Quality (AHRQ), the contracts would have to be authorized under the agencies' governing statutes. Private contractors would be required to have experience in conducting comparative clinical effectiveness research.

Both public and private entities would be required to have demonstrated experience and capacity to achieve the goals of comparative effectiveness research.

Each entity under contract with the Institute would be required to (1) abide by the same transparency and conflicts of interest requirements that apply to the Institute with respect to the management or conduct of research; (2) comply with the methodological standards adopted by the Board; (3) take into consideration public comments, provided for and transmitted by the Institute, on individual study designs before the finalization of such designs, and submit responses to such comments to the Institute which the Institute would publish with the comments and the finalized study design before the conduct of research; (4) consult with the rare disease advisory panel for the relevant study as appropriate; and (5) allow for a researcher(s) under contract to publish their findings so long as any research published is consistent with products disseminated by the Institute. Research entities under contract that do not meet the publishing requirements set by the Institute would not be allowed to enter into another contract with the Institute for a period of not less than five years.

Studies conducted by the Institute would be allowed to cover cost sharing of research participants to the extent necessary to preserve the validity of the study results, such as in the case that a study needs to be blinded.

Advisory Panels. The Chairman's Mark would require the Institute, as appropriate, to appoint expert advisory panels to assist in identifying research priorities and establishing the research project agenda. These panels would advise the Institute to ensure that information produced from such research is clinically relevant to decisions made by clinicians and patients at the point of care.

In addition, the Institute would appoint expert advisory panels to assist in carrying out the research project agenda with respect to primary research (such as clinical trials). Such panels would, upon request, advise on the research question, design, or protocol of the study and be available as a resource for technical questions that may arise during the conduct of the research.

In the event of a comparative clinical effectiveness study on a rare disease, the Institute would appoint a separate expert advisory panel for purposes of designing research studies for rare diseases and for determining the relative value and feasibility of conducting such research on a particular rare disease.

The Mark would require such panels to include representatives of practicing and research clinicians, patients, and experts in scientific and health services research, health services delivery, and evidence-based medicine who have experience in the relevant topic. The Institute would be permitted to include on the panel a representative of each manufacturer of each medical technology that is included under the relevant topic, project, or category for which the panel is established.

The Chairman's Mark would also direct the Institute to provide support and resources to help patient and consumer representatives who serve on the Board and expert advisory panels to effectively participate in technical discussions regarding complex research topics. This would

include initial and continuing education as well as the potential for regular and ongoing interactions between patients and consumer representatives. The Institute would also provide a per diem and other appropriate compensation to the patient and consumer representatives for their time.

Methodology Committee. The Chairman's Mark would establish a standing methodology committee to serve the Institute. The committee would have responsibility for developing and improving the science and methods of comparative effectiveness research. It would consist of no more than 17 members appointed by the Comptroller General. Members of the methodology committee would be experts in their scientific field, such as health services, clinical, and comparative effectiveness research, biostatistics, genomics, and research methodology. Stakeholders with such expertise could be appointed to the methodology committee.

Within two years of enactment (with periodic updates), the methodology committee would determine a process to establish and maintain detailed methodological standards for comparative clinical effectiveness studies. The standards would provide criteria for study designs that balance generalizability, timeliness and other factors. Within this time period, the committee would also provide a translation table that links comparative effectiveness research methods with specific types of research questions.

The methodology committee would also establish and maintain standards regarding clinical outcomes measures, risk-adjustment, and other aspects of research and assessment; these standards would be scientifically based and include methods by which new information, data, or advances in technology may be considered and incorporated into ongoing research. The process for developing these standards would include input and allow for public comment from all relevant experts, stakeholders, and decision-makers. The standards would also include methods by which patient subpopulations could be accounted for and evaluated.

Where appropriate, the methodology committee would build on existing work on methodological and reporting standards. In developing and updating such standards, the Institute would consult or contract with one or more of the following entities: the Institute of Medicine (IOM), the AHRQ, the National Institutes of Health (NIH), and academic, non-profit, or other private entities with relevant expertise.

The methodology committee would also be required to contract with the IOM within three years after the methodology committee members are appointed to examine the following: (1) methods by which aspects of health care delivery systems, such as benefit design, could be assessed and compared for effectiveness, risks, benefits, advantages, and disadvantages in a scientifically valid and standardized way; and (2) methods by which efficiency and value could be assessed in a scientifically valid and standardized way.

The methodology committee would submit reports to the Board concerning the committee's activities and would include recommendations for the Institute to adopt methodological and reporting standards and for other actions the committee determines necessary to comply with such standards, with the exception of the two three-year studies mentioned above.

Dissemination of Information. The Chairman's Mark would require the Institute to disseminate the findings of research to clinicians, patients, and the public in a comprehensible manner and form so that they are useful to patients and providers in making health care decisions. The dissemination of the research would (1) discuss conclusions and considerations specific to certain subpopulations, comorbidities, or risk factors, as appropriate, and (2) include considerations such as limitations of the research and discussions about what further research might be needed, as appropriate.

The Institute would be prohibited from disseminating research findings from a study or assessment that would include practice guidelines, coverage recommendations, or policy recommendations. Further, in any dissemination, the inclusion of data that would violate the privacy of research participants or violate any confidentiality agreements made with respect to use of the data would be prohibited.

In order to ensure effective communication for the purpose of informing higher quality, more effective and timelier medical decisions, the Institute would develop protocols and strategies for the dissemination of the research findings. The Institute would be required to consult with stakeholders in determining the types of dissemination that would be most useful to the stakeholders and would be allowed to utilize multiple formats for conveying findings to different audiences.

Oversight. The Chairman's Mark would require the Institute to submit an annual report to Congress, the President, and the public. The report would contain (1) a description of the activities conducted during the previous year, including the use of funds, research projects completed and underway, and a summary of the findings of such projects; (2) the research agenda and budget of the coming year; (3) a description of research priorities, dissemination protocols, and methodological standards adopted by the Institute; (4) a list of names of individuals participating in any peer-review process during a preceding year or years; (5) a description of the Institute's coordination with other private and public entities and capacity-building activities for the year; and (6) any other relevant information such as membership and conflicts of interest of Board members, Institute staff, advisory panels, and methodology committees and any bylaws adopted by the Board during the previous year.

The Chairman's Mark would establish financial and governmental oversight of the Institute. The Institute would be required to undergo annual financial audits conducted by a private entity. The Comptroller General would also review the results of the audit and submit a report to Congress annually.

The Comptroller General would have several additional oversight responsibilities with respect to the Institute. The Comptroller General would (1) review the processes established by the Institute, including those regarding the identification of research priorities and the conduct of research, in order to determine whether such research is objective and credible, produced in a manner consistent with the requirements of this section and developed in a transparent process; (2) review the overall effectiveness of the Institute and its activities, including the utilization of the research findings by health care decision makers and any effect on innovation; (3) submit a report to Congress at least every five years on the above reviews, along with recommendations

for any such legislative and administrative action as the Comptroller determines appropriate; (4) assess the adequacy and use of funding for the Institute under the PCORTF, including a determination of whether, based on utilization of the Institute's findings by public and private payers, funding from private-sector contributions, the Medicare Trust Funds, and general revenues are appropriate and should be continued or adjusted. The Comptroller would submit a report to Congress, together with any recommendations, on the adequacy of funding assessment not later than eight years after the date of enactment.

Institute Transparency and Access. The Chairman's Mark would direct the Institute to establish procedures to ensure transparency, credibility, and access through public comment periods, forums, public availability of information, and protocols for conflicts of interest.

The Institute would provide for public comment periods of not less than 45 and not more than 60 days at the following times: prior to the adoption of national priorities, research project agendas, methodological standards, peer-review processes, and dissemination protocols and strategies; prior to the finalization of individual study designs; and after the release of draft findings from systematic reviews and assessments of existing research and evidence. The Institute would transmit any public comments received in relation to draft study designs to the entity conducting the research. The Institute would support additional forums to increase public awareness and obtain and incorporate public input and feedback on the identification of research priorities, including research topics, and the establishment of the research agenda, research findings, and any other duties, activities, or processes the Institute determines appropriate.

The Institute would make the following information publicly available (disclosed through the official public Internet site and any other forums the Institute deems appropriate): (1) the process and methods for the conduct of research, including the identity of the entity conducting research, any links the entity has to industry (including links that are not directly tied to particular research being conducted under contract with the Institute); draft study designs, including research questions and the finalized study design together with associated public comments and responses to such comments, research protocols, including clinical measures taken; methods of research and analysis used; research results; key decisions made by the Institute, panels or committees of the Institute; the identity of investigators conducting such research and any potential conflicts of interest; and progress reports the Institute deems appropriate; (2) notice of each of the public comments periods established by the Institute along with any deadlines for public comments for such periods; (3) public comments submitted during each of the public comment periods; (4) bylaws, processes, and proceedings of the Institute, as feasible and appropriate; and (5) any report, research findings, and appropriate related information within 90 days after the receipt of such article by the Institute.

Conflicts of Interest. The Chairman's Mark would direct the Comptroller General to consider and disclose any conflicts of interest of potential Board appointees. Board members would be required to recuse themselves when conflicts of interest arise from participation in Board activities and when such interest is directly related to and could affect or be affected by the member's participation. The Mark would require the Institute to take into consideration any conflicts of interest of potential appointees, participants, and staff in appointing members to advisory panels and the methodology committee, in selecting individuals to contribute to any

peer-review process, and in employing executive staff. Any such conflicts of interest would be described in the annual report; in the case of peer-reviewers, such descriptions would not allow peer-reviewers to be associated with a particular study.

The Institute, its Board or staff would be prohibited from accepting gifts, bequeaths, or donations of services or property. Further, the Institute would be prohibited from establishing a corporation or generating revenues from activities other than as provided for under the Chairman's Mark.

Use of Institute Findings. The Chairman's Mark would establish several limitations around the use of the Institute's comparative effectiveness research findings. First, the Institute would not mandate coverage, reimbursement, or other policies for any public or private payer. None of the reports or research findings would be construed as mandates, guidelines, or policy recommendations. (The Secretary would not be prevented from covering the routine costs of clinical care for Medicare beneficiaries participating in research provided for by the Institute for whom such costs would normally be covered under Medicare.)

Second, the Secretary of HHS would be prohibited from denying coverage based solely on a study conducted by the Institute. The Secretary would be required to use an iterative and transparent process when using research from the Institute in making coverage determinations. The process would allow stakeholders and other individuals to provide informed and relevant information with respect to the determination, to review draft proposals of the determination and to submit public comments with respect to draft proposals. The Secretary would be required to consider other relevant evidence and studies, in addition to research findings from the Institute, as well as any evidence and research that demonstrates or suggests a benefit of coverage with respect to subpopulations, even if the research from the Institute demonstrates or suggests that, on average with respect to the general population, the benefits of coverage do not exceed the harm. The Chairman's Mark would not supersede or modify the statutory basis of the reasonable and necessary standard that is used to make coverage decisions under current law.

Third, the Secretary would be prohibited from using the Institute's research in determining coverage, or creating reimbursement or incentive programs, for a treatment in ways that treat extending the life of an elderly, disabled, or terminally ill patient of lower value than extending the life of a person who is younger, non-disabled, or not terminally ill. The Secretary would also be prohibited from using the Institute's research in determining coverage, or creating reimbursement or incentive programs, for a treatment in a manner that precludes, or with intent to discourage, an individual from choosing a health care treatment based on how the individual values the tradeoff between extending the length of their life and the risk of disability.

These limitations would not be construed to limit the application of differential copayments based on factors such as cost or type of service. Further, the limitations shall not be construed to prevent the Secretary from using comparative effectiveness evidence in determining coverage, reimbursement or incentive programs based upon comparing the difference in the effectiveness of alternative treatments in extending a patient's life due to the patient's age, disability, or terminal illness. Nothing in the Chairman's Mark would be construed to limit comparative effectiveness research or any other research, evaluation, or dissemination of information concerning the likelihood that a treatment will result in disability.

Finally, the Chairman's Mark would prohibit the Institute from developing or employing a dollars per quality adjusted life year (or similar measure that discounts the value of a life because of a person's disability) as a threshold to establish what health care is cost-effective or recommended; and the Secretary shall not use such measure (or similar measure) as a threshold to determine coverage, reimbursement, or incentives programs.

Patient-Centered Outcomes Research Trust Fund. The Chairman's Mark would create a new trust fund, called the Patient-Centered Outcomes Research Trust Fund (the 'PCORTF') in the U.S. Treasury to fund the Institute and its activities. Monies would be directed to this fund from the general fund of the Treasury as well as the Medicare Trust Funds, as described below. The Secretary of Health and Humans Services would be the trustee of the PCORTF.

The following amounts would be transferred to the PCORTF from the general funds in the Treasury: $10 million in FY2010, $50 million in FY2011, $150 million in FY2012, and $150 million for each of FY2013 through FY2019. In addition, the Secretary would transfer amounts from the Medicare Federal Hospital Insurance and the Federal Supplemental Medical Trust Funds to the PCORTF in proportion to total Medicare expenditures that come from each Fund for a given year. In FY2013, the amount would be equivalent to $1 multiplied by the average number of individuals entitled to benefits under Part A or enrolled under Part B of Medicare during the year. In FY2014 through FY2019, the amounts would be equivalent to $2, increased by annual medical inflation after FY2014 multiplied by the average number of such individuals for the given year.

Additionally, the Mark would transfer $10 million from funds appropriated to the Secretary under title VIII of Division A of the American Recovery and Reinvestment Act of 2009 (ARRA) would be transferred to the PCORTF.

In addition to the amounts transferred from the Treasury and from funds made available by ARRA, the PCORTF would also be financed from fees on insured and self-insured health plans. The Mark would create a new Subchapter B of Chapter 34 of the Internal Revenue Code with new sections 4375-4377.

The Chairman's Mark would impose a fee of $1 in FY2013 and $2 (updated by the rate of medical inflation in FY2014 and in subsequent years) in FY2014 through FY2019, on each health insurance policy in the United States multiplied by the number of lives covered under that policy. Insurance policies that primarily provide non-health benefits would be exempt. This fee would sunset after FY2019.

The Chairman's Mark would impose a fee of $1 in FY2013 and $2 (updated by the rate of medical inflation in FY2014 and in subsequent years) in FY2014 through FY2019, on each self-insured health plan multiplied by the number of lives covered under that plan. Applicable self-insured health plans in the United States would be defined as plans providing accident or health coverage provided other than through an insurance policy and maintained by a plan sponsor for the benefit of members, employees or former employees, or maintained by a multiple employer welfare arrangement of the Employee Retirement Income Security Act of 1974 (ERISA, P.L. 93-

406), or a rural electric or telephone cooperative. Plan sponsors would be defined as employers, employer organizations, or groups or associations maintaining a plan; or the entity maintaining a plan for two or more employers, joint employer-employee groups, or employee organizations, welfare arrangements, or voluntary employee's beneficiary associations (VEBAs) maintaining such plans. This fee would sunset after FY2019.

The amounts in the Patient-Centered Outcomes Research Trust Fund would be available to the Institute to carry out its duties without further appropriation. However, no amounts could be appropriated or transferred to the PCORTF if any amounts expended from the PCORTF were to be used for a purpose that is not permitted.

Coordination with the Federal Coordinating Council. The Chairman's Mark would also amend the American Recovery and Reinvestment Act of 2009 by (1) adding a duty that the Federal Coordinating Council (FCC) would provide support to the Institute; (2) ~~including the Chairperson of the Institute, to the extent such person is a Federal officer or employee, to the Board of the FCC; (3)~~ requiring the FCC to include an inventory of its activities with respect to comparative effectiveness research conducted by relevant Federal departments and agencies in the FCC's annual report; and (3)~~(4)~~ requiring the FCC to coordinate its duties with the Institute.

NCD Study. The Chairman's Mark would require the Comptroller General to submit a report to Congress within 18 months after the date of enactment on the process for making national coverage determinations under the Medicare program. The report would include a determination of whether the Secretary of HHS has complied with applicable law and regulations, including requirements for consultation with outside experts, providing appropriate public notice and comment opportunities, and making appropriate information and data available to the public and to non-voting members of advisory committees.

SUBTITLE G—ADMINISTRATIVE SIMPLIFICATION

Current Law

To promote the growth of electronic record keeping and claims processing in the nation's health care system, the Health Insurance Portability and Accountability Act (HIPAA, P.L. 104-191) instructed the Secretary of Health and Humans Services (HHS) to adopt standards for the electronic transmission of certain routine administrative and financial health care transactions, including data elements and code sets for those transactions. The nine HIPAA transactions specified in the Administrative Simplification provisions of HIPAA (Sections 1171-1179 of the Social Security Act) are: (1) health claims, (2) health care payment and remittance advice, (3) claims status inquiry and response, (4) enrollment and disenrollment in a health plan, (5) eligibility inquiry and response, (6) health plan premium payments, (7) prior authorization and referral, (8) first report of injury, and (9) health claims attachments. HIPAA also directed the Secretary to adopt a standard for transferring data elements among health plans for the coordination of benefits and the sequential processing of claims for individuals who have more than one health plan. In adopting the standards, the Secretary was to rely on the recommendations of the National Committee on Vital and Health Statistics (NCVHS), consult

with other Federal and state agencies and private organizations, and publish in the Federal Register any NCVHS recommendation regarding the adoption of a standard.

A final rule, which adopted existing and widely used electronic standards for seven of the specified transactions and the coordination of benefits, as well as code sets to be used in those transactions, was published in 2000. The transactions standards included several Accredited Standards Committee X12 (ASC X12) Version 4010 standards for health care transactions, and the National Council for Prescription Drug Programs (NCPDP) Version 5.1 standard for pharmacy drug claim transactions. The code sets adopted by the Secretary included the International Classification of Diseases, 9th Edition (ICD-9) and Current Procedural Terminology, 4th Edition (CPT-4) codes.

The HIPAA Administrative Simplification standards apply to: (1) health plans (including the Medicare program and state Medicaid plans), (2) health care clearinghouses, and (3) health care providers who transmit HIPAA-specified transactions electronically. HIPAA does not mandate that providers conduct these transactions electronically, though private health plans and state Medicaid programs increasingly require it. If providers elect to submit electronic data for one or more of the HIPAA transactions, then they must comply with the published standard for those transactions. Generally, HHS regulations implementing HIPAA allows covered entities to come into compliance within two years of the standards taking effect. In 2001, Congress enacted the Administrative Simplification Compliance Act (ASCA, P.L. 107-105), which provided for a one-year compliance extension for the HIPAA standards and code sets adopted in 2000. The Act also amended Section 1862 of the Social Security Act to require that Medicare claims be submitted electronically in the HIPAA standard format, with the exception of those from small providers and in other limited circumstances.

The health care payment and remittance advice transaction is a communication from a health plan to a provider that includes an explanation of the claim and payment for that claim. The HIPAA standard for this transaction (i.e., ASC X12N 835) can accommodate an electronic funds transfer (EFT), in which payment is electronically deposited into a designated bank account. EFT is common in the health care sector — health plan contracts often require it — but there is no EFT mandate in federal law for Medicare, Medicaid, or private health insurance. However, HHS regulation is gradually requiring providers in Medicare to receive payments via EFT.

HIPAA also directs the Secretary to review and, not more frequently than once a year, modify the Administrative Simplification standards. Again, the Secretary was to rely on the recommendations of the NCVHS and publish in the *Federal Register* any NCVHS recommendation regarding the modification of a standard. Any such modification must be completed in a manner that minimizes disruption and the cost of compliance. On January 16, 2009, the Secretary published a final rule adopting updated versions of the HIPAA electronic transactions standards to replace the versions currently in use. The rule adopts Version 5010 of the ASC X12 standards for specified health care transactions, and Version D.0 of the NCPDP standard for pharmacy transactions. The compliance deadline for the updated standards is January 1, 2012.

To date, the Secretary has not issued electronic standards for two HIPAA transactions: health claims attachment and first report of injury. In September 2005, the Secretary published a proposed standard for electronic transmission of health claims attachments. A claims attachment transaction is used to request and supply additional data necessary to adjudicate a claim and typically includes specific clinical information that a health plan needs in order to decide whether a service should be covered. The claims attachment standard has yet to be finalized. The Secretary has not proposed an electronic standard for first report of injury.

Even though standards have been adopted for seven of the nine HIPAA transactions, there is still significant variability in how those standards are implemented by health plans and clearinghouses. The standards adopted to date do not include sufficient guidelines about how to implement or operationalize them, which allows health plans and clearinghouses to differ in some of the ways they implement them. The variability in operating rules around the current standards makes it challenging, costly and inefficient for providers to conduct electronic transactions. This is one of the reasons providers in the United States do not use electronic transactions for some of the most basic transactions related to health care. The Version 5010 and D.0 standards that will be effective in 2012 will address some but not all of the issues surrounding operating rules for HIPAA transactions.

HIPAA also instructed the Secretary to adopt unique identifiers for health care providers, health plans, employers, and individuals for use in standard transactions. Unique identifiers for providers and employers have been adopted, while the health plan identifier is still under review by HHS. Congress has blocked the development of a unique identifier for individuals through language added to the annual Labor-HHS appropriations bill.

Chairman's Mark

The Chairman's Mark would establish a timeline for accelerating the development, adoption and implementation of a set of operating rules for each HIPAA transaction for which there is an existing standard. The operating rules would be consensus-based, and reflect the business rules around which health plans and providers would uniformly use the HIPAA standards. The Mark would add the electronic funds transfer (EFT) of health claims payments as a HIPAA transaction and provide for the adoption and enforcement of a standard for EFT.

The Chairman's Mark would require the Secretary to first adopt a single set of operating rules for eligibility verification, claims status, claims remittance/payment, and EFT. The goal would be to create as much uniformity in the implementation of the electronic standards as possible. The Secretary would rely on recommendations for operating rules developed by a qualified non-profit entity. The non-profit entity would be one that: (1) focuses on administrative simplification; (2) demonstrates an established multi-stakeholder (including health plans, health care providers, vendors, other standard development organizations, and relevant Federal agencies), consensus-based process to developing operating rules; (3) is guided by a public set of principles; (4) coordinates with the HIT Policy Committee, HIT Standards Committee, and complement the efforts of the National Healthcare Coordinator; (5) incorporates national standards; (6) supports nondiscrimination and conflict of interest policies; and (7) allows for public reviews and updates.

The Mark would require the NCVHS to review operating rules for HIPAA standards that are developed by the non-profit entity. The NCVHS would make a determination about whether the rules submitted by the non-profit entity were consistent with the electronic standard and represented a consensus view from the health care industry. NCVHS would then submit a recommendation to the Secretary of HHS as to whether to adopt the operating rules. The NCVHS would also review whether the rules submitted were consistent with electronic standards adopted for health information technology. If the NCVHS recommends that the Secretary adopt the operating rules developed by the non-profit entity, then the Secretary would adopt them through interim final regulation.

The Chairman's Mark would also require the Secretary of HHS to adopt operating rules for eligibility and health plan claims status transactions no later than July 1, 2011, to be effective by January 1, 2013. Such operating rules would be allowed to include rules for the use of a machine readable identification card. The Secretary would also adopt operating rules for electronic funds transfer (EFT) and claims remittance/payment no later than July 1, 2012, to be effective by January 1, 2014. The Secretary would adopt operating rules for the remaining completed HIPAA transactions, including health claims, enrollment/disenrollment, health plan premium payments, and referral certification and authorization, by July 1, 2014, to be effective by January 1, 2016. The Secretary would be authorized to issue interim final rules for the adoption and implementation of these operating rules. In addition, a 60-day public comment period would follow the publication of an interim final rule. If significant comments are received, the Secretary would republish the interim final rule within 90 days and the previously established effective dates would still apply.

Under the Chairman's Mark, the Secretary of HHS would issue a rule to create unique health plan identifiers. The rule would be based on the input of NCVHS and developed in consultation with health plan. The Secretary would release the final rule within two years of enactment to be effective no later October 1, 2012. The Mark would authorize the Secretary to adopt health plan identifiers through an interim final rule.

The Chairman's Mark would place additional requirements for health plans to comply with operating rules adopted by the Secretary of HHS. By December 31, 2013, health plans would be required to file a certification statement with the Secretary that their data and information systems comply with the most current published standards, including the operating rules, for four transactions: eligibility verification, claims status, claims remittance/payment and EFT. To be certified, health plans would demonstrate to the Secretary that they conduct these electronic transactions in a manner that fully complies with the regulations. Health plans would also provide documentation showing that they completed end-to-end testing for these transactions with their partners (i.e., hospitals and physicians).

By December 31, 2015, health plans would be required to certify to the Secretary of HHS that their data and information systems comply with the most current published standards and operating rules for four additional HIPAA transactions: health claims, enrollment/disenrollment in plans, health plan premium payments, and referral certification and authorization. Health plans would be required to provide the same level of documentation to certify compliance with these four transactions as the initial four transactions.

The Chairman's Mark would authorize the Secretary of HHS to deem a health plan certified if the health plan obtains certifications from an outside entity whose requirements meet or exceed those adopted by the Secretary. The Mark would require the Secretary to conduct periodic audits of health plans to ensure that they maintain compliance with the operating rules.

The Chairman's Mark would establish a penalty fee for health plans that do not demonstrate compliance with the HIPAA operating rules adopted by the Secretary. If a health plan does not certify compliance, then the Secretary would assess a fee by April 1, 2014, and annually thereafter until the health plan becomes certified.

The Mark would establish the penalty fee as follows: for each day that a plan is non-certified or non-compliant, the Secretary would assess a fee of $1 per covered life until certification is complete. The fee would not exceed a maximum of $20 per covered life. The penalty would be assessed per person covered by the plan for which its data systems for major medical policies are not in compliance. Data on covered lives would be derived from plans' most recent corporate filings with the Securities and Exchange Commission (SEC). The fee amount would be increased annually by the projected percentage increase in total national health expenditures, as determined by the Secretary.

The Mark would also require the Secretary to establish a process with a reasonable notice and dispute resolution mechanism before penalties could be assessed. A health plan that knowingly files an inaccurate or incomplete statement of certification or documentation of compliance would be subject to a penalty fee that is double the amount that would otherwise be imposed.

Under the Chairman's Mark, the Secretary of the Treasury would be responsible for collection of the penalty fee assessed by the Secretary of HHS. Beginning May 1, 2014, and annually thereafter, the Secretary of HHS would send a list of health plans that were assessed a penalty and the amount of the fee. By August 1, the Treasury Secretary would send a notice to each reported health plan. The notice would include the amount assessed and the payment due date (November 1 of that year). If the amount assessed was not paid by the due date, then the amount owed would increased by an interest payment determined in a manner similar to underpayment of income taxes. Further, unpaid amounts assessed under this provision would be considered debts owed to Federal agencies and may offset and reduce the amount of tax refunds otherwise payable to a health plan. The collection and offset activities would be administered through the Financial Management Services (FMS) bureau of the Department of the Treasury which provides centralized collection and payment services for the Federal government. Any fee charged or allocated for collection activities conducted by FMS would be passed on to the health plans on a pro-rata basis.

The Chairman's Mark would also provide for a process to periodically update HIPAA standards including operating rules. By 2014, the Secretary of HHS would designate a review committee to evaluate updates to existing standards and operating rules. The Secretary would be authorized to designate the NCVHS or any appropriate committee within HHS. The review committee would: (1) no later than April 1, 2014, and biannually thereafter, conduct hearings to evaluate and review existing standards and operating rule; and (2) no later than July 1, 2014, and

biannually thereafter, report to the Secretary on recommendation approved by the review committee for updating and improving such standards and operating rules. The committee would consider the standards approved by the Office of National Coordinator Health Information Technology in its review and only approve a single set of operating rules per transaction.

The Mark would authorize the Secretary to adopt recommendations from the review committee through interim final rulemaking. The Secretary would have 90 days after receipt of a report from the review committee to issue an interim final rule. The Secretary would conduct a 60-day comment period; if no significant comments are received, the effective date of the final rule would be 25 months from the close of the public comment period. However, if significant comments are received, then the Secretary would consult the review committee and publish a second interim final rule within 120 days to take into account the comments. The effective date of the second interim rule would be 24 months from the date of its publication.

Health plans would be required to comply with any updated standards or operating rules by the effective date of the applicable interim final rule. If a health plan does not comply, it would be subject to the same penalty fee established for operating rules.

The Chairman's Mark would also clarify requirements with respect to electronic payment of claims by Medicare. As of January 1, 2014, no Medicare payment would be made for benefits delivered under Part A or Part B other than by EFT or an electronic remittance in a form specified in the payment/remittance advice HIPAA standard. Also, the Mark would require the Secretary of HHS to report, by July 2013, on the extent to which: (1) Medicare and providers that serve beneficiaries under these programs, and (2) state Medicaid programs and providers, transact electronically with respect to HIPAA transactions. The reports would be submitted to the Chairmen and Ranking Members of the Ways and Means and Energy and Commerce Committees in the House of Representative and the Health, Labor and Education Programs and Finance Committees in the Senate.

Finally, the Chairman's Mark would define operating rules as the necessary business rules and guidelines for the electronic exchange of information that are not defined by the electronic standards themselves.

SUBTITLE H—SENSE OF THE SENATE REGARDING MEDICAL MALPRACTICE

Current Law

No provision.

Chairman's Mark

The Chairman's Mark would express the Sense of the Senate that health care reform presents an opportunity to address issues related to medical malpractice and medical liability insurance. The Mark would further express the Sense of the Senate that states should be encouraged to develop and test alternatives to the current civil litigation system as a way of improving patient safety, reducing medical errors, encouraging the efficient resolution of disputes, increasing the

availability of prompt and fair resolution of disputes, and improving access to liability insurance, while preserving an individual's right to seek redress in court. The Mark would express the Sense of the Senate that Congress should consider establishing a state demonstration program to evaluate alternatives to the current civil litigation system.

TITLE IV—TRANSPARENCY AND PROGRAM INTEGRITY

Limitation on Medicare Exception to the Prohibition on Certain Physician Referrals for Hospitals

Current Law

Physicians are generally prohibited from referring Medicare patients for certain services to facilities in which they (or their immediate family members) have financial interests. However, among other exceptions, physicians are not prohibited from referring patients to whole hospitals in which they have ownership or investment interests. Providers that furnish substantially all of their designated health services to individuals residing in rural areas are exempt as well.

Chairman's Mark

Beginning no later than 18 months after the date of enactment, only hospitals meeting certain requirements would be exempt from the prohibition on self-referral. Hospitals that have physician ownership and a provider agreement in operation on November 1, 2009 and that met other specified requirements would be exempt from this self-referral ban. These requirements would address conflict of interest, bona fide investments, and patient safety. In addition, the hospital could not have converted from an ambulatory surgical center to a hospital after the date of enactment.

Specifically, to address conflicts of interest, an exempt hospital would (1) submit an annual report containing the identity of each physician owner and any other information on the nature and extent of all ownership interests in the hospital; (2) have procedures in place to require that any referring physician owner disclose to each patient (by a time that permits the patient to make a meaningful decision regarding the receipt of care) their ownership interest in the hospital and, if applicable, any such ownership interest of the treating physician; (3) not condition ownership, either directly or indirectly, on the physician owners making or influencing referrals to the hospital; and (4) disclose the fact that the hospital is owned in whole or in part by physicians on any public website for the hospital and in public advertising for the hospital. Information from the annual report would be published and updated annually on the Internet website of the Centers for Medicare & Medicaid Services.

Exempt hospitals would ensure bona fide investments and proportional returns by meeting the following requirements: (1) physician owners could not own more than the percentage of the value of physician ownership determined on the date of enactment, or the investment interest in an entity whose assets include the hospital; (2) any ownership interest offered to a physician could not be offered on more favorable terms than those offered to an individual who is not a

physician; (3) the hospital could not provide loans or financing for physician investments in the hospital; (4) the hospital could not guarantee a loan, make a payment toward a loan, or otherwise subsidize a loan to any individual physician owner or group of physician owners that is related to acquiring ownership interest in the hospital; (5) investment returns must be distributed to investors in the hospital in an amount that is directly proportional to the capital investment by the hospital investor (as determined in accordance with procedures established by the Secretary); (6) compensation of and investment returns to physician owners must not include the guaranteed receipt of or exclusive right to purchase other business related interests in the hospital, including the purchase or lease of any commercial property under the control of other investors in the hospital or located near the premises of the hospital; and (7) the hospital does not offer a physician owner the opportunity to purchase or lease any property under hospital control on more favorable terms than others.

To ensure patient safety, exempt hospitals would be required to disclose to all patients prior to admission that it does not have any physician available on the premises to provide services during all hours in which the hospital is providing services. Following such a disclosure, the hospital would receive a signed acknowledgement from the patient that no physician will be present. Also the hospital would be required to have the capacity to provide assessment and initial treatment for patients and procedures for the referral and transfer of patients to hospitals with the capability to treat the needs of the patient involved.

Exempt hospitals would not be permitted to increase the number of operating rooms, procedure rooms or beds for which the hospital is licensed after the date of enactment. A procedure room includes a room in which catheterizations, angiographies, angiograms, and endoscopies are performed. A process would be established to allow certain hospitals to expand. Hospitals eligible for expansion would include: (1) a hospital that is located in a county where the population increased during the most recent five year period at a rate that is at least 150 percent of the State's population increase; (2) a hospital whose Medicare inpatient admission percentage is equal to or greater than average percentage for all hospitals located in the county; (3) a hospital that does not discriminate against beneficiaries of Federal health care programs and does not permit physicians practicing at the hospital to discriminate against such beneficiaries; (4) a hospital that is located in a state with a state average bed capacity less than the national average ; and (5) a hospital that has an average bed occupancy rate that is greater than the state average bed occupancy rate. This capacity increase would be limited to facilities on the main campus of the hospital and could not exceed 200 percent of the number of operating rooms, procedure rooms and beds for which the hospital is licensed at the time of enactment. The process for expansion would allow the opportunity for community input and should permit an applicable hospital to apply for the expansion exception up to once every two years. The Secretary would publish final decisions on an expansion no later than 60 days after receiving a complete application. The Secretary would implement this process on May 1, 2011 and would promulgate regulations to carry out this process no later than April 1, 2011. There would be no administrative or judicial review of this process.

The Secretary would be required to establish policies and procedures to ensure compliance with these requirements, beginning on their effective date. The enforcement efforts would be able to

include unannounced site reviews of hospitals. These audits should begin no later than August 1, 2011.

Physician Payment Sunshine

Current Law

No provision.

Chairman's Mark

The Chairman's Mark would amend title XI of the Social Security Act to provide for transparency in the relationship between physicians and applicable manufacturers with respect to payments and other transfers of value and physician ownership or investment interests in manufacturers. It calls for annual transparency reports, penalties for noncompliance, procedures for the submission of information and public availability of this information.

The Chairman's Mark would require any manufacturer of a covered drug, device, biological, or medical supply that makes a payment or another transfer of value to a physician, a physician medical practice, a physician group practice, or a hospital with an approved medical residency training program to report annually, in electronic form, specified information on such transactions to the Secretary of HHS. The report would include the transfer recipient's name, business address, amount of the payment, date of the payment, a description of the form of the payment, a description of the nature of the payment, if the payment is related to marketing, education, or research specific to a covered drug, device, biological or medical supply the name of that product, and any other category of information that the Secretary determines appropriate. If the recipient requests a transfer of payment to another entity or individual at the request of the recipient the manufacturer should disclose that information. Delayed reporting requirements would apply for payments made pursuant to a product development agreement or clinical trial. Some information would be excluded from these reporting requirements, including payments or transfers of $10 or less, unless the aggregate annual payments or transfers to a recipient exceeds $100, in which case all payments or transfers shall be reported, samples intended for patient use, patient educational materials, loan of a covered device for a short-term time period, discounts and rebates, payments made to a physician for the provision of health care to employees, payments to a physician who is also a licensed, non-medical professional if the payment is solely related to non-medical services, payments to a physician solely for services related to a civil or criminal action or an administrative proceeding, and in-kind items used for charity care. This reporting requirement would begin on March 31, 2012 and continue on the 90th day of each subsequent calendar year.

The Chairman's Mark also requires any such manufacturer, or related group purchasing organization to report annually to the Secretary, in electronic form, certain information regarding any ownership or investment interest (other than in a publicly traded security and mutual fund) held by a physician (or an immediate family member) in the manufacturer or group purchasing organization during the preceding year.

Manufacturers or group purchasing organizations would be subject to a civil money penalty (CMP) of not less than $1,000 but not more than $10,000 for each payment or transfer not reported. The total amount of the penalties for any annual submission shall not exceed $150,000. Any manufacturer or group purchasing organization that knowingly fails to submit information would be subject to a CMP of not less than $10,000 but not more than $100,000 for each payment or transfer not reported. The total amount of the penalties for this failure to report category of submissions shall not exceed $1,000,000 annually.

The Chairman's Mark would require the Secretary to establish procedures no later than October 1, 2010 to ensure public availability of this information. Beginning September 30, 2012 and on June 30 of subsequent years, submitted information should be available on an Internet website that meets formatting, search, and usability requirements. In addition to the transfer information, the website should include information on enforcement actions during the preceding year, background information on industry-physician relationships, a separate listing for payments related to clinical research, and other information that the Secretary deems appropriate. The Secretary should also allow recipients an opportunity to submit corrections to their information. This reporting procedure should be established after consulting the Office of the Inspector General (HHS OIG), affected industry, consumers and other parties in order to ensure that the information is presented in an appropriate context. The Secretary would be required to submit an annual report to Congress and the states beginning April 1, 2012.

Effective January 1, 2011 the Chairman's Mark would preempt any state (or political subdivision of a state) law or regulation that requires manufacturers to disclose the type of information required under this provision regarding payments or transfers to covered recipients. The Mark would not preempt any state (or political subdivision of a state) law or regulation that requires the disclosure or reporting of (1) any information not required under this provision; (2) the types of information excluded from reporting requirements under this provision, with the exception of the $10 de minimis/$100 aggregate reporting requirement; (3) information by any person or entity other than an applicable manufacturer or covered recipient described above; and (4) information reported to a Federal, state, or local government for public health purposes.

The Secretary would be required to consult with the HHS OIG on the implementation of this section.

Prescription Drug Samples

Current Law

The Prescription Drug Marketing Act of 1987 (PDMA, P.L. 100-293) allows drug manufacturers or authorized distributors to distribute drug samples to practitioners licensed to prescribe such drugs or, at the request of a licensed practitioner, to pharmacies of hospitals or other health care entities, only in response to a written request for drug samples made on a form which contains: (1) the name, address, professional designation, and signature of the practitioner making the request; (2) the identity of the drug sample requested and the quantity requested; (3) the name of the manufacturer of the drug sample requested; and (4) the date of the request. The recipient of

the drug sample is required to execute a written receipt for the drug sample upon its delivery and the return of the receipt to the manufacturer or authorized distributor of record.

Drug manufacturers or authorized distributors of record also are required to maintain records for at least three years of all drug samples distributed, destroyed, or returned to the manufacturer or authorized distributor of record, of all inventories maintained, of all thefts or significant losses of drug samples, and of all requests made for drug samples. Records and lists maintained are required to be made available by the drug manufacturer or authorized distributor of record upon request by the Secretary.

Chairman's Mark

The Chairman's Mark would require drug manufacturers and authorized distributors to report the information required under the Prescription Drug Marketing Act of 1987 to the Secretary of HHS.

Nursing Home Transparency

Current Law

Medicare and Medicaid laws require skilled nursing facilities (SNF) and nursing homes to be administered in a manner that will ensure residents' well-being. The Secretary establishes requirements for SNF and nursing homes that will protect the safety, health, welfare, and rights of residents. Facilities undergo regular survey and certification inspections to ensure their compliance with these standards. SNF and nursing home inspections identify deficiencies where facilities fail to meet Federal standards. Deficiencies can range from minor problems to major safety and life-threatening conditions. State and Federal officials may impose civil monetary penalties on facilities that fail to meet standards or fail to correct deficiencies. In extreme cases, Federal and state officials can install new facility management, assume control of facilities, or even close SNF or nursing homes that jeopardize residents' well-being.

Chairman's Mark

The Chairman's Mark would make a number of changes aimed at improving transparency of information about SNF and nursing homes, enforcement of SNF and nursing home standards and rules, and training of SNF and nursing home staff are proposed. These changes would amend both title XVIII and title XIX of the Social Security Act. They include:

Required Disclosure of Ownership. SNFs and nursing facilities would be required to make available on request by the Secretary, the HHS OIG, the state, and the state long term care ombudsman, information on ownership (including direct and indirect ownership) and additional disclosable parties as well as information describing the governing body and organizational structure of the facility. Information would be made available to the Secretary, the HHS OIG, the state and state long term care ombudsman programs upon request. To the extent that the required information is submitted to the IRS as part of Form 990, to the Securities and Exchange

Commission, or to the Secretary, facilities would be permitted to make the information available in these formats.

Information to be disclosed would include the identity of and information on each member of the governing body of the facility (name, title, period of service); each person or entity who is an officer, director, member, partner, trustee, or managing employee of the facility; and each person or entity who is an additional disclosable party of the facility.

Additional disclosable parties would be defined as any persons or entities (1) that exercise operational, managerial or financial control over the facility or part thereof, or provides policies or procedures for any of the operations of the facility, or provides financial or cash management services to the facility; (2) lease or sublease real property to the facility, or owns a whole or part interest equal to or exceeding five percent of the total value of such real property; (3) ~~lend funds or provide financial guarantees which is equal to or exceeds $50,000; and (4)~~ that provide management or administrative services, management or clinical consulting services, or accounting or financial services to the facility.

The reporting of a person or entity's organizational structure would also be required. Organizational structure would be defined as officers, directors and shareholders who have an ownership interest equal to or greater than five percent in the case of corporations. For a limited liability company, organizational structure would be defined as members and managers; for a general partnership, the partners; for a limited partnership, general partners and any limited partners who have an ownership interest equal to ten percent or greater in the limited partnership; for a trust, the trustees; for an individual, contact information; and for any other person or entity, such information as the Secretary determines appropriate.

The Secretary and the states would be required to develop a standardized format through regulation for facilities to report information about ownership and additional disclosable parties within two years of enactment.

The Secretary, within one year of promulgating regulations requiring reporting by facilities, would be required to make available to the public information about ownership and additional disclosable parties. The Secretary would also be required to provide guidance and technical assistance to states on how to adopt the standardized format.

Accountability Requirements. The Chairman's Mark would require SNFs and nursing homes to develop and implement compliance and ethics programs to be followed by their employees and agents. The Secretary would be required to develop regulations, working with the HHS Inspector General, for an ethics and compliance program, which may include a model compliance program, within two years of enactment. The Secretary may vary program requirements on the elements and formality the elements and formality of the program based on the size of the organization. The compliance program would be required to have standards and procedures designed to detect criminal, civil and administrative violations under the Social Security Act.

The Secretary would create regulations on quality assurance and performance improvement (QAPI) plans. SNF and nursing homes would be required to implement QAPI plans and submit

those plans to the Secretary. The Secretary would be required to provide technical assistance to facilities on development of "best practices" in order to meet QAPI standards.

Nursing Home Compare Website. The Chairman's Mark would require the Secretary to include additional information on the Medicare *Nursing Home Compare* website. This additional information includes: (1) standardized staffing data on nursing staff and other staff providing medical and therapy services available on facilities that is submitted by facilities in a uniform format; (2) links to state internet websites regarding state survey and certification programs, and links to Form 2567 (or successor form) inspection reports, links to facility plans of correction or responses to such reports and information to guide consumers in how to interpret and understand these reports; (3) a standardized complaint form including explanatory material on how to use the complaint forms, and how to file a complaint with the state survey and certification program and the state long term care ombudsman program; (4) a summary of information on enforcement action against the facility that includes substantiated complaints and remedies proposed and imposed during the preceding three years; and (5) a summary of facility expenditures for direct care staffing based on data submitted.

The Secretary would be required to establish a process to review the accuracy, clarity of the presentation, timeliness, and comprehensiveness of information currently reported on *Nursing Home Compare*; and a process to modify or revamp the site in accordance with comments received after review. In conducting the review, the Secretary would be required to consult with state long term care ombudsman programs, consumer advocacy groups, provider stakeholder groups, and other representatives of programs or groups as the Secretary determines appropriate.

States would be required to submit survey information to the Secretary no later than they send such information to the facility, and requires the Secretary to use this information to update *Nursing Home Compare* as expeditiously as practicable. Facilities would be required to have available on request the preceding three years' of inspection reports (Form 2567 reports), complaint investigations and the facility's plan of correction or other response to the Form 2567 report. Facilities would also be required to post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. The Secretary would be required to issue guidance to states on establishing electronic links to Form 2567 reports, to facility plan of correction reports or other responses to 2567 reports, and posting of complaint investigation reports.

Reporting of Expenditures. The Chairman's Mark would amend the Social Security Act by adding requirements that SNF and nursing homes report expenditures for wages and benefits for direct care staff on facility cost reports. The reporting of expenditures on wages and benefits for direct care staff would be required to be broken out into categories including registered nurses, licensed professional nurses, certified nurse assistants, and other medical and therapy staff. The Secretary would be required to consult with government and private sector cost report experts to assist in categorizing by functional area SNF expenditure data, as well as in making it publicly available.

Standardized Complaint Form. The Chairman's Mark would require the Secretary to develop a standardized form for SNF and nursing facility residents and their representatives to use in

submitting quality of care complaints. The new standard complaint form would not prevent nursing facility residents from submitting claims in other ways too, including orally. States would be required to establish complaint resolution processes with procedures to assure accurate tracking of complaints received, including a notification to the complainant that a complaint has been received; procedures to determine the likely severity of a complaint and for the investigation of a complaint; and deadlines for responding to a complaint and for notifying the complainant of the outcome of the investigation. Such processes would be required to ensure that legal representatives or other responsible parties are not denied access to a resident or otherwise retaliated against if they have complained about the quality of care provided by the facility, or other issues relating to the facility.

Ensuring Staffing Accountability. The Chairman's Mark would require the Secretary to establish a process to require SNF and nursing facilities to regularly report staffing data, including agency and contract staff, by staff position categories (based on payroll and other verifiable and auditable data). The reporting requirements would include the category of work an employee performs such as whether the employee is an RN, LPN, LVN, CNA, or other medical or therapy staff providing direct resident services, resident census data, information on employee turnover and tenure, and the hours of care provided per resident per day. The Secretary would be required to consult with stakeholders in developing the reporting requirements. The process would be electronic and data would be reported in a uniform format. The Secretary would submit a report to Congress no later than six months after the completion of a one-year design phase. Not later than one year following the evaluation, the Secretary would require facilities to begin electronically submitting staffing information in a uniform format.

Civil Monetary Penalties. The Chairman's Mark would require the Secretary to promulgate regulations providing facilities with the opportunity for participation in an independent informal dispute resolution process that would produce a written record and occur within 30 days of imposition of the penalty. In instances where deficiencies are cited at the level of actual harm and immediate jeopardy, the Secretary would have the authority to place civil monetary penalties (CMPs) in an escrow account following completion of the informal dispute resolution process, or the date that is 90 days after the date of the imposition of the CMP, whichever is earlier. Monetary amounts collected and placed in escrow would be kept in an interest bearing escrow account pending the resolution of any appeals.

The Secretary and states would have the authority to reduce CMPs if the deficiency was self-reported and promptly corrected within ten calendar days after imposition. Reductions would not be made for self-reported deficiencies cited at the immediate jeopardy level, at the actual harm level if the harm was found to be a "pattern" or "widespread," and for deficiencies that result in the death of a resident. Facilities cited for a repeat deficiency that had been self-reported during the preceding year would not eligible for a reduction.

The Secretary would be authorized to use a portion of collected CMPs to fund activities that benefit residents. These activities include projects that strengthen and support resident and family councils, offset the costs of relocating residents to home and community-based settings or another facility, and support and protect residents in situations where a facility closes or is decertified. Such funds would also be used for facility improvement initiatives approved by the

Secretary, including joint training of facility staff and surveyors; technical assistance for facilities implementing quality assurance programs; and appointment of temporary management firms.

National Independent Monitor Pilot Program. The Chairman's Mark would require the Secretary to develop, test, and implement a two-year pilot for an independent monitor program. The independent monitor program would oversee large interstate and intrastate SNF and nursing home chains. The Secretary would develop protocols for addressing quality and safety problems at the corporate management level occurring in individual homes that are owned or operated by certain chains, including those with homes in the Special Focus Facility program, and those with a record of repeated serious safety and quality of care deficiencies.

Chains that receive a report containing findings and recommendations from the independent monitor would be required to submit a report outlining corrective actions that will be taken within ten days. If a chain declines to implement the independent monitor's recommendations, the chain would be required submit reasons why it will not do so. After receiving the chain's response, the independent monitor would be required to finalize recommendations and to submit a report to the chain and the facilities of the chain, the Secretary, and the relevant state or states, as appropriate. Chains would be responsible for a portion of the costs associated with appointment of independent monitors. The Secretary would have authority to waive Medicare and Medicaid laws in order to carry out the independent monitor pilot program. The HHS OIG would evaluate the independent monitor program to determine the feasibility of establishing a permanent independent monitor program, as well as appropriate procedures and mechanisms to implement such a permanent program.

Notification of Facility Closure. The Chairman's Mark would require SNFs and nursing homes to notify in a timely fashion state, Federal, and stakeholder officials, as well as residents and their representatives of an impending nursing facility closure. Facilities would be required in the notice to issue a plan for the transfer and relocation of residents.

The administrator of a facility that is preparing to close would be required to provide written notification to residents, legal representatives of residents or other responsible parties, the state, the Secretary and the long term ombudsman program. This notification would have to be made at least 60 days before closure. Facilities would have to prepare a plan for closing the facility by a specified date specified by the state. The state would be required to approve the plan and ensure the safe transfer of residents to another facility or alternative setting that the state finds appropriate in terms of quality, services and location and takes into consideration the needs and best interests of each resident.

In the case of a facility where the Secretary terminates the facility's participation, the Secretary would be required to provide written notification to the parties above not later than the date that the Secretary determines appropriate. Facilities would not be permitted to admit new residents on or after the date on which written notification is submitted. The Secretary would continue making payments to a facility to support residents until they are relocated, as the Secretary determines appropriate.

Demonstration Projects on Culture Change and use of Information Technology in Nursing Homes. The Chairman's Mark would require the Secretary to conduct two demonstration projects for nursing homes and SNF: (1) for the development of best practices for facilities involved in culture change; and (2) for the development of best practices in facilities for the use of information technology to improve resident care. The Secretary would be required to submit a report to Congress after completion of the demonstration projects that evaluates the projects and makes recommendations for legislation and administrative actions. The demonstration projects cannot exceed three years.

Dementia and Abuse Prevention Training. The Chairman's Mark would add staff training requirements for SNF and nursing homes. The Secretary would revise initial nurse aide training, competency, and evaluation program requirements to include dementia management training and patient abuse prevention. If determined to be appropriate, the Secretary also may include dementia management training and patient abuse prevention in ongoing nurse aide training, competency, and evaluation program requirements.

Nursing Home Background Checks. The Secretary would be required to establish a nationwide program for national and State background checks on direct patient access employees of certain long-term care (LTC) facilities or providers and provide Federal matching funds to states to conduct these activities. Except for certain modifications described below, the Secretary would be required to carry out the nationwide program under similar terms and conditions as the Background Check Pilot program under section 307 of the Medicare Modernization Act of 2003 (MMA). The Committee intends that the Secretary make relevant changes to the provisions based upon experience from the MMA pilot program and that are reflected in the legislative language. Under the nationwide program, the Secretary would be required to enter into agreements with newly participating States, as specified, and certain previously participating States, as specified.

According to the procedures established under the pilot program, certain LTC providers would be required to obtain state and national criminal history and other background checks on their prospective employees through such means as the Secretary determines appropriate. To conduct these checks, states would utilize a search of state-based abuse and neglect registries and specified state and Federal databases and records, including a fingerprint check. States would also be required to describe and test methods that reduce duplicative fingerprinting, including the development of a "rap back" capability, as specified. The Committee intends that the Secretary implement this provision in a fashion that does not result in application fees for potential long term care workers.

States that enter into an agreement with the Secretary would be responsible for monitoring compliance with the requirements of the nationwide program and have specified procedures in place, including procedures to: (1) conduct screening and criminal history background checks; (2) monitor compliance by LTC facilities and providers; (3) provide for a provisional period of employment of a direct patient access employee, as specified; (4) provide procedures for an independent process by which a provisional employee or an employee may request an appeal, or dispute the accuracy of, the information obtained in a background check, as specified; (5) provide for the designation of a single State agency with specified responsibilities; (6) determine

which individuals are direct patient access employees; (7) as appropriate, specify disqualifying offenses, including convictions for violent crimes; and (8) describe and test methods that reduce duplicative fingerprinting, as specified.

States would be required to guarantee (directly or through donations from public or private entities) a designated amount of non-Federal contributions to the program. The Federal government would provide a match equal to three times the amount a state guarantees; except that Federal funds would not exceed $3 million for newly participating states and $1.5 million for previously participating states.

The term "LTC facility or provider" would be defined to mean the following types of facilities or providers which receive payment for services under Medicare or Medicaid: skilled nursing facilities; nursing facilities; home health agencies; hospice providers; LTC hospitals; providers of personal care services; providers of adult day care; residential care providers that arrange for, or directly provide, LTC services, including certain assisted living facilities that provide a nursing home level of care established by the Secretary; intermediate care facilities for the mentally retarded (ICF/MRs); and other LTC facilities or providers of services under Medicare and/or Medicaid that the participating state determines appropriate. The term "direct patient access employee" would be defined to mean any individual who has access to a patient or resident of a LTC facility, or a patient's or resident's personal property or funds, through employment or contract and who has duties that involve (or may involve) one-on-one contact with a patient or resident of a facility or provider, as determined by the state for purposes of the nationwide program. Such term does not include volunteers unless they have equivalent duties that involve (or may involve) one-on-one contact with a patient or resident of a LTC facility or provider.

The HHS Inspector General would be required to conduct an evaluation of the nationwide program and submit a report to Congress no later than 180 days after completion of the national program. The Secretary of the Treasury would be required to transfer to HHS an amount specified by the HHS Secretary as necessary (not to exceed $160 million) to carry out the nationwide program for fiscal years 2010 through 2012. Such amounts would be required to remain available until expended.

Imaging Self-referral Sunshine

Current Law

Section 1877(b)(2) of the Social Security Act states that if a physician (or an immediate family member of a physician) has a financial relationship with an entity, the physician may not make a referral to the entity for the furnishing of designated health services for which payment may be made under Medicare or Medicaid. One of the many exceptions to this prohibition is for in-office ancillary services. This exception permits the furnishing of certain designated health services that are ancillary to the referring physician's medical services and where certain supervision, location, and billing requirements are met.

Chairman's Mark

The in-office ancillary exception would include a requirement that with respect to magnetic resonance imaging, computed tomography, positron emission tomography, and any other designated health services as determined by the Secretary, the referring physician must inform the individual at the time of the referral that the individual may obtain the services from a person other than the referring physician, a physician who is a member of the same group practice as the referring physician, or an individual who is directly supervised by the physician or by another physician in the group practice. The individual must be provided with a written list of suppliers who furnish services in the area in which the individual resides. This new requirement would apply to services furnished after January 1, 2010.

Hospital Average Charge Information

Current Law

No provision.

Chairman's Mark

Beginning in 2011, the Chairman's Mark would establish a national requirement for acute care hospitals to make their charges for each Medicare diagnostic related group (DRG) available to the public and upon request to any patient served by the facility. Hospitals would be required to provide the average charge and the range between the 2nd and 4th quintiles of charges across all commercial payers and for self-pay patients for each DRG; hospitals would update their information on an annual basis. If the hospital does not comply with the requirement, the Secretary of Health and Human Services would be authorized to impose a civil money penalty on the facility in the amount of $50,000.

TITLE V—FRAUD, WASTE, AND ABUSE

Provider Screening

Current Law

Medicare statute provides the Secretary of HHS with general authority to promulgate regulations for the efficient administration of the Medicare program and specific authority for enrolling providers in Medicare and Medicaid. Under this authority, the Centers for Medicare & Medicaid Services (CMS) has implemented regulations requiring providers and suppliers to submit information to enroll in the Medicare program and receive billing privileges. As part of the enrollment process, providers and suppliers are required to submit information necessary to verify identity and state licensure. CMS also reserves the right to perform on-site inspections of a provider or supplier to verify compliance with program standards. If enrollment requirements are not met, CMS may revoke Medicare billing privileges. For example, CMS may deny a provider's or supplier's enrollment in Medicare or revoke a provider's billing privileges for the

following reasons: non-compliance with enrollment requirements, exclusion from participation in Federal health care programs, conviction of a felony, or the submission of false or misleading information on the enrollment application. Although it is not a statutory requirement, it is CMS policy that providers and suppliers resubmit and recertify the accuracy of their enrollment information every five years.

CMS requires Medicare contractors to query the following databases prior to approving an application for enrollment in Medicare: *Qualifier.net*, the Medicare Exclusions Database (List of Excluded Individuals/Entities or LEIE), and the Government Services Administration (GSA) debarment list. In a 2003 program transmittal, CMS mandated that contractors stop querying the Healthcare Integrity and Protection Data Bank (HIPDB) when providers enroll in the program because it is duplicative and it is not cost effective

Chairman's Mark

The Chairman's Mark would require that the Secretary screen all providers and suppliers before granting Medicare billing privileges. At a minimum all providers and suppliers would be subject to licensure checks. Certain groups of providers and suppliers would be subject to additional screening measures according to risk, as defined by the Secretary. The additional types of screening measures could include: submission of fingerprints, criminal background checks, multistate data base inquiries, and random or unannounced site visits. An application fee of $350 would be imposed on providers and suppliers to cover the costs of screening. Current providers could be subject to a discounted screening fee of $250 if they pay it within 12 months of enactment. A hardship exception to the fee would be permitted, as would waiver of the fee for Medicaid providers for whom the state can demonstrate the fee would impede beneficiary access to care. All providers, including physicians who order items or services, would be required to be Medicare enrolled physicians or eligible professionals before they would be allowed to order or prescribe services that would incur any cost to the Medicare program. Some new providers or suppliers could also be subjected to enhanced oversight, such as prepayment review and payment caps, for a provisional period of six to 12 months.

The Chairman's Mark would also impose new disclosure requirements on providers and suppliers enrolling in Medicare. Applicants would be required to disclose affiliations with any enrolled entity that has uncollected Medicare or Medicaid debt. The Secretary would be authorized to deny enrollment in Medicare if these affiliations pose an undue risk to the program. The Secretary would also be authorized to require surety bonds up to $500,000 (the amount of the surety bond would be commensurate with the volume of billing) and, if necessary, impose moratoria on the enrollment of certain groups of new providers or suppliers to prevent fraud. Permissive exclusions and/or civil monetary penalties would be established for false statements on provider or supplier enrollment applications.

The Mark would also give states authority to impose similar screening procedures in Medicaid, including subjecting providers and suppliers to enhanced oversight and establishing new disclosure requirements. States would be authorized to deny participation to providers and suppliers that do not follow the screening procedures. States failing to create effective screening programs would be subjected to a financial penalty through a reduction in their Federal Medical

Assistance Percentage (FMAP). Additionally, states would be required to initiate termination proceedings for any provider or supplier excluded from Medicare or any other state's Medicaid program.

Data Matching

Complete "One PI" Integrated Data Repository

Current Law

Under the Medicare Integrity Program (MIP), CMS contracts with private entities to conduct a variety of activities designed to protect Medicare from fraud, waste, and abuse. Activities include auditing providers, identifying and recovering improper payments, educating providers about fraudulent providers, and instituting a Medicare-Medicaid data matching program. The Medicare-Medicaid data matching program, commonly referred to as the "Medi-Medi" program, authorizes the Secretary to work with the states, the Attorney General, and the HHS OIG to coordinate anti-fraud efforts. Specifically, Medi-Medi allows for the matching of claims that are submitted to Medicare and Medicaid to identify potentially fraudulent activity committed against both programs.

In addition, CMS is required to share data with the Internal Revenue Service (IRS) and the Social Security Administration (SSA) as part of its IRS/SSA/CMS data matching program. Under the IRS/SSA/CMS data matching program, employers are required to provide information on their Medicare-eligible workers' and spouses' health care coverage to CMS. Medicare statute prohibits Medicare payments for any item or service when payment has been made or can reasonably be expected to be made by a third-party payer. The program helps Medicare identify claims for which Medicare should not be the primary payer.

Medicaid laws require Medicaid program integrity and related fraud and abuse activities at the state level. Medicaid program integrity activities include: auditing, identifying Federal overpayments, education and training, referring cases of suspected fraud and abuse to Medicaid Fraud Control Units, disclosure of ownership and control information, and development and maintenance of Medicaid Management Information Systems (MMIS) computer systems. States also must operate eligibility determination systems that support data matching through the Public Assistance Reporting Information System (PARIS). Using PARIS, states are able to identify individuals who are receiving benefits under public programs in neighboring states. Additionally, the Secretary is required to establish a Medicaid Integrity Program and contract with vendors to provide services to identify fraud, waste, and abuse.

Chairman's Mark

The Chairman's Mark would require CMS to complete development of the comprehensive "One PI" Integrated Data Repository (IDR). The "One PI" IDR would expand existing program integrity data sources and expand data sharing and data matching across Federal health care claims and payment data (including HHS, SSA, the Departments of Veterans Affairs (VA), Defense (DOD), and Justice (DOJ)). In addition to including all claims and payment data for

Medicare and Medicaid, the "One PI" IDR would enable existing and new data sources to be integrated, such as: (1) quality-of-care under fee for service, managed care, and waivers, (2) Medicaid encounter data, (3) health plan performance, (4) ownership, control, and business relationships, (5) survey and certification; (6) resident/patient neglect or abuse, (7) adverse actions, (8) site visits, (9) penalties and settlements, and (10) data on results from other program monitoring.

The "One PI" IDR would be accompanied by additional authority for HHS OIG and DOJ to use these data, including secondary data sources, to identify and investigate potential fraud and abuse. CMS would provide technical assistance to users of the IDR. New civil penalties would be imposed for the intentional submission of erroneous data to the IDR. Additionally, states that fail to report encounter data could be subject to a reduction in their Federal financial participation (FFP) under Medicaid.

Consolidate and Expand Existing Provider Databases

Current Law

The Social Security Act requires the Secretary to develop and maintain a national health care fraud and abuse data collection program for the reporting of adverse actions taken against health care providers or suppliers. The HHS OIG issues regulations implementing the Healthcare Integrity and Protection Data Bank (HIPDB). The statute requires the following types of health care related adverse actions be reported to the HIPDB: civil judgments, Federal or state criminal convictions, actions taken by Federal or state licensing agencies, and provider exclusions from Medicare and Medicaid. Only final adverse actions are reportable to the HIPDB. Administrative fines, citations, corrective action plans, and other personnel actions are not reportable except under certain circumstances. Settlements, in which a finding of liability has not been established, are also not reportable. Both Federal and state government agencies as well as health plans are required to report to the HIPDB. Health plans that fail to report are subject to a civil monetary penalty of $25,000. The Secretary is required to publish a report identifying government agencies that fail to report to the HIPDB. HIPDB cannot duplicate the reporting requirements established for the National Practitioner Data Bank (NPDB).

Title IV of the Health Care Quality Improvement Act of 1986 (HCQIA, P.L. 99-660), as amended, established the NPDB. The NPDB collects and releases data related to the professional competence of physicians, dentists, and certain health care practitioners. The types of information included in the NPDB are medical malpractice payments, certain adverse licensure actions, adverse privilege actions, adverse professional society actions, and exclusions from Medicare and Medicaid. The statute defines the entities eligible to report and query the databank. Malpractice payers that fail to report are subject to a civil monetary penalty.

Section 1921 of the Social Security Act expanded the scope of reporting requirements for the NPDB to encompass additional adverse licensure actions and actions taken by state licensing and certification agencies, peer review organizations, and private accreditation organizations. Section 1921 also required that actions taken against all health care practitioners be included in the

databank. States are required to have a system for reporting adverse actions to the NPDB. A final rule implementing section 1921 has not yet been promulgated.

Chairman's Mark

The existing provider databases (HIPDB, NPDB, and LEIE) would be expanded and consolidated with a national patient abuse/neglect registry into a centralized sanctions data system. This data system would include information on providers in Medicare and all state Medicaid programs, including provider ownership and business relationships, history of adverse actions, and results of site visits or other monitoring by any program. Data on the fraud settlements that occur during the year would be reported to the consolidated database. State licensure boards and Federal and state law enforcement agencies would be able to access the data. The Medicare and Medicaid programs would be required to verify any applicant's status in the provider database prior to issuing provider/supplier numbers.

Additionally, the Chairman's Mark would require states to report to CMS information from their Medicaid Management Information Systems databases on a regular basis, as determined by the Secretary. States failing to report would be subject to a financial penalty through a reduction in their FMAP.

Provider Compliance and Penalties

Current Law

Conditions of Participation and Coverage. The Social Security Act mandates the establishment of minimum health and safety standards that must be met by providers (hospitals, hospices, nursing homes, and home health agencies) and suppliers participating in the Medicare and Medicaid programs. In order to receive payment, providers and suppliers must meet these health and safety standards. Generally, state agencies, under contract with CMS, survey providers and certain suppliers to determine compliance with the conditions or standards set forth in the statute and regulations. Alternatively, a provider can be deemed to meet these requirements if it has been accredited by an approved national accreditation body which has demonstrated that its inspection program ensures that all applicable conditions are met or exceeded. CMS has the authority to conduct a survey of an accredited provider or supplier to validate its organization's accreditation process. These surveys can be conducted on a representative sample basis, or in response to substantial allegations of noncompliance. If a provider is noncompliant, CMS may: revoke the provider's enrollment, deny payment, require a corrective action plan, or impose certain penalties.

Program Sanctions. Under Medicare's peer review or Quality Improvement Organization (QIO) program, the Secretary has the authority to impose sanctions on Medicare participating providers for non-compliance. Health care providers that receive Medicare payment are required to provide services that are both medically necessary and economically efficient. Medicare providers and suppliers are also required to provide services that meet professionally recognized standards of care. If a QIO finds that a provider has failed in a substantial number of cases to meet these requirements, or has committed a gross violation of care, the Secretary may exclude the provider

from Federal health care programs. The Secretary may also impose a fine of up to $10,000 for each instance of medically improper or unnecessary care.

Payment. Currently, there is a 36-month period allowed for claims filing under Medicare Parts A and B. CMS and its contractors have the authority to withhold payment in whole or in part if there is reliable evidence of an overpayment or fraud. CMS regulations stipulate the procedures CMS and its contractors must follow when deciding to suspend payment.

Overpayments. In accordance with CMS instructions, overpayments must be repaid to CMS within 30 days of receiving a demand letter. If the debt is not paid in full after 30 days, interest would be assessed and CMS reserves the right to collect the overpayment by offset. Providers have the option to request an extended repayment plan to pay off the debt.

Deterrence/Civil and Criminal Penalties. HHS OIG is authorized to impose civil penalties on any person, including an organization, agency, or other entity, that knowingly presents or causes to be presented to a Federal or state employee or agent certain false or fraudulent claims. A penalty of not more than $15,000 may be assessed against individuals that knowingly give false or misleading information to influence the decision to discharge an individual from a hospital. Entities that are excluded from Medicare or Medicaid, but retain an ownership or controlling interest in another participating entity, may be civilly fined not more than $10,000 per day. Civil monetary penalties (CMPs) of not more than $50,000 may be levied against individuals that knowingly and willfully make false statements or receive kickbacks in connection with reimbursement from a Federal health program. Under one of the prohibited claims, an individual or entity excluded from a Federal health care program that submits a claim for reimbursement to a program, or causes such a claim to be submitted, may be subject to a CMP of up to $10,000 for each item or service furnished during the period that the person or entity was excluded. The individual or entity may also be subject to treble damages for the amount claimed for each item or service. The Secretary may issue subpoenas and require the attendance and testimony of witnesses and the production of any other evidence at an investigational inquiry. The Secretary may also delegate this authority to HHS OIG for purposes of any investigation under the CMP statute.

The False Claims Act provides penalties for the submission of a false claim for payment or approval to an officer or employee of the Federal government. Violations may be punished with a CMP between $5,000 and $10,000, plus treble damages.

Under the Health Insurance Portability and Accountability Act (HIPAA, P.L. 104-191), it is illegal for anyone to willfully prevent, obstruct, mislead, or delay the communication of information or records relating to a violation of a "Federal health care offense." Section 241 of HIPAA defined "Federal health care offense" to be a number of criminal acts related to health care under the Federal criminal code.

Provider Self-Disclosure Protocol. The Federal prohibition on physician self-referrals (section 1877 of the Social Security Act) generally provides that if a physician (or an immediate family member of a physician) has a "financial relationship" with an entity, the physician may not make a referral to the entity for the furnishing of designated health services (DHS) for which payment

may be made under Medicare or Medicaid. Also, the entity may not present (or cause to be presented) a claim to the Federal health care program or bill to any individual, third-party payer, or other entity for DHS furnished pursuant to a prohibited referral.

Under section 1128B of the Social Security Act, commonly referred to as the anti-kickback statute, it is a felony for a person to knowingly and willfully offer, pay, solicit, or receive anything of value (*i.e.*, "remuneration"), directly or indirectly, overtly or covertly, in cash or in kind, in return for a referral or to induce generation of business reimbursable under a Federal health care program.

Violations of these statutes may be subject to various penalties. Persons found guilty of violating the anti-kickback statute may be subject to a fine of up to $25,000, imprisonment of up to five years, and exclusion from participation in Federal health care programs for up to one year. Violators of the physician self-referral law may be subject to sanctions including a denial of payment for relevant services, CMPs, and exclusion from participation in the Medicare and Medicaid programs. In addition, the physician self-referral law requires a person who collects any amount that was billed in violation of the Social Security Act to refund the amount to the individual billed in a timely manner.

In 1998, the HHS Office of the Inspector General (HHS OIG) issued a Self-Disclosure Protocol (SDP), which includes a process under which a health care provider can voluntarily self-disclose evidence of potential fraud, in an effort, to avoid the costs or disruptions that may be associated with an investigation or litigation. On March 24, 2009, HHS OIG issued an "Open Letter to Health Care Providers" that makes refinements to the SDP. In the Open Letter, HHS OIG announced that it would no longer accept disclosure of a matter that involves only liability under the physician self-referral law in "the absence of a colorable anti-kickback statute violation." Further, for anti-kickback-related submissions accepted into the SDP following the date of the letter, HHS OIG requires a minimum $50,000 settlement amount to resolve the matter.

Chairman's Mark

Conditions of Participation and Coverage. Medicare and Medicaid providers and suppliers would be required to implement compliance programs as a Condition of Participation. The Secretary of HHS, in consultation with HHS OIG and CMS, would establish core elements for inclusion in a compliance program. The Secretary of HHS would also establish a timeline for the establishment of the core elements and for implementation by providers and suppliers.

Also, physicians and other suppliers would be required to keep documentation on referrals to programs at high risk of fraud and abuse and provide access to such documentation upon request of the Secretary. If a physician or supplier is not able to provide documentation of such referrals, the Secretary may disenroll the physician or supplier for a period of not more than one year. Additionally, as a condition of payment, physicians must have a face-to-face encounter with the patient before making a referral for home health or durable medical equipment (DME).

Program Sanctions. Intermediate sanctions and program safeguards would be established to provide greater flexibility to CMS and law enforcement to address problems. For example,

administrative remedies, as defined by the Secretary to be commensurate with the offense or conspiracy, would be established for knowing participation by a beneficiary in a health care fraud scheme.

Payment. The maximum period for submission of Medicare claims would be reduced to not more than 12 months. Also, the Secretary, in consultation with HHS OIG and CMS, could suspend payments to providers and suppliers pending an investigation of credible allegations of fraud.

Overpayments. The 60 days providers and suppliers have to repay Medicare overpayments would be modified to either 60 days after the date on which the overpayment was made or the date the corresponding cost report is due. Providers and suppliers would be required to repay any Medicare or Medicaid overpayment identified through an internal compliance audit. Additionally, any person who knows of an overpayment would be required to return the overpayment to the Secretary, the state, or a Medicare contractor and notify the aforementioned party in writing to whom the overpayment was returned.

Deterrence/Civil and Criminal Penalties. The civil monetary penalty (CMP) law would be amended in several instances to increase penalties and extend use of CMPs. A CMP would be established for each instance of a hospital's failure to report an adverse action affecting the clinical privileges of a physician. The CMP law (at Section 1128A(a)(5) relating to beneficiary inducements), would be amended to tailor the prohibition to address harmful conduct and relieve the burden on certain charitable and other innocuous programs currently covered by the broad reach of the statute. The imposition of a CMP would be authorized on an excluded person who orders or prescribes (rather than directly furnishes) items or services reimbursed by Federal health care programs. Penalties for submitting false claims and for submitting false statements material to a false claim would be increased. Penalties would also be enhanced for delaying inspections and for the obstruction of program audits. For Medicare Advantage and Part D plans, penalties would be enhanced for misrepresentation or submission of falsified information as well as for marketing violations. The testimonial subpoena authority to program exclusion investigations would be extended.

The provision would also amend the Anti-kickback statute to add language defining "willfully" As "a person acted voluntarily and purposefully to do what the law forbids and the person need not have actual knowledge of the law or specific intent to violate that law."

Provider Self-Disclosure Protocol. The Secretary would be required to establish, within 180 days, a mechanism for providers to voluntarily disclose specific information regarding actual and potential violations of the physician self-referral law. The mechanism would be similar to the Provider Self-Disclosure Protocol operated by the HHS OIG and would apply to any violation of the physician self-referral law and violations of the anti-kickback statute of less than $50,000.The mechanism would be available to all health care providers and would not be limited to a particular industry, specialty, or service. The mechanism would also offer an incentive to encourage providers to participate, such as a damage calculation near the lower-end of the statutory spectrum. To ensure successful participation, the Secretary would have the authority to create disclosure requirements similar to those set forth by the HHS OIG in an April 15, 2008

open letter to health care providers. Finally, the mechanism would include an information sharing strategy to apply to the HHS OIG and the DOJ.

The Secretary would not be required to resolve all matters disclosed in this manner. However, the Secretary would be required to work closely with providers that come forward in good faith seeking a resolution. Neither the HHS OIG nor the DOJ would be precluded from opening an investigation into a provider while the disclosure protocol is being implemented. Any resolution entered into by the Secretary and the provider would not be binding on the DOJ or other Federal or state agency.

The Secretary would have the authority to promulgate the necessary regulations for fulfilling these requirements.

No later than one year following the enactment date of the mechanism, the Secretary would be required to submit a report to the appropriate committees of jurisdiction in Congress on the use of the protocol, including information on the number of participants, the amount of recoveries collected, and the cooperation between HHS, the HHS OIG, and DOJ.

Program Exclusions

Current Law

HHS OIG has the authority to exclude health care providers from participation in Federal health care programs. Exclusions from Federal health programs are mandatory under certain circumstances, and permissive in others (*i.e.*, HHS OIG has discretion in whether to exclude an entity or individual). Exclusion is mandatory for those convicted of certain offenses, including: (1) a criminal offense relating to the delivery of an item or service under Medicare, Medicaid, or a state health care program, (2) a criminal offense relating to neglect or abuse of patients in connection with the delivery of a health care item or service, or (3) a felony relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance. HHS OIG has permissive authority to exclude an entity or an individual from a Federal health program under numerous circumstances, including: conviction of certain misdemeanors relating to fraud, theft, embezzlement, breach of fiduciary duty or other financial misconduct; a conviction based on an interference with or obstruction of an investigation into a criminal offense; and revocation or suspension of a health care practitioner's license for reasons bearing on the individual's or entity's professional competence, professional performance, or financial integrity.

Generally, in the case of a mandatory exclusion, the minimum period of exclusion is five years. However, upon the request of the administrator of a Federal health care program who determines that the exclusion would impose a hardship on individuals entitled to benefits under Medicare Part A or enrolled under Medicare Part B (or both), the Secretary may waive the exclusion under certain circumstances with respect to that program in the case of an individual or entity that is the sole community physician or sole source of essential specialized services in a community.

Chairman's Mark

Section 1128(c)(3)(B) would be amended to clarify that hardship waivers of an HHS OIG exclusion can be based on hardship imposed on beneficiaries of any Federal health care program.

Recovery Audit Contractors

Current Law

Recovery Audit Contractors (RACs) are private organizations that contract with the Centers for Medicare & Medicaid Services (CMS) to identify and collect improper payments made in Medicare's fee-for-service (FFS) program. Congress originally required the Secretary of Health and Human Services to conduct a three-year demonstration program using RACs in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA, P.L. 108-173). In December 2006, Congress passed the Tax Relief and Health Care Act of 2006 (TRHCA, P.L. 109-432), which made the program permanent and mandated the expansion of RACs nationwide by 2010. CMS began the national rollout of the permanent program in 19 states in March 2009.

Chairman's Mark

The Chairman's Mark would extend the RAC program to Medicare Parts C and D and Medicaid. This expansion would require three items:

1. The 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.

Program Integrity Funding and Reporting Requirements

Current Law

Health Care Fraud and Abuse Control. Medicare program integrity and anti-fraud activities are funded through the Health Care Fraud and Abuse Control (HCFAC) program,. HCFAC was established by HIPAA, which sought to increase and stabilize Federal funding for health care anti-fraud activities, including the Medicare Integrity Program (MIP). HCFAC funds are directed to the enforcement and prosecution of health care fraud. Between fiscal years 1998 and 2008, total funding for program integrity and health care fraud activities increased from an estimated $0.7 billion to $1.1 billion.

HIPAA appropriated funds under HCFAC to HHS, DOJ, and the Federal Bureau of Investigation (FBI) for anti-fraud activities undertaken for fiscal years 1997 through 2003. For each fiscal year after 2003, the amount was capped at the 2003 level. The annual appropriations for HCFAC remained capped at the FY2003 level until 2007. In December 2006, Congress passed the Tax Relief and Health Care Act of 2006 which extended the mandatory annual appropriation for

HCFAC to 2010. For fiscal years 2007 through 2010, the mandatory annual appropriation is the limit for the preceding year plus the percentage increase in the consumer price index (CPI) for urban consumers. For each fiscal year beyond 2010, the mandatory annual appropriation is capped at the FY2010 level. Total funding for HCFAC for FY2008 is $376 million.

HIPAA also appropriated funds to MIP for fiscal years 1997 through 2003. Between FY1997 and FY2003, funding for MIP increased from $440 million to $720 million. For fiscal years 2004 and 2005, the annual MIP appropriation remained at the FY2003 level. In 2005, Congress passed the Deficit Reduction Act, which raised funding for the MIP program by $112 million for FY2006. This increased the annual MIP appropriation from $720 million to $832 million for FY2006 only. Twelve million dollars of this additional appropriation was earmarked for the Medi-Medi data matching program. The DRA provided increasing amounts for the Medi-Medi program through year 2010.

Every year, HHS and the DOJ are required to release a joint annual report to Congress on HCFAC results and accomplishments. These reports are released late summer or early fall and include numbers and examples of enforcement actions, program accomplishments, and amounts deposited into the Health Insurance Trust Fund resulting from health care fraud enforcement activities. Congress did not require that HHS and DOJ include expenditures or results for the MIP program in these reports.

Medicaid Integrity Program. Established by DRA, the Medicaid Integrity Program (MIP) is modeled after Medicare's MIP program. Medicaid MIP provides HHS with dedicated resources to promote Medicaid integrity, to contract with entities to reduce fraud, waste, and abuse, and to add 100 full-time equivalent MIP staff. Annual MIP reports to Congress on program accomplishments and use of funds are required. In addition, the Secretary is required to develop comprehensive five-year plans for Medicaid MIP.

Chairman's Mark

HCFAC funding would be increased by $10 million each year for ten years, and would remain available until expended. The provision would also permanently apply the CPI adjustment to HCFAC funding.

The Medicare and Medicaid Integrity Programs evaluation requirements would be amended. Reporting requirements would be established for Medicare MIP contractors, modeled on those established for the Medicaid MIP.

National Correct Coding Initiative. The Mark would require states to use of the National Correct Coding Initiative (NCCI) in Medicaid. The Mark would amend Section 1903(r) of the Social Security Act to require states to have an MMIS that, effective for claims filed on or after October 1, 2010, incorporates compatible elements of the NCCI (or any successor initiative) and such other elements of that Initiative (or such other national correct coding methodologies) as the Secretary identifies in accordance with specified requirements. Not later than September 1, 2010, the Secretary would be required to:

- identify those methodologies of the NCCI (or any successor initiative to promote correct coding and to control improper coding leading to inappropriate payment) which are compatible to claims filed under Medicaid;

- identify those methodologies of such Initiative (or such other national correct coding methodologies) that should be incorporated into claims filed under Medicaid with respect to items and services for which no national correct coding methodologies have been established under such Initiative with respect to Medicare;

- notify states of the elements identified (and of any other national correct coding methodologies identified) and how states are to incorporate such elements (and methodologies) into claims filed under Medicaid; and

- submit a report to Congress that includes the notice to states and an analysis supporting the identification of the elements (or methodologies).

If the Secretary determines that state legislation is required in order for a Medicaid state plan to meet the additional requirements imposed by the provision, the state plan would not be regarded as failing to comply before the first day of the first calendar quarter beginning after the close of the first regular session of the state legislature that begins after the date of enactment. In the case of a state that has a 2-year legislative session, each year of the session would be considered a separate regular session of the state legislature.

Adjustments to the Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies Competitive Acquisition Program

Current Law

Medicare Part B covers a wide variety of durable medical equipment, prosthetics, orthotics, and other medical supplies (DMEPOS) if they are medically necessary and are prescribed by a physician.

Medicare pays for most durable medical equipment (DME) on the basis of a fee schedule. The Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA, 108-173) required the Secretary to establish a competitive acquisition program for specified durable medical equipment; the single payment amount derived from the competitive acquisition program would replace the Medicare fee schedule payments. The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA, P.L. 110-271) delayed the phase-in and made changes to the program. The program is to be phased-in, starting in nine of the largest metropolitan statistical areas (MSAs) in 2009 (round 1); expanding to an additional 70 of the largest MSAs in 2011 (round two) and remaining areas after 2011.

Starting in 2011, the Secretary has the authority to use information on payments determined in competitive acquisition areas to adjust payments for items and services in non-competitive acquisition areas. Before 2015, the following three types of areas are exempt from the competitive acquisition program: (a) rural areas; (b) metropolitan statistical areas (MSA) not

selected under round 1 or round 2 with a population of less than 250,000; and (c) areas with a low population density within an MSA that is otherwise selected to be part of the competitive acquisition program.

Chairman's Mark

The Chairman's Mark would require the Secretary to expand the number of areas to be included in Round Two of the program from 79 of the largest MSAs to 100 of the largest MSAs by including the next 21 largest MSAs by population. The provision would also require that the Secretary extend the competitive acquisition program, or apply competitively-bid rates, to the remaining areas by 2016. All other provisions in current law would remain in place, such as the Secretary's discretion to exempt rural areas and areas with low population density within a MSA.

TITLE VI—REVENUE ITEMS

Excise Tax on High Cost Insurance

Current Law

Taxation of Insurance Companies. Current law provides special rules for determining the taxable income of insurance companies (subchapter L of the Code). Separate sets of rules apply to life insurance companies and to property and casualty insurance companies. Insurance companies generally are subject to Federal income tax at regular corporate income tax rates.

An insurance company that provides health insurance is subject to Federal income tax as either a life insurance company or as a property insurance company, depending on its mix of lines of business and on the resulting portion of its reserves that are treated as life insurance reserves. For Federal income tax purposes, an insurance company is treated as a life insurance company if the sum of its (1) life insurance reserves and (2) unearned premiums and unpaid losses on noncancellable life, accident or health contracts not included in life insurance reserves, comprise more than 50 percent of its total reserves.[44]

Some insurance providers may be exempt from Federal income tax under section 501(a) if specific requirements are satisfied. Section 501(c)(8), for example, describes certain fraternal beneficiary societies, orders, or associations operating under the lodge system or for the exclusive benefit of their members that provide for the payment of life, sick, accident, or other benefits to the members or their dependents. Section 501(c)(9) describes certain voluntary employees' beneficiary associations that provide for the payment of life, sick, accident, or other benefits to the members of the association or their dependents or designated beneficiaries. Section 501(c)(12)(A) describes certain benevolent life insurance associations of a purely local character. Section 501(c)(15) describes certain small non-life insurance companies with annual gross receipts of no more than $600,000 ($150,000 in the case of a mutual insurance company). Section 501(c)(26) describes certain membership organizations established to provide health insurance to certain high-risk individuals. Section 501(c)(27) describes certain organizations

[44] Sec. 816(a).

established to provide workmen's compensation insurance. A health maintenance organization that is tax-exempt under section 501(c)(3) or (4) is not treated as providing prohibited[45] commercial-type insurance, in the case of incidental health insurance provided by the health maintenance organization that is of a kind customarily provided by such organizations.

Treatment of Employer-Sponsored Plans Health Coverage and Self-Employed Individuals. As with other compensation, the cost of employer provided health coverage is a deductible business expense under section 162. Employer-provided health insurance coverage is generally not included in an employee's gross income.

In addition, employees participating in a cafeteria plan may be able to pay the portion of premiums for health insurance coverage not otherwise paid for by their employers on a pre-tax basis through salary reduction.[46] Such salary reduction contributions are treated as employer contributions for Federal income purposes, and are thus excluded from gross income.

Employers may agree to reimburse medical expenses of their employees (and their spouses and dependents), not covered by a health insurance plan, through flexible spending arrangements which allow reimbursement not in excess of a specified dollar amount (either elected by an employee under a cafeteria plan or otherwise specified by the employer). Reimbursements under these arrangements are also excludible from gross income as employer-provided health coverage.

A flexible spending arrangement for medical expenses under a cafeteria plan (Health FSA) is an unfunded arrangement under which employees are given the option to reduce their current cash compensation and instead have the amount made available for use in reimbursing the employee for his or her medical expenses.[47] Health FSAs that are funded on a salary reduction basis are subject to the requirements for cafeteria plans, including a requirement that amounts remaining under a Health FSA at the end of a plan year must be forfeited by the employee (referred to as the "use-it-or-lose-it rule").[48]

Alternatively, the employer may specify a dollar amount that is available for medical expense reimbursement. These arrangements are commonly called Health Reimbursement Arrangements (HRAs). Some of the rules applicable to HRAs and Health FSAs are similar (e.g., the amounts in the arrangements can only be used to reimburse medical expenses and not for other purposes), but the rules are not identical. In particular, HRAs cannot be funded on a salary reduction basis and the use-it-or-lose-it rule does not apply. Thus, amounts remaining at the end of the year may be carried forward to be used to reimburse medical expenses in following years.[49]

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[45] Sec. 501(m).

[46] Sec. 125.

[47] Sec. 125. Proposed Treas. Reg. sec. 1.125-5 provides rules for Health FSAs. There is a similar type of flexible spending arrangement for dependent care expenses.

[48] Sec. 125(d)(2). A cafeteria plan is permitted to allow a grace period not to exceed two and one-half months immediately following the end of the plan year during which unused amounts may be used. Notice 2005-42, 2005-1 C.B. 1204.

[49] Guidance with respect to HRAs, including the interaction of FSAs and HRAs in the case of an individual covered under both, is provided in Notice 2002-45, 2002-2 C.B. 93.

Current law provides that individuals with a high deductible health plan (and generally no other health plan) may establish and make tax-deductible contributions to a health savings account (HSA). An HSA is subject to a condition that the individual is covered under a high deductible health plan (purchased either through the individual market or through an employer). Subject to certain limitations,[50] contributions made to an HSA by an employer, including contributions made through a cafeteria plan through salary reduction, are excluded from income (and from wages for payroll tax purposes). Contributions made by individuals are deductible for income tax purposes, regardless of whether the individuals itemize.

The Employee Retirement Income Security Act of 1974 (ERISA, P.L. 93-406) preempts state law relating to certain employee benefit plans, including employer-sponsored health plans. While ERISA specifically provides that its preemption rule does not exempt or relieve any person from any state law which regulates insurance, ERISA also provides that an employee benefit plan is not deemed to be engaged in the business of insurance for purposes of any state law regulating insurance companies or insurance contracts. As a result of this ERISA preemption, self-insured employer-sponsored health plans need not provide benefits that are mandated under state insurance law.

While ERISA does not require an employer to offer health benefits, it does require compliance if an employer chooses to offer health benefits, such as compliance with plan fiduciary standards, reporting and disclosure requirements, and procedures for appealing denied benefit claims. ERISA was amended (as well as the Public Health Service Act and the Internal Revenue Code) in the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA, P.L. 99-272) and the Health Insurance Portability and Accountability Act of 1996 (HIPAA, P.L.104-191), adding other Federal requirements for health plans, including rules for health care continuation coverage, limitations on exclusions from coverage based on pre-existing conditions, and a few benefit requirements such as minimum hospital stay requirements for mothers following the birth of a child.

COBRA requires that a group health plan offer continuation coverage to qualified beneficiaries in the case of a qualifying event (such as a loss of employment).[51] A plan may require payment of a premium for any period of continuation coverage. The amount of such premium generally may not exceed 102 percent of the "applicable premium" for such period and the premium must be payable, at the election of the payer, in monthly installments. The applicable premium for any period of continuation coverage means the cost to the plan for such period of coverage for similarly situated non-COBRA beneficiaries with respect to whom a qualifying event has not

[50] For 2009, the maximum aggregate annual contribution that can be made to an HSA is $3,000 in the case of self-only coverage and $5,950 in the case of family coverage ($3,050 and $6,150 for 2010). The annual contribution limits are increased for individuals who have attained age 55 by the end of the taxable year (referred to as "catch-up contributions"). In the case of policyholders and covered spouses who are age 55 or older, the HSA annual contribution limit is greater than the otherwise applicable limit by $1,000 in 2009 and thereafter. Contributions, including catch-up contributions, cannot be made once an individual is enrolled in Medicare.

[51] A group health plan is defined as a plan (including a self-insured plan) of, or contributed to by, an employer (including a self-employed person) or employee organization to provide health care (directly or otherwise) to the employees, former employees, the employer, others associated or formerly associated with the employer in a business relationship, or their families. The COBRA requirements are enforced through the Code, ERISA, and the Public Health Service Act (PHSA).

occurred, and is determined without regard to whether the cost is paid by the employer or employee. There are special rules for determining the applicable premium in the case of self-insured plans. Under the special rules for self-insured plans, the applicable premium generally is equal to a reasonable estimate of the cost of providing coverage for similarly situated beneficiaries which is determined on an actuarial basis and takes into account such other factors as the Secretary of Treasury may prescribe in regulations.

Current law imposes an excise tax on group health plans that fail to meet HIPAA and COBRA requirements.[52] The excise tax generally is equal to $100 per day per failure during the period of noncompliance and is imposed on the employer sponsoring the plan.

Reporting Requirements. Under current law, the value of the employee's health insurance benefits is not reported to the IRS or any other Federal agency because, as discussed above, the value of the employer contribution to health coverage is excludible from employee income.

Under current law, every employer is required to furnish each employee and the Federal government with a statement of compensation information, including wages, paid by the employer to the employee, and the taxes withheld from such wages during the calendar year. The statement, made on the Form W-2, must be provided to each employee by January 31 of the succeeding year.

Currently, there is no employer requirement for the value of employer-provided health insurance coverage on the Form W-2 (unlike the requirement to report wages paid to employees). Some employers, however, voluntarily report the amount of salary reduction under a cafeteria plan resulting in tax-free employee benefits in box 14 of the Form W-2.

Deduction for Health Insurance Costs of Self-Employed Individuals. Under current law, self-employed individuals may deduct the cost of health insurance for themselves and their spouses and dependents.[53] The deduction is not available for any month in which the self-employed individual is eligible to participate in an employer-subsidized health plan. Moreover, the deduction may not exceed the individual's earned income from self-employment. The deduction applies only to the cost of insurance (i.e., it does not apply to out-of-pocket expenses that are not reimbursed by insurance). The deduction does not apply for self-employment tax purposes. For purposes of the deduction, a more than 2 percent shareholder-employee of an S corporation is treated the same as a self-employed individual. Thus, the exclusion for employer provided health care coverage does not apply to such individuals, but they are entitled to the deduction for health insurance costs as if they were self-employed.

Deductibility of Excise Taxes. In general, excise taxes may be deductible under section 162 of the Code if such taxes are paid or incurred within a taxable year in carrying on a trade or business.

Chairman's Mark

[52] Secs. 4980B and 4980D.

[53] Sec. 162(l).

The Chairman's Mark imposes an excise tax on insurers if the aggregate value of employer-sponsored health coverage for an employee exceeds a threshold amount. The tax is equal to 40~~35~~ percent of the aggregate value that exceeds a threshold amount. The threshold amount is $8,000 for individual coverage and $21,000 for family coverage for 2013. The threshold amounts are indexed to the Consumer Price Index for Urban Consumers (CPI-U) as determined by the Department of Labor beginning in 2014 plus one percent. The excise tax is imposed pro rata on the issuers of the insurance. In the case of a self-insured group health plan, a Health FSA, an HRA, the excise tax is paid by the plan administrator. Where the employer acts as plan administrator to a self-insured group health plan, a Health FSA, or an HRA and with respect to employer contributions to an HSA, the excise tax is paid by the employer.

In determining the amount by which the value of employer sponsored health insurance coverage exceeds the threshold amount, the aggregate value of all employer-sponsored health insurance coverage is taken into account, including coverage in the form of reimbursements under a Health FSA or an HRA, employer contributions to an HSA, and coverage for dental, vision, and other supplementary health insurance coverage.[54] This amount subject to the high-premium excise tax does not include fixed indemnity health coverage that is purchased by the employee with after-tax dollars.

Employer-sponsored health insurance coverage is health coverage offered by an employer to an employee without regard to whether the employer pays for the coverage (and thus the coverage is excludible from the employee's gross income) or the employee pays for the coverage with after-tax dollars. In the case of a self-employed individual, employer-sponsored health insurance coverage is coverage for any portion of which the self-employed individual claims a deduction under section 162(l).

Calculation and Pro Ration of Excise Tax and Reporting Requirements

Amount of applicable premium

Under the Chairman's Mark, the aggregate value of all employer-sponsored health insurance coverage, including dental, vision, and other supplementary health insurance coverage is generally calculated in the same manner as the applicable premiums for the taxable year for the employee determined under the rules for COBRA continuation coverage. If the plan provides for the same COBRA continuation coverage premium for both individual coverage and family coverage, the plan would be required to calculate separate individual and family premiums for this purpose. In determining the coverage value for retirees, employers would be able to elect to treat pre-65 retirees together with post-65 retirees.

Value of coverage in the form of Health FSA reimbursements

In the case of a Health FSA from which reimbursements are limited to the amount of the salary reduction, the value of employer-provided coverage is equal to the dollar amount of the

[54] The value of employer-sponsored coverage for disability benefits or long term care under an accident or health plan is not taken into account in the determination of whether the value of health coverage exceeds the threshold amount.

aggregate salary reduction contributions for the year. To the extent that the Health FSA provides for reimbursement in excess of the amount of the employee's salary reduction, the value of the coverage generally is determined in the same manner as the applicable premium for COBRA continuation coverage. If the plan provides for the same COBRA continuation coverage premium for both individual coverage and family coverage, the plan would be required to calculate separate individual and family premiums for this purpose.

Amount subject to the excise tax and reporting requirement

The amount subject to the excise tax on high cost employer-sponsored coverage for each employee is the sum of the aggregate premiums for health insurance coverage, the amount of any salary reduction contributions to a Health FSA for the taxable year, and the dollar amount of employer contributions to an HSA, minus the dollar amount of the threshold. The aggregate premiums for health insurance coverage include all employer-sponsored health coverage including coverage for major medical, dental, vision and other supplementary health insurance coverage. The applicable premium for health coverage provided through an HRA is also included in this aggregate amount.

This amount 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.

Under a separate provision (described below), an employer is required to disclose the aggregate premiums for health insurance coverage for each employee on his or her annual Form W-2.

Under the Mark, the excise tax is allocated pro rata among the insurers, with each insurer responsible for payment of the excise tax on an amount equal to the amount subject to the total excise tax multiplied by a fraction, the numerator of which is the amount of employer-sponsored health insurance coverage provided by that insurer to the employee and the denominator of which is the aggregate value of all employer-sponsored health insurance coverage provided to the employee. In the case of a self-insured group health plan, a Health FSA, an HRA or employer contributions to an HSA, the excise tax is allocated to the plan administrator. The employer is responsible for calculating the amount subject to the excise tax allocable to each insurer and plan administrator and for reporting these amounts to each insurer, plan administrator and the Secretary, in such form and at such time as the Secretary may prescribe. Each insurer and plan administrator is then responsible for calculating, reporting and paying the excise tax to the IRS on such forms and at such time as the Secretary may prescribe.

For example, for an employee who elects family coverage under a fully-insured health care policy covering major medical and dental with a value of $28,000, the amount subject to the excise tax is $7,000 ($28,000 less the threshold of $21,000). The employer reports $7,000 as taxable to the insurer, which calculates and remits the excise tax to the IRS.

Alternatively, an employee who elects family coverage under a fully-insured major medical policy with a value of $23,000 and a separate fully-insured dental policy with a value of $2,000

and who contributes $3,000 to a Health FSA has an aggregate health insurance coverage value of $28,000. The amount subject to the excise tax is $7,000 ($28,000 less the threshold of $21,000). The employer reports $5,750 ($7,000 x $23,000/$28,000) as taxable to the major medical insurer and $500 ($7,000 x $2,000/$28,000) as taxable to the dental insurer, each of which then calculates and remits the excise tax to the IRS. If the employer uses a third-party administrator for the Health FSA, the employer reports $750 ($7,000 x $3,000/$28,000) to the administrator and the administrator calculates and remits the excise tax to the IRS. (If the employer is acting as the plan administrator of the Health FSA, the employer is responsible for calculating and remitting the excise tax on the $750 to the IRS).

Penalty for Under Reporting Liability for Tax to Insurers. If the employer reports to insurers and plan administrators (and the IRS) a lower amount of insurance cost subject to the excise tax than required, the employer is subject to a penalty equal to any additional excise tax that each such insurer and administrator would have owed if the employer had reported correctly, increased for interest from the date that the tax was otherwise due to the date paid by the employer. This may occur, for example, if the employer undervalues the aggregate premium and thereby lowers the amount subject to the excise tax for all insurers and plan administrators (including the employer when acting as plan administrator of a self-insured plan). This penalty may be waived if the employer can show that the failure is due to reasonable cause and not to willful neglect. The penalty is in addition to the amount of excise tax owed, which may not be waived.

Certain Transition Relief and Other Rules. Under a transition rule for health insurance plans maintained in the 17 states in which health care was least affordable for the year ended December 31, 2012, as determined by the Secretary, the threshold amount is initially increased by 20 percent. The Secretary shall determine the 17 highest cost states based on data available for 2012. The transition rule applies with respect to coverage of a specific individual based on the individual's residence on the first day of a coverage period beginning during the transition period. The initial 20 percent increase is reduced by half each year thereafter (e.g., to ten percent for the first taxable year beginning after December 31, 2013 and to 5 percent for the first taxable year beginning after December 31, 2014) until the additional premium amount is eliminated entirely for taxable years beginning after December 31, 2015. The Secretary shall determine the 17 highest cost states based on data available for 2012. The transition rule applies on an individual basis with respect to coverage of a specific individual based on the individual's residence on the first day of a coverage period beginning during the transition period.

For retired individuals over the age of 55, the threshold amount is increased by $1,850 for individual coverage and $5,000 for family coverage. The additional amounts are indexed to the CPI-U, as determined by the Department of Labor beginning in 2014, plus one percent.

For plans that cover employees engaged in high risk professions, the threshold amount is increased by $1,850 for individual coverage and $5,000 for family coverage. The additional amounts are indexed to the CPI-U, as determined by the Department of Labor beginning in 2014, plus one percent. For purposes of this rule, employees considered to be engaged in a high risk profession are law enforcement officers, firefighters, members of a rescue squad or ambulance crew, and individuals engaged in the construction, mining, agriculture (but not food processing), forestry or fishing industries.

Under this provision, an individual's threshold cannot be increased by more than $1,850 for individual coverage or $5,000 for family coverage (indexed as described above), even if the individual would qualify for an increased threshold both on account of his or her status as a retiree over age 55 and as a participant in a plan that covers employees in a high risk profession.

The Chairman's Mark provides that the amount of the excise tax imposed is not deductible for Federal income tax purposes.

Effective Date

The Chairman's Mark is effective for taxable years beginning after December 31, 2012.

Employer Health Insurance Reporting

Current Law

In many cases, an employer pays for all or a portion of its employees' health insurance coverage as an employee benefit. This benefit often includes premiums for major medical, dental, and other supplementary health insurance coverage. Under present law, the value of employer-provided health coverage is not required to be reported to the IRS or any other Federal agency. The value of the employer contribution to health coverage is excludible from an employee's income.

Under current law, every employer is required to furnish each employee and the Federal government with a statement of compensation information, including wages, paid by the employer to the employee, and the taxes withheld from such wages during the calendar year. The statement, made on the Form W-2, must be provided to each employee by January 31 of the succeeding year.

Currently, there is no employer reporting requirement for the value of employer-provided health insurance coverage on the Form W-2 (unlike the requirement to report wages paid to employees). Some employers, however, voluntarily report the amount of salary reduction under a cafeteria plan resulting in tax-free employee benefits in box 14 of the Form W-2.

Chairman's Mark

An employer would be required to disclose the value of the benefit provided by the employer for each employee's health insurance coverage on the employee's annual Form W-2. To the extent that the employee receives health insurance coverage under multiple plans, the employer would disclose the aggregate value of all such health coverage (excluding the value of a health flexible spending arrangement). For example, an employee receiving health insurance coverage under a major medical plan, a dental plan, and a vision plan would only be required to report the total value of the combination of all of these health related insurance policies. For this purpose, employers would generally use the same value for all similarly situated employees receiving the same category of coverage (such as single or family health insurance coverage).

Under the Chairman's Mark, the method of determining the value of employer-provided health insurance coverage would be to use the same calculation as is currently used in determining the

employer-provided portion of the applicable premiums for the taxable year for the employee determined under the rules for COBRA continuation coverage under Code section 4980B(f)(4) (and accompanying Treasury regulations), including the special rule for self-insured plans. If the plan provides for the same COBRA continuation coverage premium for both individual coverage and family coverage, the plan would be required to calculate separate individual and family premiums for this purpose.

Effective Date

The Chairman's Mark would be effective beginning in the first taxable year after December 31, 2009.

Modify the Definition of Qualified Medical Expenses

Current Law

Individual Deduction for Medical Expenses. Expenses for medical care, not compensated for by insurance or otherwise, are deductible by an individual under the rules relating to itemized deductions to the extent the expenses exceed 7.5 percent of AGI.[55] Medical care generally is defined broadly as amounts paid for diagnoses, cure, mitigation, treatment or prevention of disease, or for the purpose of affecting any structure of the body.[56] However, any amount paid during a taxable year for medicine or drugs is explicitly deductible as a medical expense only if the medicine or drug is a prescribed drug or is insulin.[57] Thus, any amount paid for over-the-counter medicine is not deductible as a medical expense, even if prescribed or recommended by a doctor.[58]

Exclusion for Employer Provided Health Care. The Code generally provides that employees are not taxed on (that is, may "exclude" from gross income) the value of employer-provided health coverage under an accident or health plan.[59] In addition, any reimbursements under an accident or health plan for medical care expenses for employees, their spouses, and their dependents generally are excluded from gross income.[60] An employer may agree to reimburse expenses for medical care of its employees (and their spouses and dependents), not covered by a health insurance plan, through a flexible spending arrangement (FSA) which allows reimbursement not in excess of a specified dollar amount. Such dollar amount is either elected by an employee under a cafeteria plan (Health FSA) or otherwise specified by the employer under an arrangement called a health reimbursement arrangement (HRA). Reimbursements under these arrangements are also excludible from gross income as employer-provided health coverage. The general definition of medical care without the explicit limitation on medicine applies for

[55] Sec. 213(a).

[56] Sec. 213(d). There are certain limitations on the general definition including a rule that cosmetic surgery or similar procedures are generally not medical care.

[57] Sec. 213(b).

[58] Rev. Rul. 2003-58, 2003-1 CB 959.

[59] Sec. 106.

[60] Sec. 105(b).

purposes of the exclusion for employer provided health coverage and medical care.[61] Thus, under an HRA or under a Health FSA, amounts paid for over-the-counter medicine are treated as medical expenses, and reimbursements for such amounts are excludible from gross income.

Medical Savings Arrangements. Present law provides that individuals with a high deductible health plan (and generally no other health plan) purchased either through the individual market or through an employer may establish and make tax-deductible contributions to a health savings account (HSA).[62] Subject to certain limitations,[63] contributions made to an HSA by an employer, including contributions made through a cafeteria plan through salary reduction, are excluded from income (and from wages for payroll tax purposes). Contributions made by individuals are deductible for income tax purposes, regardless of whether the individuals itemize. Distributions from an HSA that are used for qualified medical expenses are excludible from gross income.[64] The general definition of medical care without the explicit limitation on medicine also applies for purposes of this exclusion.[65] Similar rules apply for another type of medical savings arrangement called an Archer MSA.[66] Thus, a distribution from a HSA or an Archer MSA used to purchase over-the-counter medicine also is excludible as an amount used for qualified medical expenses.

Chairman's Mark

Under the provision, with respect to medicine, the definition of medical expense for purposes of employer provided health coverage (including HRAs and Health FSAs), HSAs, and Archer MSAs, generally is conformed to the definition for purposes of the itemized deduction for medical expenses. However, this change does not apply to doctor prescribed over-the-counter medicine. Thus, under the provision, the cost of over-the-counter medicine (other than doctor prescribed) may not be reimbursed through a Health FSA or HRA. In addition, the cost of over-the-counter medicines (other than doctor prescribed) may not be reimbursed on a tax-free basis through a HSA or Archer MSA.

Effective Date

The Chairman's Mark is effective for taxable years beginning after December 31, 2009.

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[61] Sec. 105(b) provides that reimbursements for medical care within the meaning of section 213(d) pursuant to employer provided health coverage are excludible from gross income. The definition of medical care in section 213(d) does not include the prescription drug limitation in section 213(b).

[62] Sec. 223.

[63] For 2009, the maximum aggregate annual contribution that can be made to an HSA is $3,000 in the case of self-only coverage and $5,950 in the case of family coverage ($3,050 and $6,150 for 2010). The annual contribution limits are increased for individuals who have attained age 55 by the end of the taxable year (referred to as "catch-up contributions"). In the case of policyholders and covered spouses who are age 55 or older, the HSA annual contribution limit is greater than the otherwise applicable limit by $1,000 in 2009 and thereafter. Contributions, including catch-up contributions, cannot be made once an individual is enrolled in Medicare.

[64] Sec. 223(f).

[65] Sec. 223(d)(2).

[66] Sec. 220.

Health Savings Accounts

Current Law

Current law provides that individuals with a high deductible health plan (and generally no other health plan) may establish and make tax-deductible contributions to a health savings account (HSA).[67] An HSA is a tax-exempt account held by a trustee or custodian for the benefit of the individual. An HSA is subject to a condition that the individual is covered under a high deductible health plan (purchased either through the individual market or through an employer). The decision to create and fund an HSA is made on an individual-by-individual basis and does not require any action on the part of the employer.

Subject to certain limitations, contributions made to an HSA by an employer, including contributions made through a cafeteria plan through salary reduction, are excluded from income (and from wages for payroll tax purposes). Contributions made by individuals are deductible for income tax purposes, regardless of whether the individuals itemize. Income from investments made in HSAs is not taxable and the overall income is not taxable upon disbursement for medical expenses.

For 2009, the maximum aggregate annual contribution that can be made to an HSA is $3,000 in the case of self-only coverage and $5,950 in the case of family coverage ($3,050 and $6,150 for 2010). The annual contribution limits are increased for individuals who have attained age 55 by the end of the taxable year (referred to as "catch-up contributions"). In the case of policyholders and covered spouses who are age 55 or older, the HSA annual contribution limit is greater than the otherwise applicable limit by $1,000 in 2009 and thereafter. Contributions, including catch-up contributions, cannot be made once an individual is enrolled in Medicare.

A high deductible health plan is a health plan that has an annual deductible that is at least $1,150 for self-only coverage or $2,300 for family coverage for 2009 (increasing to $1,200 and $2,400 for 2010) and that limits the sum of the annual deductible and other payments that the individual must make in respect of covered benefits to no more than $5,800 in the case of self-only coverage and $11,600 in the case of family coverage for 2009 (increasing to $5,950 and $11,900 for 2010).

Distributions from an HSA that are used for qualified medical expenses are excludible from gross income. Distributions from an HSA that are not used for qualified medical expenses are includible in gross income. An additional ten percent tax is added for all HSA disbursements not made for qualified medical expenses. The additional ten percent tax does not apply, however, if

[67] An individual with other coverage in addition to a high deductible health plan is still eligible for an HSA if such other coverage is "permitted insurance" or "permitted coverage." Permitted insurance is: (1) insurance if substantially all of the coverage provided under such insurance relates to (a) liabilities incurred under worker's compensation law, (b) tort liabilities, (c) liabilities relating to ownership or use of property (e.g., auto insurance), or (d) such other similar liabilities as the Secretary may prescribe by regulations; (2) insurance for a specified disease or illness; and (3) insurance that provides a fixed payment for hospitalization. Permitted coverage is coverage (whether provided through insurance or otherwise) for accidents, disability, dental care, vision care, or long term care. With respect to coverage for years beginning after December 31, 2006, certain coverage under a Health Flexible Spending Account is disregarded in determining eligibility for an HSA.

the distribution is made after death, disability, or attainment of age of Medicare eligibility (currently age 65). Unlike reimbursements from a flexible spending arrangement or health reimbursement arrangement, distributions from an HSA are not required to be substantiated by the employer or a third party for the distributions to be excludible from income.

Like individual retirement accounts (IRAs), the individual owns his or her HSA, and thus the individual is required to maintain books and records with respect to the expense and claim the exclusion for a distribution from the HSA on their tax return. The determination of whether the distribution is for a qualified medical expense is subject to individual self-reporting and IRS enforcement.

Chairman's Mark

The additional tax on distributions from an HSA that are not used for qualified medical expenses is increased to 20 percent of the disbursed amount.

Effective Date

The change would be effective for disbursements made during tax years starting after December 31, 2010~~2009~~.

Limiting Flexible Spending Arrangements under Cafeteria Plans

Current Law

Exclusion from Income for Employer-Provided Health Coverage. The Code generally provides that employees are not taxed on (that is, may "exclude" from gross income) the value of employer-provided health coverage under an accident or health plan.[68] In addition, any reimbursements under an accident or health plan for medical care expenses for employees, their spouses, and their dependents generally are excluded from gross income.[69] The exclusion applies both to health coverage in the case in which an employer absorbs the cost of employees' medical expenses not covered by insurance (i.e., a self-insured plan) as well as in the case in which the employer purchases health insurance coverage for its employees. There is no limit on the amount of employer-provided health coverage that is excludible. A similar rule excludes employer provided health insurance coverage from the employees' wages for payroll tax purposes.[70]

Employers may also provide health coverage in the form of an agreement to reimburse medical expenses of their employees (and their spouses and dependents), not reimbursed by a health

[68] Sec. 106. Health coverage provided to active members of the uniformed services, military retirees, and their dependents are excludible under section 134. That section provides an exclusion for "qualified military benefits," defined as benefits received by reason of status or service as a member of the uniformed services and which were excludible from gross income on September 9, 1986, under any provision of law, regulation, or administrative practice then in effect.

[69] Sec. 105(b).

[70] Secs. 3121(a)(2), and 3306(a)(2). See also section 3231(e)(1) for a similar rule with respect to compensation for purposes of Railroad Retirement Tax.

insurance plan, through flexible spending arrangements which allow reimbursement for medical care not in excess of a specified dollar amount (either elected by an employee under a cafeteria plan or otherwise specified by the employer). Health coverage provided in the form of one of these arrangements is also excludible from gross income as employer-provided health coverage under an accident or health plan.[71]

Flexible Spending Arrangement Under a Cafeteria Plan. A flexible spending arrangement for medical expenses under a cafeteria plan (Health FSA) is an unfunded arrangement under which employees are given the option to reduce their current cash compensation and instead have the amount of the salary reduction made available for use in reimbursing the employee for his or her medical expenses.[72] The maximum amount of reimbursement from a Health FSA must be available at all times during the period of coverage.[73] Health FSAs are subject to the general requirements for cafeteria plans, including a requirement that amounts remaining under a Health FSA at the end of a plan year must be forfeited by the employee (referred to as the "use-it-or-lose-it rule").[74] A Health FSA is permitted to allow a grace period not to exceed two and one-half months immediately following the end of the plan year during which unused amounts may be used.[75] A Health FSA can also include employer flex-credits which are non-elective employer contributions that the employer makes for every employee eligible to participate in the employer's cafeteria plan, to be used only for one or more tax excludible qualified benefits (but not as cash or a taxable benefit).[76]

A flexible spending arrangement including a Health FSA (under a cafeteria plan) is generally distinguishable from other employer provided health coverage by the relationship between the value of the coverage for a year and the maximum amount of reimbursement reasonably available during the same period. A flexible spending arrangement for health coverage generally is defined as a benefit program which provides employees with coverage under which specific incurred medical care expenses may be reimbursed (subject to reimbursement maximums and other conditions) and the maximum amount of reimbursement reasonably available is less than 500 percent of the value of such coverage.[77]

Health Reimbursement Arrangement. Rather than offering a Health FSA through a cafeteria plan, an employer may specify a dollar amount that is available for medical expense reimbursement. These arrangements are commonly called Health Reimbursement Arrangements (HRAs). Some of the rules applicable to HRAs and Health FSAs are similar (e.g., the amounts in the arrangements can only be used to reimburse medical expenses and not for other purposes), but the rules are not identical. In particular, HRAs cannot be funded on a salary reduction basis

[71] Sec. 106.

[72] Sec. 125 and proposed Treas. Reg. sec. 1.125-5.

[73] Proposed Treas. Reg. 1.125-5(d).

[74] Sec. 125(d)(2) and proposed Treas. Reg.1.125-5(c).

[75] Notice 2005-42, 2005-1 C.B. 1204 and proposed Treas. Reg.1.125-1(e).

[76] Proposed Treas. Reg. sec. 1-125-5(b).

[77] Sec. 106(c)(2) and proposed Treas. Reg.1.125-5(a).

and the use-it-or-lose-it rule does not apply. Thus, amounts remaining at the end of the year may be carried forward to be used to reimburse medical expenses in following years.[78]

Chairman's Mark

Under the Chairman's Mark, salary reductions by an employee for a taxable year for purposes of coverage under a Health FSA under a cafeteria plan are limited to $2,500 ~~$2,000~~.[79] Thus, when an employee is given the option to reduce his or her current cash compensation and instead have the amount of the salary reduction made available for use in reimbursing the employee for his or her medical expenses, the amount of the reduction in cash compensation is limited to $2,500~~$2,000~~ for a taxable year. The Mark does not limit the exclusion for health coverage offered through an HRA.

Effective Date

The Chairman's Mark is effective for taxable year beginning after December 31, 2010~~2012~~.

Corporate Information Reporting

Current Law

Current law imposes a variety of information reporting requirements on participants in certain transactions.[80] These requirements are intended to assist taxpayers in preparing their income tax returns and to help the IRS determine whether such returns are correct and complete. One of the principal methods of improving tax compliance with respect to a form of income is to require information reporting by the third-party payer. When such payers are required to provide the IRS with information with respect to taxable payments, the likelihood that the recipient will properly include the payment in income greatly increases.[81]

The chief provision governing information reporting by payers requires an information return[82] by every person engaged in a trade or business who makes payments aggregating $600 or more in the course of that payer's trade or business to a single payee.[83] Payments subject to reporting include fixed or determinable income or compensation, and do not include payments for goods or certain enumerated types of payments that are subject to other specific reporting

[78] Guidance with respect to HRAs, including the interaction of FSAs and HRAs in the case of an individual covered under both, is provided in Notice 2002-45, 2002-2 C.B. 93.

[79] The proposal does not change the present law treatment as described in proposed Treas. Reg, 1.125-5 for dependent care flexible spending arrangements or an adoption assistance flexible spending arrangements.

[80] Secs. 6031 through 6060.

[81] See, U.S. Dept. of Treasury report, "Update on Reducing the Federal Tax Gap and Improving Voluntary Compliance", (July 8, 2009), available at www.irs.gov/pub/newsroom/tax_gap_report_-final_version.pdf.

[82] The information return is generally submitted electronically as a Form-1099 or Form-1096, although certain payments to beneficiaries or employees may require use of Forms W-3 or W-2, respectively. Treas. Reg. sec. 1.6041-1(a)(2).

[83] Sec. 6041(a).

requirements.[84] The payer is required to provide the recipient of the payment with an annual statement showing the aggregate payments made and contact information for the payer.[85] Payments to corporations generally, exempt organizations, governmental entities, international organizations, or retirement plans are excepted from reporting by regulation.[86]

Failure to comply with these requirements results in penalties, which may include a penalty for failure to file the information return,[87] and a penalty for failure to furnish payee statements[88] or failure to comply with other various reporting requirements.[89]

Chairman's Mark

The Chairman's Mark would modify the general information reporting requirement by eliminating the exception for payments to corporations. The class of payments with respect to which reporting is required would be clarified to include gross proceeds for both property and services. The present law regulatory exception for payments to exempt or governmental organizations, international organizations and retirement plans is not affected by this provision. In addition, the Secretary would be authorized to promulgate regulations necessary to avoid duplicative information reporting.

Effective Date

The Chairman's Mark is effective for payments made ~~in taxable years beginning~~ after December 31, 2011.

Requirements for Section 501(c)(3) Hospitals

Current Law

Tax Exemption. Charitable organizations, i.e., organizations described in section 501(c)(3), generally are exempt from Federal income tax, are eligible to receive tax deductible contributions,[90] have access to tax-exempt financing through state and local governments (described in more detail below),[91] and generally are exempt from state and local taxes. A charitable organization must operate primarily in pursuit of one or more tax-exempt purposes

[84] Sec. 6041(a) requires reporting as to "other fixed or determinable gains, profits, and income (other than payments to which section 6042(a)(1), 69044(a)(1), 6047(c), 6049(a) or 6050N(a) applies and other than payments with respect to which a statement is required under authority of section 6042(a), 6044(a)(2) or 6045)[.]" The payments thus excepted include most interest, royalties, and dividends.

[85] Sec. 6041(d).

[86] Treas. Reg. sec. 1-6041-3(p). Certain for-profit health provider corporations are not covered by this general exception, including those organizations providing billing services for such companies.

[87] Sec. 6721.

[88] Sec. 6722.

[89] Sec. 6723.

[90] Sec. 170.

[91] Sec. 145.

constituting the basis of its tax exemption.[92] The Code specifies such purposes as religious, charitable, scientific, educational, literary, testing for public safety, to foster international amateur sports competition, or for the prevention of cruelty to children or animals. In general, an organization is organized and operated for charitable purposes if it provides relief for the poor and distressed or the underprivileged.[93]

The Code does not provide a *per se* exemption for hospitals. Rather, a hospital qualifies for exemption if it is organized and operated for a charitable purpose and otherwise meets the requirements of section 501(c)(3).[94] The promotion of health has been recognized by the Internal Revenue Service (IRS) as a charitable purpose that is beneficial to the community as a whole.[95] It includes not only the establishment or maintenance of charitable hospitals, but clinics, homes for the aged, and other providers of health care.

Since 1969, the IRS has applied a "community benefit" standard for determining whether a hospital is charitable.[96] According to Revenue Ruling 69-545, community benefit can include, for example: maintaining an emergency room open to all persons regardless of ability to pay; having an independent board of trustees composed of representatives of the community; operating with an open medical staff policy, with privileges available to all qualifying physicians; providing charity care; and utilizing surplus funds to improve the quality of patient care, expand facilities, and advance medical training, education and research. Beginning in 2009, hospitals generally are required to submit information on community benefit on their annual information returns filed with the IRS.[97] Present law does not include sanctions short of revocation of tax-exempt status for hospitals that fail to satisfy the community benefit standard.

Although section 501(c)(3) hospitals generally are exempt from Federal tax on their net income, such organizations are subject to the unrelated business income tax on income derived from a trade or business regularly carried on by the organization that is not substantially related to the performance of the organization's tax-exempt functions.[98] In general, interest, rents, royalties, and annuities are excluded from the unrelated business income of tax-exempt organizations.[99]

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[92] Treas. Reg. sec. 1.501(c)(3)-1(c)(1).

[93] Treas. Reg. sec. 1.501(c)(3)-1(d)(2).

[94] Although nonprofit hospitals generally are recognized as tax-exempt by virtue of being "charitable" organizations, some might qualify for exemption as educational or scientific organizations because they are organized and operated primarily for medical education and research purposes.

[95] Rev. Rul. 69-545, 1969-2 C.B. 117; see also Restatement (Second) of Trusts secs. 368, 372 (1959); see Bruce R. Hopkins, *The Law of Tax-Exempt Organizations*, sec. 6.3 (8th ed. 2003) (discussing various forms of health-care providers that may qualify for exemption under section 501(c)(3)).

[96] Rev. Rul. 69-545, 1969-2 C.B. 117. From 1956 until 1969, the IRS applied a "financial ability" standard, requiring that a charitable hospital be "operated to the extent of its financial ability for those not able to pay for the services rendered and not exclusively for those who are able and expected to pay." Rev. Rul. 56-185, 1956-1 C.B. 202.

[97] IRS Form 990, Schedule H.

[98] Secs. 511-514.

[99] Sec. 512(b).

Charitable Contributions. In general, a deduction is permitted for charitable contributions, including charitable contributions to tax-exempt hospitals, subject to certain limitations that depend on the type of taxpayer, the property contributed, and the donee organization. The amount of deduction generally equals the fair market value of the contributed property on the date of the contribution. Charitable deductions are provided for income, estate, and gift tax purposes.[100]

Tax-exempt Financing. In addition to issuing tax-exempt bonds for government operations and services, state and local governments may issue tax-exempt bonds to finance the activities of charitable organizations described in section 501(c)(3). Because interest income on tax-exempt bonds is excluded from gross income, investors generally are willing to accept a lower pre-tax rate of return on such bonds than they might otherwise accept on a taxable investment. This, in turn, lowers the cost of capital for the users of such financing. Both capital expenditures and limited working capital expenditures of charitable organizations described in section 501(c)(3) of the Code generally may be financed with tax-exempt bonds. Private, non-profit hospitals frequently are the beneficiaries of this type of financing.

Bonds issued by state and local governments may be classified as either governmental bonds or private activity bonds. Governmental bonds are bonds the proceeds of which are primarily used to finance governmental functions or which are repaid with governmental funds. Private activity bonds are bonds in which the state or local government serves as a conduit providing financing to nongovernmental persons (e.g., private businesses or individuals). For these purposes, the term "nongovernmental person" generally includes the Federal government and all other individuals and entities other than states or local governments, including section 501(c)(3) organizations. The exclusion from income for interest on state and local bonds does not apply to private activity bonds, unless the bonds are issued for certain permitted purposes ("qualified private activity bonds") and other Code requirements are met.

Reporting and Disclosure Requirements. Exempt organizations are required to file an annual information return, stating specifically the items of gross income, receipts, disbursements, and such other information as the Secretary may prescribe.[101] Section 501(c)(3) organizations that are classified as public charities must file Form 990 (Return of Organization Exempt From Income Tax),[102] including Schedule A, which requests information specific to section 501(c)(3) organizations. Additionally, an organization that operates at least one facility that is, or is required to be, licensed, registered, or similarly recognized by a state s a hospital must complete Schedule H (Form 990), which requests information regarding charity care, community benefits, bad debt expense, and certain management company and joint venture arrangements of a hospital.

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[100] Secs. 170, 2055, and 2522, respectively.

[101] Sec. 6033(a). An organization that has not received a determination of its tax-exempt status, but that claims tax-exempt status under section 501(a), is subject to the same annual reporting requirements and exceptions as organizations that have received a tax-exemption determination.

[102] Social welfare organizations, labor organizations, agricultural organizations, horticultural organizations, and business leagues are subject to the generally applicable Form 990, Form 990-EZ, and Form 990-T annual filing requirements.

An organization described in section 501(c) or (d) generally is also required to make available for public inspection for a period of three years a copy of its annual information return (Form 990) and exemption application materials.[103] This requirement is satisfied if the organization has made the annual return and exemption application widely available (e.g., by posting such information on its website).[104]

Chairman's Mark

Additional Requirements for Section 501(c)(3) Hospitals.[105] The Chairman's Mark would establish new requirements applicable to section 501(c)(3) hospitals. The new requirements are in addition to, and not in lieu of, the requirements otherwise applicable to an organization described in section 501(c)(3). The requirements generally would apply to any section 501(c)(3) organization that operates at least one hospital facility. For purposes of the provision, a hospital facility generally includes: (1) any facility that is, or is required to be, licensed, registered, or similarly recognized by a state as a hospital; and (2) any other facility or organization the Secretary of the Treasury (hereinafter "Secretary"), in consultation with the Health and Human Services Secretary and after public comment, determines has the provision of hospital care as its principal purpose. An organization subject to the provision would be required to comply with the following requirements with respect to each hospital facility operated by such organization.

Community health needs assessment

Each hospital facility would be required to conduct a community health needs assessment at least once every three years and adopt an implementation strategy to meet the community needs identified through such assessment. The assessment may be based on current information collected by a public health agency or non-profit organizations and may be conducted together with one or more other organizations, including related organizations. The assessment process must take into account input from persons who represent the broad interests of the community served by the hospital, including those with special knowledge or expertise of public health issues. The hospital must disclose in its annual information report to the IRS (i.e., Form 990 and related schedules) how it is addressing the needs identified in the assessment and, if all identified needs are not addressed, the reasons why (e.g. lack of financial or human resources). Each hospital facility would be required to make the assessment widely available. Failure to complete a community needs assessment in any applicable three-year period would result in a penalty on the organization of up to $50,000. Failure to disclose how it is meeting needs identified in the assessment would be subject to existing incomplete return penalties.

Financial assistance policy

Each hospital facility would be required to adopt, implement, and widely publicize a written financial assistance policy. Each hospital facility would be required to adopt and implement a policy to provide emergency medical treatment to individuals. The policy must prevent

[103] Sec. 6104(d).

[104] Sec. 6104(d)(4); Treas. Reg. sec. 301.6104(d)-2(b).

[105] No inference is intended regarding whether an organization satisfies the present law community benefit standard.

discrimination in the provision of emergency medical treatment, including denial of service, against those eligible for financial assistance under the facility's financial assistance policy or those eligible for government assistance. The financial assistance policy should indicate the eligibility criteria for financial assistance and whether such assistance includes free or discounted care. For those eligible for discounted care, the policy should indicate the basis for calculating the amounts that will be billed to such patients. The policy should also indicate how to apply for such assistance. If hospital does not have a separate billing and collections policy, the financial assistance policy must also indicate what actions the hospital may take in the event of non-response or non-payment, including collections action and reporting to credit rating agencies.

Limitation on charges

Each hospital facility would be required to bill patients who qualify for financial assistance no more than the amount generally billed to insured patients. A hospital facility may not use gross charges(i.e., chargemaster rates), when billing individuals who qualify for financial assistance. Amounts billed to those who qualify for financial assistance may be based on either the best, or an average of the three best, negotiated commercial rates, or Medicare rates.

Collection processes

The Chairman's Mark provides that a hospital facility (or its affiliates) generally would be required to follow current Medicare law and regulations regarding collection of debts, but may not undertake certain extraordinary collection actions (even if otherwise permitted by law) against a patient without first making reasonable attempts to inform the patient about the hospital's financial assistance policy. Such extraordinary collection actions would include lawsuits, liens on residences, arrests, body attachments, or other similar collection processes. The Secretary shall issue guidance concerning what attempts to determine eligibility for financial assistance constitute "reasonable attempts." It is intended that for this purpose, "reasonable attempts" would include notification by the hospital of its financial assistance policy upon admission and in written and oral communications with the patient regarding the patient's bill, including invoices and telephone calls, before collection action or reporting to credit rating agencies is initiated.

Reporting and Disclosure Requirements. The Chairman's Mark would include new reporting and disclosure requirements. Under the Mark, the IRS would be required to review information about a hospital's community benefit activities (currently reported on Form 990, Schedule H) at least once every three years. Such review is intended to be similar to review of companies registered with the Securities and Exchange Commission.[106] The Mark would require each organization to which the Mark applies to make its audited financial statements widely available. If an organization or facility is included in consolidated financial statements, the consolidated entity's audited financial statements must also be widely available.

The Chairman's Mark would require the Secretary and the Secretary of Health and Human Services to annually report to Congress the levels of charity care, bad debt expenses, unreimbursed costs of means-tested government programs, and unreimbursed costs of non-

[106] See http://www.sec.gov/divisions/corpfin/cffilingreview.htm for SEC procedures.

means tested government programs incurred by private tax-exempt, taxable, and governmental hospitals as well as the cost of community benefit activities incurred by private tax-exempt hospitals. In addition, the Secretary, in conjunction with the Secretary of Health and Human Services, must conduct a study of the trends in these amounts with to the results of the study provided to Congress five years from date of enactment.

Effective Date

The Chairman's Mark would be effective for taxable years beginning after the date of enactment.

Annual Fee on Manufacturers and Importers of Branded Drugs

Current Law

There are two Medicare trust funds under current law, the Hospital Insurance (HI) fund and the Supplementary Medical Insurance (SMI) fund.[107] The HI trust fund is primarily funded through payroll tax on covered earnings. Employers and employees each pay 1.45 percent of wages, while self-employed workers pay 2.9 percent of a portion of their net earnings from self-employment. Other HI trust fund revenue sources include a portion of the Federal income taxes paid on Social Security benefits, and interest paid on the U.S. Treasury securities held in the HI trust fund. For the SMI trust fund, transfers from the general fund of the Treasury represent the largest source of revenue, but additional revenues include monthly premiums paid by beneficiaries, and interest paid on the U.S. Treasury securities held in the SMI trust fund.

Current law does not impose an annual sector fee creditable to the Medicare trust funds on companies that manufacture or import branded prescription drugs for sale in the United States.

Chairman's Mark

The Chairman's Mark would impose a fee on any person that manufactures or imports prescription drugs for sale in the United States. Fees collected would be credited to the Medicare SMI trust fund. The aggregate fee on the sector would be $2.3 billion payable annually beginning in 2010. Under the Mark, the aggregate fee would be apportioned among the covered entities each year based on each entity's relative market share of covered domestic sales for the prior year. The Mark would require that the fee be paid on an annual basis.

A "covered entity" would be defined under the Mark as any manufacturer or importer of certain drugs or biologics offered for sale under prescription in the United States and would include both domestic and foreign manufacturers and importers of such products. For purposes of the Mark, the term covered entity would include a parent, its affiliates, and other related parties.

Under the Chairman's Mark, "covered domestic sales" would include sales of branded prescription drugs made to or funded by "specified government programs." Branded

[107] See 2009 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, available at http://www.cms.hhs.gov/ReportsTrustFunds/downloads/tr2009.pdf.

prescription drugs would be defined to include single source or innovator multiple source drugs, but would exclude orphan drugs.[108]

"Specified government programs" are: Medicare, Medicaid, Veterans Administration and TRICARE. The Mark would provide that the Secretaries of the respective agencies responsible for administration of the specified government programs report to the Secretary of the Treasury the covered domestic sales of branded prescription drugs for each covered entity for the prior calendar year. The Secretary of the Treasury would establish individual assessments by determining the relative market share for each covered entity. A covered entity's relative market share would be the entity's total covered domestic sales from all specified government programs as a percentage of the total covered domestic sales from all specified government programs for all covered entities. In determining each covered entity's relative market share, covered domestic sales will be taken into account as follows: 0 percent of sales up to $5 million; ten percent of sales over $5 million and up to $125 million; 40 percent of sales over $125 million and up to $225 million; 75 percent of sales over $225 million and up to $400 million; and 100 percent of sales over $400 million. The fee assessed is determined by the covered entity's market share in the preceding calendar year.

The fees assessed under the Chairman's Mark would not be deductible for U.S. income tax purposes.

Effective Date

The Chairman's Mark would be effective for calendar year 2010 and thereafter, with respect to domestic covered sales in calendar year 2009 and thereafter.

Annual Fee on Manufacturers and Importers of Medical Devices

Current Law

Current law does not impose an annual sector fee on companies that manufacture or import medical devices for sale in the United States.

Chairman's Mark

The Chairman's Mark would impose a fee on any person that manufactures or imports medical devices offered for sale in the United States. The aggregate fee on the sector would be $4 billion payable annually beginning in 2010. Under the Mark, the aggregate fee would be apportioned among the covered entities each year based on each entity's relative market share of covered domestic sales for the prior year. The Mark would require that the fee be paid on an annual basis.

A "covered entity" would be defined under the Chairman's Mark as any manufacturer or importer of medical devices offered for sale in the United States and would include both

[108] Orphan drugs would be defined under the proposal as those drugs that would qualify the developer of such drug for the section 45C tax credit.

domestic and foreign manufacturers and importers of such products. For purposes of the Mark, the term covered entity would include a parent, its affiliates, and other related parties.

Under the Chairman's Mark, "covered domestic sales" would include U.S. sales of medical devices regulated by the Food and Drug Administration as a medical device[109] and subject to premarketing and postmarketing regulatory controls. The term would not include sales attributable to Class I products (as classified under the FDA product classification system) and would exclude sales of products intended for use on animals. The term would also not include sales of Class II products that are sold at retail for up to $100 per unit from the definition of covered domestic sales.

The Chairman's Mark would provide that the Secretary of the Treasury require any covered entity to file an annual report of its covered domestic sales for the prior calendar year. The Secretary would establish individual assessments by determining the relative market share for each covered entity. A covered entity's relative market share would be the entity's covered domestic sales as a percentage of the total reported covered domestic sales for all covered entities. In determining each covered entity's relative market share, covered domestic sales will be taken into account as follows: 0 percent of sales up to $5 million; 50 percent of sales over $5 million and up to $25 million; and 100 percent of sales over $25 million. The fee assessed is determined by the covered entity's market share in the preceding calendar year.

The fees assessed under the Chairman's Mark would not be deductible for U.S. income tax purposes.

The Secretary of the U.S. Department of Veterans Affairs shall review and report to Congress on the effect that the fees on branded drugs and medical devices have on (1) the cost of medical care provided to veterans and (2) veterans' access to medical devices and branded drugs.

Effective Date

The Chairman's Mark would be effective for calendar year 2010 and thereafter, with respect to domestic covered sales in calendar year 2009 and thereafter.

Annual Fee on Health Insurance Providers

Current Law

Current law provides special rules for determining the taxable income of insurance companies (subchapter L of the Code). Separate sets of rules apply to life insurance companies and to

[109] A product labeled, promoted or used in a manner that meets the definition in section 201(h) of the Federal Food, Drug, and Cosmetic Act. For these purposes, a device is "an instrument, apparatus, implement, machine, contrivance, implant, in vitro reagent, or other similar or related article, including any component, part, or accessory, which is (1) recognized in the official National Formulary, or the United States Pharmacopeia, or any supplement to them, (2) intended for use in the diagnosis of disease or other conditions, or in the cure, mitigation, treatment, or prevention of disease, in man or other animals, or (3) intended to affect the structure or any function of the body of man or other animals, and which does not achieve its primary intended purposes through chemical action within or on the body of man or other animals and which is not dependent upon being metabolized for the achievement of its primary intended purposes."

property and casualty insurance companies. Insurance companies are subject to Federal income tax at regular corporate income tax rates.

An insurance company that provides health insurance is subject to Federal income tax as either a life insurance company or as a property insurance company, depending on its mix of lines of business and on the resulting portion of its reserves that are treated as life insurance reserves. For Federal income tax purposes, an insurance company is treated as a life insurance company if the sum of its (1) life insurance reserves and (2) unearned premiums and unpaid losses on noncancellable life, accident or health contracts not included in life insurance reserves, comprise more than 50 percent of its total reserves.[110]

Some insurance providers may be exempt from Federal income tax under section 501(a) if specific requirements are satisfied. Section 501(c)(8), for example, describes certain fraternal beneficiary societies, orders, or associations operating under the lodge system or for the exclusive benefit of their members that provide for the payment of life, sick, accident, or other benefits to the members or their dependents. Section 501(c)(9) describes certain voluntary employees' beneficiary associations that provide for the payment of life, sick, accident, or other benefits to the members of the association or their dependents or designated beneficiaries. Section 501(c)(12)(A) describes certain benevolent life insurance associations of a purely local character. Section 501(c)(15) describes certain small non-life insurance companies with annual gross receipts of no more than $600,000 ($150,000 in the case of a mutual insurance company). Section 501(c)(26) describes certain membership organizations established to provide health insurance to certain high-risk individuals. Section 501(c)(27) describes certain organizations established to provide workmen's compensation insurance.

An excise tax applies to premiums paid to foreign insurers and reinsurers covering U.S. risks.[111] The excise tax is imposed on a gross basis at the rate of one percent on reinsurance and life insurance premiums, and at the rate of four percent on property and casualty insurance premiums. The excise tax does not apply to premiums that are effectively connected with the conduct of a U.S. trade or business or that are exempted from the excise tax under an applicable income tax treaty. The excise tax paid by one party cannot be credited if, for example, the risk is reinsured with a second party in a transaction that is also subject to the excise tax.

Current law does not impose an annual sector fee on U.S. health insurance providers.

Chairman's Mark

Under the Chairman's Mark, an annual fee applies to any U.S. health insurance provider with respect to health insurance.

A U.S. health insurance provider includes any company subject to Federal income tax as an insurance company under part I or part II of subchapter L of the Code, as well as any organization exempt from Federal income tax under section 501(a) of the Code that provides insurance. In addition, a U.S. health insurance provider includes (1) any insurer that sells

[110] Sec. 816(a).

[111] Secs. 4371-4374.

employer-sponsored group health care coverage to employees that are either U.S. citizens or are employed in the United States, and (2) any insurer that sells health care insurance to individuals or groups of individuals (whether or not U.S. citizens) in the United States. A Federal, state, or other governmental entity is not a U.S. health insurance provider. However, a company or organization that underwrites policies for government-funded insurance is a U.S. health insurance provider for purposes of the Mark. An employer that self-insures its employees' health risks is not considered a U.S. health insurance provider for purposes of the Mark.

The aggregate annual fee for all U.S. health insurance providers is $6.7 billion. Under the Chairman's Mark, the aggregate fee is apportioned among the providers based on relative market share.

A U.S. health insurance provider is required to file with the Treasury Department an annual report of the amount of its "net premiums written" with respect to health insurance for the prior calendar year. The Secretary of the Treasury establishes individual assessments by determining the relative market share for each U.S. health insurance provider. A company's or organization's relative market share is the U.S. health insurance provider's net premiums written with respect to health insurance as a percentage of the total reported net premiums written with respect to health insurance for all U.S. health insurance providers. The fee assessed is determined by the provider's market share in the preceding calendar year.

"Net premiums written" with respect to health insurance means the company's or organization's gross amount of health insurance and health reinsurance premiums, reduced by premiums for health reinsurance ceded (taking into account ceding commissions).

The fees assessed under the Chairman's Mark would not be deductible for U.S. income tax purposes.

Effective Date

The Chairman's Mark is effective for calendar year 2010 and thereafter, with respect to health insurance premiums written in 2009 and thereafter.

~~**Annual Fee on Clinical Laboratories**~~

~~*Current Law*~~

~~Under current law, clinical laboratories are subject to Federal income and employment taxes. Current law does not impose an annual sector fee on clinical laboratories operating in the United States.~~

~~*Chairman's Mark*~~

~~The Chairman's Mark would impose a fee on any covered entity offering clinical laboratory services in the United States. The aggregate fee on the clinical laboratory sector would be $750 million annually, beginning in 2010. Under the Mark, the aggregate fee would be apportioned among the covered entities each year based on each entity's relative market share of covered~~

~~domestic laboratory service revenue for the prior year. The Mark would require that the fee be paid on an annual basis.~~

~~A "covered entity" would be defined under the Chairman's Mark as any company that provides services for the biological, microbiological, serological, chemical, immuno-hematological, hematological, biophysical, cytological, pathological, or other examination of materials derived from the human body for the purpose of providing information for the diagnosis, prevention, or treatment of any disease or impairment of, or the assessment of the health of, human beings.~~[112] ~~For purposes of the Mark, the term covered entity would include a parent, its affiliates, and other related parties.~~

~~Under the Chairman's Mark, "covered domestic laboratory service revenue" would include revenue resulting from providing laboratory services in the United States. Covered domestic laboratory service revenue would not include revenue from laboratory services performed by a hospital for inpatients of the hospital.~~

~~The Chairman's Mark would provide that the Secretary of the Treasury require any covered entity to file an annual report of its covered domestic laboratory service revenue for the prior calendar year. The Secretary would establish individual assessments by determining the relative market share for each covered entity. A covered entity's relative market share would be the entity's covered domestic laboratory service revenue as a percentage of the total reported covered domestic laboratory service revenue for all covered entities. In determining each covered entity's relative market share, covered domestic laboratory service revenue will be taken into account as follows: zero percent of revenues up to $500,000 and 100 percent of revenues over $500,000. The fee assessed is determined by the covered entity's market share in the preceding calendar year.~~

~~The fees assessed under the Chairman's Mark would not be deductible for U.S. income tax purposes.~~

~~*Effective Date*~~

~~The Chairman's Mark would be effective for calendar year 2010 and thereafter, with respect to covered domestic laboratory service revenue in 2009 and thereafter.~~

Repeal Business Deduction for Federal Subsidies for Certain Retiree Prescription Drug Plans

Current Law

In General. Sponsors[113] of qualified retiree prescription drug plans are eligible for subsidy payments from the Secretary of Health and Human Services with respect to a portion of each

~~[112] 42 USC Sec. 263(a).~~

[113] The identity of the plan sponsor is determined in accordance with section 16(B) of the Employee Retirement Income Security Act of 1974 ("ERISA"), except that for cases where a plan is maintained jointly by one employer and an employee organization, and the employer is the primary source of financing, the employer is the plan sponsor.

qualified covered retiree's gross covered prescription drug costs ("qualified retiree prescription drug plan subsidy").[114] A qualified retiree prescription drug plan is employment-based retiree health coverage[115] that has an actuarial value at least as great as the Medicare Part D standard plan for the risk pool and that meets certain other disclosure and recordkeeping requirements.[116] These qualified retiree prescription drug plan subsidies are excludible from the plan sponsor's gross income for the purposes of regular income tax and alternative minimum tax (including the adjustment for adjusted current earnings).[117]

Subsidy Amounts. For each qualifying covered retiree enrolled for a coverage year in a qualified retiree prescription drug plan, the qualified retiree prescription drug plan subsidy is equal to 28 percent of the portion of the allowable retiree costs paid by the plan sponsor on behalf of the retiree that exceed the cost threshold but do not exceed the cost limit. A qualifying covered retiree is an individual who is eligible for Medicare but not enrolled in either a Medicare Part D prescription drug plan (PDP) or a Medicare Advantage-Prescription Drug (MA-PD) plan, but who is covered under a qualified retiree prescription drug plan. Allowable retiree costs generally are, with respect to prescription drug costs under a qualified retiree prescription drug plan, the part of the actual costs paid by the plan sponsor on behalf of a qualifying covered retiree under the plan.[118] Both the threshold and limit are indexed to the percentage increase in Medicare per capita prescription drug costs; the cost threshold was $250 in 2006 ($295 in 2009) and the cost limit was $5,000 in 2006 ($6,000 in 2009).[119]

Expenses Relating to Tax Exempt Income. In general, no deduction is allowed under any provision of the Code for any expense or amount which would otherwise be allowable as a deduction if such expense or amount is allocable to a class or classes of exempt income.[120] Thus, expenses or amounts paid or incurred with respect to the subsidies excluded from income under

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[114] Sec. 1860D-22 of the Social Security Act (SSA), 42 USC Sec. 1395w-132.

115 Employment-based retiree health coverage is health insurance coverage or other coverage of health care costs (whether provided by voluntary insurance coverage or pursuant to statutory or contractual obligation) for Medicare Part D eligible individuals (their spouses and dependents) under group health plans based on their status as retired participants in such plans. For purposes of the subsidy, group health plans generally include employee welfare benefit plans (as defined in section 607(1) of ERISA) that provide medical care (as defined in section 213(d)), Federal and State governmental plans, collectively bargained plans, and church plans.

[116] In addition to meeting the actuarial value standard, the plan sponsor must also maintain and provide the Secretary of HHS access to records that meet the Secretary of HHS's requirements for purposes of audits and other oversight activities necessary to ensure the adequacy of prescription drug coverage and the accuracy of payments made to eligible individuals under the plan. In addition, the plan sponsor must disclose to the Secretary of HHS whether the plan meets the actuarial equivalence requirement and if it does not, must disclose to retirees the limitations of their ability to enroll in Medicare Part D and that non-creditable coverage enrollment is subject to penalties such as fees for late enrollment. 42 USC 1395w-132(a)(2).

[117] Sec. 139A.

[118] For purposes of calculating allowable retiree costs, actual costs paid are net of discounts, chargebacks, and average percentage rebates, and exclude administrative costs.

[119] Davis, Patricia, M. "Medicare Part D Prescription Drug Benefit," Congressional Research Service. June 1, 2009. The cost threshold is indexed in the same manner as the Medicare Part D annual deductible, while the cost limit is indexed in the same manner as the Medicare Part D annual out-of-pocket threshold.

[120] Sec. 265(a) and Treas. Reg. sec. 1.265-1(a).

section 139A would not be deductible, but a provision under section 139A specifies that the exclusion of the qualified retiree prescription drug plan subsidy from income is not taken into account in determining whether any deduction is allowable with respect to any covered retiree prescription drug costs that are taken into account in determining the subsidy payment. Therefore, under current law a taxpayer may claim a business deduction for covered retiree prescription drug expenses incurred notwithstanding that the taxpayer excludes from income qualified retiree prescription drug plan subsidies allocable to such expenses.

Chairman's Mark

The Chairman's Mark eliminates the rule that the exclusion for subsidy payments is not taken into account for purposes of determining whether a deduction is allowable with respect to retiree prescription drug expenses. Thus, under the Mark, the amount otherwise allowable as a deduction for retiree prescription drug expenses is reduced by the amount of the excludible subsidy payments received.

Effective Date

The Chairman's Mark is effective for taxable years beginning after December 31, 2010.

Modify the Itemized Deduction for Medical Expenses

Current Law

Regular Income Tax. For regular income tax purposes, individuals are allowed an itemized deduction for unreimbursed medical expenses, but only to the extent that such expenses exceed 7.5 percent of adjusted gross income ("AGI").[121]

This deduction is available both to insured and uninsured individuals; thus, for example, an individual with employer-provided health insurance (or certain other forms of tax-subsidized health benefits) may also claim the itemized deduction for the individual's medical expenses not covered by that insurance if the 7.5 percent AGI threshold is met. The medical deduction encompasses health insurance premiums to the extent they have not been excluded from taxable income through the employer exclusion or self-insured deduction.

Alternative Minimum Tax. For purposes of the alternative minimum tax ("AMT"), medical expenses are deductible only to the extent that they exceed 10 percent of AGI.

Chairman's Mark

This provision increases the threshold for the deduction from 7.5 percent of AGI to 10 percent of AGI for regular income tax purposes. Individuals age 65 and older (and their spouses) are exempt from the increased threshold and would continue to be eligible to claim the Section 213 deduction if their medical expenses exceed 7.5 percent of AGI. The proposal does not change the AMT treatment of the itemized deduction for medical expenses.

[121] Sec. 213.

The proposal is effective for taxable years beginning after December 31, 2012. The exception for individuals age 65 and older (and their spouses) would apply to taxable years beginning after December 31, 2012 and ending before January 1, 2017.

Credit to Encourage New Therapies

Modeled after existing tax credits for investments in qualifying advanced energy projects (IRC §48C), the provision 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 provision 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.

Executive Compensation

The Chairman's Mark 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 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 section414(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.

Failsafe

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.

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Before the Finance Committee can vote on final passage of ―America's Healthy Future Act of 2009, the conceptual language in plain English and a complete cost analysis by the Congressional Budget Office must be publically available on the Finance Committee's website ahead of the vote.