BlueCross BlueShield Association

DRAFT
4/22/10

Detailed Summary

Patient Protection and Affordable Care Act (PPACA), P.L. 111-148
Health Care and Education Reconciliation Act (HCERA), P.L. 111-152

Dates of Enactment: President Obama signed the Patient Protection and Affordable Care Act (PPACA), P.L. 111-148, on March 23, 2010. This generally is the date referenced when provisions take effect on enactment or at a certain time after enactment. The package of "fixes," the Health Care and Education Reconciliation Act (HCERA), P.L. 111-152, was signed on March 30, 2010.

Legal Advice and Compliance Disclosure: The information provided in this document is not intended to advise your Plan how it may comply with any provisions of the referenced legislation or related legislation or regulations, nor it is otherwise intended to impart any legal advice. If you have any questions about how to comply with this or any other law or regulation, we recommend that you consult with your Plan's legal department.

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NEAR-TERM INSURANCE MARKET REFORMS	
Annual/Lifetime Limits	• **Lifetime Limits.** Prohibits lifetime dollar limits on essential benefits, effective for plan years starting 6 months after enactment. Applies to all markets, including grandfathered group and individual plans. • **Annual Limits.** Prohibits annual dollar limits on essential benefits, effective for plan years starting 6 months after enactment. Before 1/1/14, restricted annual limits may be permitted, as determined by HHS, to ensure minimal impact on premiums. Effective 1/1/14, prohibits annual limits on the dollar value of all essential benefits. Applies to new plans in all markets and to grandfathered group plans. • "Per beneficiary" annual or lifetime limits are permissible for items and services that are not part of the essential health benefits. (PPACA §§ 1001, 10101(a); HCERA § 2301(a)(4); PHSA § 2711)
Rescissions	Permits rescissions only for fraud or intentional misrepresentation of material fact and with prior notice to the enrollee. Applies to all markets, including grandfathered plans. Effective for plan years starting 6 months after enactment. (PPACA § 1001; HCERA § 2301(a)(4)(A)(iii); PHSA § 2712)
Preventive Health Services	• Requires coverage of the following preventive health services with no cost-sharing: o Evidence-based items/services with a rating of "A" or "B" in the current recommendations of the U.S. Preventive Services Task Force (USPSTF). (Current USPSTF recommendations for breast cancer screening, mammography and prevention will be considered the most current, other than those issued in or around 11/09.) o Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC). o Evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA) for infants, children and adolescents. o With respect to women, additional preventive care and screenings provided for in guidelines supported by HRSA. • Directs HHS to establish a minimum interval – of no less than one year – between the date on which a recommendation or guideline is issued and the plan year with respect to which the requirement is effective. • Permits HHS to develop guidelines permitting plans to utilize "value-based insurance designs." • Applies to all markets (but not grandfathered plans). Effective for plan years starting 6 months after enactment. (PPACA § 1001; PHSA § 2713)
Dependent Coverage	• Requires plans that provide dependent coverage to continue to make coverage available until an adult child (married or unmarried) turns 26. • Does not require plans to make coverage available to a child of a child receiving dependent coverage. • Directs HHS to define by regulation the dependents to which this applies. • Applies to all markets. Applies to grandfathered group and individual plans. For grandfathered group health plans, not applicable prior to 1/1/14 if the dependent is eligible to enroll in an employer-based plan. • Effective for plan years starting 6 months after enactment. (PPACA § 1001; HCERA §§ 2301(a)(4)(A), 2301(b); PHSA § 2714)
Uniform Explanation of Coverage and Transparency Requirements	• **Uniform Coverage Summaries** o No later than 24 months after enactment, requires plans to provide a summary of benefits and coverage explanation that meets standards developed by HHS. Such documents must be provided at the time of application or enrollment and at policy/certificate delivery. o *Standards Development.* Directs HHS, within 12 months of enactment, to develop such standards, in consultation with the NAIC and a working group composed of representatives of health insurance-related consumer advocacy organizations, health insurers, health professionals, patient advocates and other qualified individuals. Provides for periodic reviews and updates of such standards. o *Standards* ▪ Must be in a uniform format no longer than 4 pages and using print no smaller than 12-point font. ▪ Must be presented in a culturally and linguistically appropriate manner and using terminology that average enrollees can understand. ▪ Contents. Must include: • Uniform definitions of standard insurance and medical terms.

	- **Insurance related terms** to be defined include at least: premium; deductible; coinsurance; copayment; OOP limit; preferred and non-preferred provider; out-of-network copayments; UCR fees; excluded services; and grievance and appeals. - **Medical terms** to be defined include at least: hospitalization; hospital outpatient care; emergency room care; physician services; Rx drug coverage; DME; home health care; skilled nursing care; rehabilitation services; hospice services; and emergency medical transportation. • A description of coverage, including cost-sharing for each of the categories of essential benefits (and other benefits identified by HHS). • Exceptions, reductions and limitations on coverage. • Cost-sharing provisions. • Renewability and continuation of coverage provisions. • A "coverage facts label" that includes examples to illustrate common benefits scenarios, including pregnancy or chronic medical conditions and related cost-sharing (with scenarios based on recognized clinical practice guidelines). • A statement of whether the plan provides minimum essential coverage and ensures that the plan's share of total allowed costs is not less than 60%). • A statement that the outline is a summary of the policy and that the coverage document itself should be consulted for contractual provisions. • A contact number for consumers and an Internet web address where a copy of the actual coverage policy or certificate of coverage can be reviewed and obtained. o *Notice of Mid-Year Changes.* Requires at least 60 days notice in advance of any material modification in plan or coverage not reflected in most recent summary. o Allows summaries to be paper or electronic. o Preempts related state standards that provide less information to consumers than is required under this provision. o Provides for penalties for willfully not providing of up to $1,000 per failure. o Applies to all markets, including to grandfathered plans. Effective 24 months after enactment. (PPACA §§ 1001, 10103(d)(3); PHSA § 2715)
Transparency/ Disclosure Requirements	Requires plans in all markets to comply with transparency and disclosure requirements applicable to Exchange-participating plans: o *Transparency in Coverage.* Submit the following information to HHS and the state insurance commissioner, and make it available to the public: claims payment policies and practices, periodic financial disclosures, enrollment/disenrollment data, data on claims denial and rating practices, information on cost-sharing and payments for non-network coverage and information on enrollee rights. o *Cost-Sharing Transparency*. Permit individuals to learn the amount of cost-sharing with respect to specific items or services by a participating provider upon request; at minimum, such information must be available through an Internet website. Effective for plan years beginning on or after 6 months after enactment. Applies to plans in all markets (but not to grandfathered plans). (PPACA §§ 10101(c), 10104(f); PHSA § 2715A)
Salary Non-Discrimination	Requires insured group health plans (other than grandfathered plans) to meet current IRC § 105(h)(2) requirements prohibiting discrimination in favor of highly compensated individuals in terms of eligibility and benefits. Effective for plan years starting 6 months after enactment. (PPACA §§ 1001, 10101(d); PHSA § 2716)
Quality of Care Reporting	• **Quality Reporting.** Requires all group and individual plans (except grandfathered plans) to comply with annual quality reporting requirements to be established by HHS within 2 years of enactment. Plans must submit annual reports to HHS and to enrollees during each open enrollment period on whether the plan's benefits meet the elements of a required quality program, and HHS must make the reports available through an Internet website. Allows HHS to develop penalties for noncompliance. Also allows HHS to provide exceptions to the reporting requirements for plans that "substantially meet the goals" of this provision. Required elements of a quality program: o *Improve health outcomes* through activities such as quality reporting, effective case management, care coordination, case management and medication and care compliance initiatives, including through the use of the medical home model. o Implement activities to *prevent hospital readmissions* through a hospital discharge program that includes patient-centered education and counseling, comprehensive discharge planning and post-discharge reinforcement by an appropriate health professional.

	o Implement activities to *improve patient safety and reduce medical errors*, through use of best clinical practices, evidence-based medicine and HIT. o *Implement wellness and prevention programs*, which may include the following: ▪ Smoking cessation or weight management ▪ Stress management ▪ Physical fitness or nutrition ▪ Heart disease or diabetes prevention ▪ Healthy lifestyle support • NOTE: This section does not require that plans report outcomes, only that they report that they support these quality-related activities. A separate section, PPACA §10329, directs HHS to develop a method to assess health plan value. • **Study and Report.** Within 180 days of the promulgation of the HHS regulations, requires the GAO to review the regulations, and report to Congress on the impact of these activities on the quality and cost of health care. (PPACA § 1001; PHSA § 2717)
Medical Loss Ratios	• *Loss Ratio Reporting.* Requires loss ratio reporting for plan years starting 6 months after enactment. Makes required reports available on the HHS website. • *Rebates.* Requires rebates for MLRs below required levels starting in 2011. Sets MLRs of 80% in the individual and small group markets and 85% in the large group market. Permits states to set higher percentages. Allows HHS to set an MLR below 80% for the individual market in particular states if HHS determines that a higher level could "destabilize" the individual market in that state. Also allows HHS to adjust the individual market if appropriate on account of volatility due to the establishment of state Exchanges. • *MLR Calculation* o Requires plans to calculate the ratio of total premium revenue (after accounting for risk adjustment, reinsurance and risk corridor payments) spent on: ▪ "Reimbursement for clinical services" and costs for "activities that improve health care quality" to ▪ All other non-claims costs, excluding federal and state taxes and licensing or regulatory fees. o By 12/31/10, requires the NAIC (subject to certification by HHS) to establish uniform definitions of these terms and standardized methodologies for calculating MLRs, taking into account the special circumstances of smaller plans, different types of plans and newer plans. o Bases calculations on 3 years of data starting in 2014. • Applies to all insured plans (individual and group), including grandfathered plans. (PPACA §§ 1001, 10101(f), 10103(d)(3); PHSA § 2718)
Patient Protections	
- PCPs	Requires plans that require or provide for designation of a participating primary care provider (PCP) to permit individuals to select any participating PCP available to accept such individuals. Applies to all markets (but not to grandfathered plans). Effective for plan years starting 6 months after enactment. (PPACA § 10101(h); PHSA § 2719A(a))
- Access to Pediatric Care	Requires plans that require or provide for designation of a participating primary care provider (PCP) for a child to permit individuals to select any participating pediatrician. Applies to all markets (but not to grandfathered plans). Effective for plan years starting 6 months after enactment. (PPACA § 10101(h); PHSA § 2719A(c))
- Emergency Care	• Requires plans to cover emergency services without prior authorization or regardless of whether the provider participates in the plan's network. • Requires equivalent cost-sharing for network and non-network providers, and prohibits any limitations more restrictive than those imposed on services provided by network providers. • Uses a "prudent layperson" definition of emergency medical condition. • Applies to all markets (but not to grandfathered plans). • Effective for plan years starting 6 months after enactment. (PPACA § 10101(h); PHSA § 2719A(b))
- Direct Access to	Requires plans in all markets (but not grandfathered plans) to provide direct access to participating OB/GYNs. Effective for plan years starting 6 months after

OB/GYNs	enactment. (PPACA § 10101(h); PHSA § 2719A(d))
- Appeals	• **Internal Appeals** o Requires group plans to have in effect an internal claims and appeals process that initially incorporates the existing DOL claims and appeals procedures, updated as necessary with any standards established by DOL. Requires nongroup plans to have in effect an internal claims and appeals process that initially incorporates claims and appeals procedures under existing law, updated in accordance with any standards set by HHS for this market. o Provide notice to enrollees of available internal and external appeals processes, and the availability of any applicable office of health insurance consumer assistance or ombudsman to help enrollees with the appeals processes. o Allow enrollees to review their files, present evidence and testimony and receive continued coverage pending the appeals outcome. • **External Review.** Requires plans in all markets to: o Comply with state external review requirements that, at minimum, include the protections in the NAIC's External Review Model Act; or o For states without an external review process that meets these requirements and for self-funded plans, implement an external review process that meets minimum standards established by HHS through guidance. • Permits HHS to deem an external review process of a group plan or insurer in operation as of the date of enactment as compliant with these requirements. • Applies to insured plans in all markets and self-funded plans (but not to grandfathered plans). • Effective for plan years starting 6 months after enactment. (PPACA §§ 1001, 10101(g); PHSA § 2719)
Consumer Information	• **Consumer Information.** Provides state grants to establish, expand or support offices of health insurance consumer assistance or health insurance ombudsman programs. o *Eligibility.* To be eligible for a grant, a state must designate an independent office of health insurance consumer assistance or an ombudsman that receives and responds to inquiries and complaints concerning health insurance coverage with respect to federal health insurance requirements and under state law. o *Duties.* Such office or ombudsman must: 1) help file complaints and appeals and provide information about the external appeal process; 2) collect, track and quantify problems and inquiries; 3) educate consumers on their rights and responsibilities; 4) help with enrollment in coverage by providing information, referral and assistance; and 5) resolve problems with obtaining premium tax credits. o *Data Collection and Secretarial Action.* Requires such office or ombudsman to collect and report data to HHS on the types of problems and inquires they receive from consumers. Directs HHS to use such data to identify areas where more enforcement action is needed and to share the data with state insurance regulators and Labor and Treasury for their enforcement activities. o *Funding.* Appropriates $30 million for the first fiscal year and "such sums as may be necessary" for subsequent years. o *Effective Date.* Enactment. (PPACA § 1002; PHSA § 2793) • **Hospital Charge Data.** Requires all hospitals to disclose annually a list of its standard charges for items and services, including for Medicare DRGs. Effective 6 months after enactment. (PPACA § 10101(f); PHSA § 2718(e))
Rate Review	• **Rate Review.** Beginning with the 2010 plan year, requires HHS (in conjunction with states) to establish a process for review of unreasonable premium increases. Requires: o Insurers to submit a justification for increases prior to implementation and post such information on their websites. o State insurance commissioners to provide HHS with information about trends in premium increases in different rating areas and make recommendations as to whether issuers should be excluded from Exchange participation due to patterns of excessive or unjustified premium increases. o Starting with plan years beginning in 2014, requires HHS (in conjunction with states) to monitor premium increases both inside and outside of Exchanges. o Direct states, in considering whether to allow large employers to purchase coverage through the Exchange (see PPACA § 1312(f)(2)(B)), to take into account any excess of premium growth outside of the Exchange as compared to premium growth inside the Exchange. o Provides $250 million in state grants during 2010-2014 to help states carry out this provision. Limits grants to individual states to no less than $1

	million and no more than $5 million for a grant year. o Applies to all individual and group health insurance coverage. Effective for plan years beginning 6 months after enactment. (PPACA § 1003; PHSA § 2794) • Establishes **Medical Reimbursement Data Centers** at academic or other nonprofit entities to collect medical reimbursement data from insurers, to organize and analyze such information and to make it available to insurers, providers, researchers, policymakers and the general public. Directs such Centers to: o Develop (and update) fee schedules and other database tools that reflect market rates for medical services and geographic differences in those rates. o Make health care cost information available to the public through an Internet website. o Publish information on methodologies used to analyze health charge data and make such data available to researchers and policymakers. o Specifically notes that insurers are not required to provide data to these Centers. (PPACA § 10101(i))
High Risk Pools	Directs HHS to establish temporary, national high risk pool program, within 90 days after enactment. Allows states or non-profit entities to be given responsibility to administer the program. Sunsets the program on 1/1/14, when the state Exchanges become effective. • **Risk Pool Requirements.** Requires qualified high risk pools to: o Provide coverage to all eligible individuals without any preexisting condition restrictions. o Provide coverage for at least 65% of plan costs. o Limit OOP costs to those for HDHPs. o Require premiums to be set at 100% of standard rates, and allow premiums to vary only according to the adjusted community rating rules under this bill (PPACA § 1201; PHSA § 2701), except that rates can vary by age in a range of 4:1 (vs. 3:1 under PPACA § 2701). • **Eligibility.** Defines eligible individuals as those without creditable coverage in past 6 months and who have a pre-existing condition as determined by HHS guidelines. • **Anti-Dumping.** Requires HHS to establish criteria for determining whether insurers and group health plans have discouraged individuals from remaining enrolled in prior coverage based on health status. Requires issuers and employers who engage in such behavior to reimburse the program for such individuals who subsequently enroll in the program. Such determinations are to be based on criteria established by HHS and must include at least the following circumstances: o Offering of money or other financial considerations for disenrolling from prior coverage. o In cases where the premium for prior private coverage exceeds the premium under the new HHS program: 1) the prior coverage is a policy no longer being actively marketed by the insurer; or 2) the prior coverage is one for which duration or health status can be considered in determining renewal premiums. • **Oversight.** Requires HHS to establish an appeals process to enable individuals to appeal determinations under this provision as well as procedures to protect against fraud and abuse. • **Funding.** Appropriates $5 billion to pay claims and administrative costs of the high risk pool that are in excess of premiums collected. Allows HHS to stop taking applications for participation in the program to comply with this funding limit. Also provides for HHS to make "such adjustments as necessary" to eliminate any remaining deficit after such funds are spent. • **Transition to Exchange.** Requires HHS to develop procedures to provide for the transition of program enrollees into plans offered through an Exchange, including allowing for an extension of coverage after the risk pool provision is terminated, if HHS deems this necessary to avoid a lapse in coverage. • **Relation to State Law.** Supersedes existing state laws or regulations (other than state licensing laws or laws relating to plan solvency) with respect to qualified high risk pools established in accordance with this provision. (PPACA § 1101)
Early Retiree Reinsurance	Directs HHS to establish a temporary reinsurance program within 90 days of enactment to assist employment-based plans with the costs of providing health benefits to early retirees and their dependents. Sunsets the program on 1/1/14. • **Eligible Employers.** Eligible retirees must be 55 or older, not Medicare-eligible and not active employees. • **Eligible Coverage.** To participate in the program, employment-based health plans must: o Implement programs/procedures to generate cost-savings for individuals with chronic and high-cost conditions.

	o Provide documentation of the actual cost of medical claims involved. o Submit an application and be certified by HHS. • **Payments/Claims** o Reimburses 80% of claims between $15,000 and $90,000, subject to annual increases based on the medical care component of the CPI. o Plans must submit claims charges (including both plan share and enrollee cost-share). Requires claims to be based on the actual amount expended by the plan, taking into account negotiated price concessions (e.g., discounts, rebates, etc.). • **Use of Payments.** Requires reinsurance payments be used to lower costs for the plan, including employer costs and retiree costs (e.g., premiums, cost-sharing). Payments cannot be sued as general revenues for employers. Direct HHS to monitor the use of such payments by employers. • **Other.** Requires HHS to: 1) establish an appeals process to permit employment-based plans to appeal claims determinations; 2) establish procedures to protect against fraud and abuse; and 3) conduct annual audits of claims data. • **Funding.** Appropriates $5 billion for this provision. Allows HHS to stop taking applications for participation in the program to comply with this funding limit. (PPACA §§ 1102, 10102(a))
Internet Portal	**Internet Portal.** Requires HHS (in consultation with states) to establish a mechanism (including an Internet website) through which individuals and small employers can identify affordable coverage options, effective by 7/1/10. • *Required Information.* Requires websites to provide information on at least the following coverage options (to the extent practicable): private insurance coverage; Medicaid and CHIP coverage; state high risk pool coverage; coverage under the new high risk pool program; and coverage within the small group market, including reinsurance for early retirees (PPACA § 1102) and small business tax credits (PPACA § 1421). • *Standardized Formats.* Directs HHS to develop a standardized format for presenting this information within 60 days of enactment. Requires such format to require information on MLRs, eligibility, availability, premiums and cost-sharing, and to be consistent with the standards adopted for uniform coverage explanations under PHSA § 2715. Permits HHS to contract out this requirement. (PPACA §§ 1103(a), 10102(b))
Children's Pre-Ex Exclusion Periods	No pre-ex exclusion periods for individuals under age 19. Applies to all markets and grandfathered group health plans. Effective plan years beginning 6 months after date of enactment. (PPACA § 10103(e)(2)) (In a 3/29/10 letter, HHS announced its intent to issue regulations clarifying: (1) children with pre-existing conditions could not be denied access to their parent's coverage; and (2) insurers would not be allowed to insure a child, but exclude coverage for the child's pre-existing condition.)
Conforming Amendments to PHSA, ERISA, and IRC	Makes a number of conforming amendments throughout the PHSA to further consistency with new PPACA substantive provisions, and reorders and renumbers PHSA subparts and sections. Conforming amendments include applying mental health parity to the individual market, eliminating small group market guaranteed issue exceptions for lack of association membership or failure to meet contribution/participation requirements, and making small group market size 1-100. Also incorporates PHSA requirements into ERISA and IRC. (PPACA § 1563)
MAJOR INSURANCE MARKET REFORMS	
Pre-Ex Exclusion Periods	No pre-ex exclusion periods for new coverage in all markets and grandfathered group health plans starting in 2014. (PPACA § 1201; HCERA § 2301(a)(4)(B)(i); PHSA § 2704)
Rating and Pooling	• **Rating Adjustments.** Permits adjustments only for: o Age (3:1 for adults), within standard age bands established by HHS in consultation with NAIC o Family composition (individual or family) o Tobacco (1.5:1) o Geography (Rating areas to be established by states and reviewed by HHS) o With respect to family coverage, the rating variations permitted for age and tobacco shall be applied to the portion of the premium attributable to each family member Applies to individual and small group markets (but not grandfathered plans). Effective in 2014. (PPACA § 1201; PHSA § 2701) • **Market Definitions.** Requires states to include the self-employed and employers up to 100 in their small group markets; however, states have the option to keep small group market at 1-50 in 2014 and 2015. (PPACA § 1304)

	• If a state permits large employers to purchase coverage through an Exchange (which they can do starting in 2017), the rating rules would extend to insured large employers as well. (PPACA §§ 1312(f)(2)(B), 10103(a)) • **Separate Pools.** Requires separate pools for individual and small group, but permits states to merge the markets. Requires these pools to include policies from both inside and outside Exchange (except for grandfathered coverage; specifies that state laws requiring grandfathered plans to be included in a pool shall not apply). Effective 2014. (PPACA § 1312(c))
Guaranteed Issue	Requires guaranteed issue during annual open enrollment and special enrollment periods for qualifying events in accordance with regulations promulgated by HHS consistent with ERISA §603 (COBRA special enrollment periods). Modifies current HIPAA provisions requiring guaranteed issue in the small group market (current PHSA § 2711, re-designated as PHSA § 2731) but eliminates current small group law exceptions for failure to meet participation/contribution requirements and exceptions for association coverage). Applies to individual and group markets (but not to grandfathered plans). (PPACA §§ 1201, 1562(c)(8)(D)-(E); PHSA § 2702)
Non-Discrimination	• Extends current HIPAA rules (at PHSA § 2702(a)) prohibiting group health plans from establishing rules for eligibility to enroll in coverage based on specified status-related factors (health status, medical condition, claims experience, receipt of health care, medical history, generic information and evidence of insurability) to the individual market. To this list, adds "any other health status-related factor determined appropriate" by HHS. (PPACA § 1201; PHSA § 2705) • Extends current HIPAA rules prohibiting group health plans from charging enrollees higher premiums based on health status (current PHSA § 2702(b)) to the individual market. (PPACA § 1201; PHSA § 2704(B)) • Applies to insured plans in all markets (but not to grandfathered plans).
Guaranteed Renewability	Requires guaranteed renewability starting in 2014 (Note: Unlike the guaranteed issue provision, this does not eliminate the HIPAA group participation/contribution requirements). Applies to all insured markets (but not to grandfathered plans). (PPACA § 1201, PHSA § 2703)
Wellness Programs	**Premium Variation for Participation in Employer Wellness Programs.** Permits employers to vary premiums by as much as 30% for employee participation in certain health promotion and disease prevention programs. Effective 1/1/14. • *Programs Not Subject to Requirements* o Programs where participation is not based on a health status factor. o Programs that do not link rewards to a standard related to a health status factor – so long as participation is made available to all "similarly situated individuals." o Programs that do not provide rewards – so long as participation is made available to all "similarly situated individuals." Specific programs listed as not subject to requirements: ▪ Programs that reimburse some/all of fitness membership costs. ▪ Diagnostic testing programs that provide rewards for participation and do not base any rewards on outcomes. ▪ Programs that encourage preventive care through waivers of cost-sharing (e.g., for well baby care). ▪ Programs that reimburse the costs of smoking cessation programs, regardless of whether the individual quits smoking. ▪ Programs that provide rewards to individuals for attending a periodic health education seminar. • *Requirements*. The following requirements apply to programs that condition rewards based on satisfying a standard related to a health status factor: o <u>30% Limit</u>. Rewards for such programs may not exceed 30% of the cost of employee-only coverage, determined based on the total amount of employer and employee contributions (or, if dependents are eligible for the program, 30% of the cost of coverage in which an employee and any dependent are enrolled). Allows HHS to increase this ceiling to 50%. o <u>Awards</u> ▪ Allows the reward to take the form of premium discounts or rebates, the absence of a surcharge, a waiver of cost-sharing mechanisms or the value of a benefit that would not otherwise be covered under the plan. ▪ Plan shall give individuals eligible for the program the opportunity to qualify for the award at least once a year. ▪ The full reward must be available to all similarly situated individuals.

	▪ Plans must provide a reasonable alternative standard (or waiver of the applicable standard) for obtaining the reward for an individual for whom it is unreasonably difficult due to a medical condition or for whom it is medically inadvisable to attempt to satisfy the standard. Permits plans, "if reasonable under the circumstances," to seek verification, such as a statement from an individual's physician, that a health status factor makes it medically inadvisable or unreasonably difficult for the individual to satisfy or attempt to satisfy the program standard. Requires plans to disclose in all plan materials that describe the terms of the wellness program the availability of any alternative standard or the possibility of a waiver of the program standards. (Plan materials that disclose the availability of a wellness programs without describing its terms do not require such disclosure.) o Program Design. Requires the wellness program to be "reasonably designed to promote health or prevent disease" – that is, it must have a "reasonable chance" of improving health or preventing disease in participating individuals; must not be overly burdensome; must not be a subterfuge for discriminating based on a health status factor; and is not "highly suspect" in the method chosen to promote health/prevent disease. o Grandfather Clause. Grandfathers all existing wellness programs established prior to the date of enactment of this section and that complied with all applicable regulations. • **Individual Market Wellness Program Demonstration**. By 7/1/14, directs HHS, in consultation with Treasury and DOL, to establish a 10-state demonstration project under which participating states apply the wellness provisions described above (for the group market) to individual market coverage. Permits expansion of the demonstration starting on 7/1/17, if the demonstration efforts are found to be effective. To participate in the demonstration, requires participating states to: 1) design their projects to avoid any coverage decreases or any increase in federal costs related to available individual tax credits; 2) ensure that consumer protection standards are met; 3) ensure that premium discounts under the program do not create undue burdens for individuals, do not lead to cost-shifting and are not a subterfuge for discrimination. • **Reporting**. Requires HHS to report to Congress on the effectiveness of wellness programs within 3 years of the date of enactment, including collecting data from employers on their wellness programs. (PPACA § 1201; PHSA § 2705)
Provider Non-Discrimination	Prohibits discrimination against providers acting within the scope of the license or certification with respect to participation under a plan. Specifies that this provision is not an "any willing provider" requirement and that the provision does not prohibit reimbursement based on quality or performance. Applies to all markets (but not to grandfathered plans). Effective 1/1/14. (PPACA § 1201; PHSA § 2706(a))
Clinical Trials Coverage	Requires coverage of routine costs for and prohibits discrimination against clinical trial participants. Applies to insured plans in all markets and self-funded plans (but not grandfathered plans). • *Routine Patient Costs.* Defines these costs to include all items and services consistent with the coverage provided that is typically covered for a qualified individual who is not enrolled in a clinical trial. Specifically excludes: the investigational item/device/service itself; items and services provided solely to satisfy data collection and analysis needs; and services clearly inconsistent with widely accepted and established standards of care for a diagnosis. • *Use of In-Network Providers.* Permits plans to require enrollees to participate in the trial through a participating provider, if such providers are participating in the trial and will accept the individual as a trial participant. • *Non-Network Coverage.* Applies the general requirements of this provision to enrollees participating in approved trials being conducted out-of-state, unless that plan does not otherwise cover out-of-network benefits. • *Qualified Individuals.* Enrollees who are eligible to participate in an approved trial according to the trial protocol for cancer or other life-threatening diseases and either: 1) the referring health care professional is a participating provider and has concluded that the individual's participation would be appropriate; or 2) the individual provides medical and scientific information establishing that his/her participation would be appropriate. • *Approved Clinical Trial.* Defined as a phase I, II, III or IV clinical trial for the prevention, detection or treatment of cancer or other life-threatening disease or condition, that is also one of the following: o A federally funded trial sponsored by: the NIH, the CDC, AHRQ, CMS, a cooperative group or center of any of the previous entities or the Departments of Defense (DOD) or Veterans Affairs (VA); a qualified non-governmental research entity identified in guidelines issued by the NIH for center support grants; or the DOD, VA or Department of Energy if the study has been reviewed and approved through a peer review system. o A study conducted under an investigational new drug application reviewed by the FDA or a drug trial that is exempt from having an investigational new drug application. • *FEHBP.* Applies this provision to health plans offered under the FEHBP.

	• *Treatment of State Clinical Trials Laws.* Does not preempt state clinical trials laws that go beyond the requirements of this provision. • Effective 1/1/14. (PPACA § 10103(c))
No Excessive Waiting Periods	• Limits waiting periods under all group health plans (periods before which an employee is eligible for coverage) to 90 days starting in 2014. Applies to all markets, including all grandfathered coverage. (PPACA §§ 1201, 10103(b); HCERA § 2301(a)(4)(A)(i); PHSA § 2708)
Transition/ Grandfathering	• Grandfathers existing coverage under rating, benefit and certain other rules as long as such coverage is renewed. Subjects new coverage to new rules. • Permits family members of current enrollees and new employees to enroll in grandfathered coverage. • Applies grandfathered status to coverage maintained under an insured collective bargaining agreement (until the date that such agreement terminates). • Grandfathered status is indefinite; the provision is silent regarding changes in terms or conditions of such coverage; however, grandfathered status applies to coverage in effect on date of bill's enactment – not in 2014 when major reforms go into effect. (PPACA §§ 1251, 10103(d), 10103(e)(1))
Level Playing Field	• Requires any state regulation or amendment adopted under PPACA to apply uniformly to all health plans in each insurance market to which it applies (as of 1/1/14). (PPACA § 1252) • Appears that self-funded MEWAs would not be subject to insurance market reform rules applicable to insured benefits (i.e., rating restrictions, guaranteed issue/renewability). However, appears that self-funded MEWAs would be subject to general group health plan rules applicable to self-funded plans (at least at employer level), and fully insured MEWAs would be subject to insurance market reform rules applicable to insurers. (PPACA § 1301(b)(1)(B))
Reports/Studies	• **Self-Funded Plans.** Annual DOL reports to Congress on self-funded plans, due 12 months after enactment. (PPACA § 10103(f); PHSA § 1253) • **Large Group Market.** HHS study of large group market including evaluation of extent to which the insurance reforms may cause adverse selection in the large group market or encourage smaller employers to self-fund, due one year after enactment. (PPACA § 10103(f); PHSA § 1254) • **Denials.** GAO study on denials of coverage and enrollment (and the reasons for such denials) by insured and self-funded group plans (including both qualified and nonqualified health plans), due one year after enactment to HHS and DOL. Directs GAO to include data on denials that were later approved by a plan. Requires the report to be made available by HHS and DOL on a public Internet website. (PPACA § 10107(b); § 1562) • **Health Plan Value.** HHS to develop methodology, in consultation with relevant stakeholders (including insurers, consumers, employers and providers) to measure health plan value. Requires such methodology to consider overall costs to enrollees; quality of care; efficiency of the plan in providing care; relative risk of plan enrollees; and actuarial value (or other comparative measure of covered benefits). Report due to Congress 18 months after enactment. (PPACA § 10329)
Temporary Individual Market Reinsurance	• **Overview.** Mandatory state-run reinsurance program (2014-2016) for the individual market. Requires non-profit state-run reinsurance entities to collect payments and use amounts collected to make reinsurance payments to health insurance issuers that cover high-risk individuals for any plan year beginning in such 3-year period. (PPACA § 1341) • **Eligible Coverage.** Individual market coverage, except for grandfathered coverage. • **Health Plan Contributions.** Requires all health insurance plans (individual and group markets) and third-party administrators (on behalf of group plans) to contribute $25 billion over this 3-year period to a reinsurance program for individual policies. • **Model Regulation.** Requires HHS, in consultation with the NAIC to establish a model regulation to carry out this provision. The model regulation must address: o *Identification of High-Risk Individuals*. Requires regulations to establish a method for determining high-risk individuals including a list of at least 50 but not more than 100 high-risk medical conditions or any other comparable objective method recommended by the American Academy of Actuaries. o *Payments.* Requires the formula for determining payment amounts to issuers to provide for the equitable allocation of available funds through reconciliation. Such formula may be designed to provide a schedule of payments that specifies the amount that will be paid for each of the specified conditions or may use any other comparable method recommended by the American Academy of Actuaries. o *Required Contributions* ▪ Method. Permits contributions to be based on: 1) the percentage of revenue of each issuer and the total costs of providing benefits for self-funded plans; or 2) a specified amount per enrollee that may be required to be paid in advance or periodically throughout a plan year.

	▪ Proportionality. Requires contributions for issuers to proportionally reflect their fully insured commercial book of business for all major medical products and the total value of all fees charged and the costs of coverage administered by the issuer as a TPA. However, each issuer's contribution must also reflect its proportionate share of an additional $2 billion for 2014 and 2015 and an additional $1 billion in 2016. ▪ Administrative Fee. Contributions also can include an amount to fund the administrative expenses of the reinsurance entity. ▪ Aggregate Amounts. Requires aggregate contribution amounts for all sates to equal $10 billion for 2014, $6 billion for 2015 and $4 billion for 2016. • **Relation to State High Risk Pools**. Requires states to eliminate or modify their high risk pools to the extent necessary to carry out the reinsurance program. Permits states to coordinate their high risk pools with this program, to the extent not inconsistent with this provision. (PPACA §§ 1341, 10104(r))
Risk Corridors	• **Overview.** Mandatory federal risk corridor program (2014-2016) for qualified health benefit plans in the individual and small group markets (excluding grandfathered coverage). (While not entirely clear, the intent may be to apply this section only to "qualified health benefit plans" within the Exchange. • **Medicare Part D Model.** Requires the risk corridors to be modeled after those used to adjust payments to regional PPOs in Medicare Part D. • **Payments** o *Payments Out.* If a participating plan's allowable costs are >103% but not >108% of a target amount, the plan would be paid 50% of the amount in excess of 103% of the target amount. If the allowable costs are >108%, the plan would be paid 2.5% of the target amount plus 80% of allowable costs >108% of the target amount. o *Payments In.* If a participating plan's allowable costs are <97% but not <92% of a target amount, the plan would pay in 50% of the excess of 97% of the target amount over the allowable costs. If the allowable costs are <92%, the plan would pay in 2.5% of the target amount plus 80% of the excess of 92% of the target amount over the allowable costs. o *Allowable Costs.* Defined as the total costs (other than administrative costs) of the plan in providing covered benefits. Allowable costs are reduced by any risk adjustment and reinsurance payments received under § 1341 and § 1343. o *Target Amount*. Defined as total premiums (including any premium subsidies), less administrative costs. (PPACA § 1342)
Risk Adjustment	• **Overview.** Mandatory, state-run risk adjustment programs for the individual and small group markets (developed by HHS in consultation with states), excluding grandfathered coverage, starting in 2014. Applies to insured business only. • **Program design.** Requires HHS to establish criteria and methods for carrying out such risk-adjustment activities. Allows HHS to utilize criteria and methods similar to those utilized under the Medicare Advantage and the Medicare Part D Programs. • **Assessments.** Requires states to assess a charge on "low actuarial risk plans," defined as plans whose enrollees' actuarial risk for one year is less than the average actuarial risk of all enrollees in all plans or coverage in the state for the same year. • **Payments.** Requires states to provide payment to "high actuarial risk plans," defined as plans whose enrollees' actuarial risk for one year is greater than the average actuarial risk of all enrollees in all plans in the state for the same year. (PPACA § 1343)
State Waiver	States can apply for waivers to opt out of the following requirements if they implement programs that ensure their residents have coverage that is at least as comprehensive as the coverage required under Exchange plans. HHS will determine the scope of the waiver based on a state's application. • **Requirements that Can Be Waived:** o Establishment of qualified health plans. (PPACA §§ 1301-1304) o Health benefit Exchanges. (PPACA §§ 1311-1312) o Reduced cost-sharing for individuals. (PPACA § 1402) o Individual tax credit. (new IRC § 36B) o Employer responsibility requirements. (new IRC § 4980H) o Individual responsibility requirement. (new IRC § 5000A) • **State Applications.** Must contain a comprehensive description of state plan that will meet the requirements for a waiver as well as a 10-year budget plan that is budget neutral for the federal government and an assurance that the state has enacted a law providing for state action under a waiver, including implementation of the state plan. Directs HHS to develop a coordinated process permitting states to submit a single application for a waiver under Medicare, Medicaid and/or CHIP. HHS to make determination on waiver applications within 180 days of receipt.

	• **Subsidy Pass-Through.** For state waivers under which individuals and small employers would not qualify for the bill's tax credit/subsidy provisions, provides for the funds that would have been paid on behalf of Exchange participants in the absence of a waiver to be paid to the state to help implement the state plan under the waiver. • **Criteria for Granting Waivers.** Permits HHS to grant waiver requests if HHS determines that the state plan will: o Provide coverage that is at least as comprehensive as the essential health benefits coverage and that has cost-sharing protections against excessive OOP expenditures that are at least as affordable as under this bill. o Extend coverage to at least a comparable number of residents as under this bill. o Not increase the federal deficit. • **Transparency.** Requires HHS to issue regulations within 180 days of enactment the provide for: o A process for public notice and comment at the state level as relates to state waivers, including hearings o Waiver applications that ensure disclosure of: 1) the provisions of law that the state seeks to waive; and 2) the specific plans of the state to ensure the waiver will be in compliance with the criteria for granting waivers and the requirement to enact a state law to provide for state actions under a waiver. • **Waiver Length.** No waivers can extend longer than 5 years unless such an extension is requested and granted by HHS. Effective for plan years beginning 1/1/17. (PPACA § 1332)
Benefit Requirements	• **Individual and Small Group Markets.** Requires all insurers in the individual and small group markets to meet the same requirements as Exchange plans with respect to: o Providing coverage of the essential benefits package o Meeting cost-sharing requirements for essential benefits o Offering at least one of the Bronze, Silver, Gold or Platinum benefit plans (or a catastrophic plan). (See "Qualified Health Plans" section for more details.) Effective 1/1/14. (PPACA § 1201; PHSA § 2707(a)) • **Group Markets.** Requires all group health plans to meet cost-sharing limits required under § 1302(c)(1)-(2), which limit deductibles to $2,000 for individuals and $4,000 for families and limit annual out-of-pocket maximum to HDHP levels for HSA plans. Effective 1/1/14. (PPACA § 1201; PHSA § 2707(b)) • **Insured Plans.** Requires insurers who offer any level of coverage (Bronze, Silver, Gold or Platinum) re: the essential benefits package to also offer coverage at that level for child-only plans. (PPACA § 1201; PHSA § 2707(c)) These requirements do not apply to grandfathered plans.
Other	• **State Benefit Mandates.** Continues to apply state benefit mandates to coverage outside of Exchanges. (PPACA § 1312(d)(2)). States can mandate additional benefits inside Exchanges but they must make payments to cover the additional costs for such benefits for those that are subsidy eligible. Requires these state payments to be made directly to individual enrollees or to the health plans in which such individuals are enrolled. For the multi-state plans OPM is required to offer through state Exchanges, states are allowed to mandate additional benefits but must cover the costs for all enrollees from that state (including those who are not subsidy eligible). As with single-state plans, such payments could be made directly to individual enrollees or to the health plans in which such individuals are enrolled. Effective 1/1/14. (PPACA §§ 1311(d)(3), PHSA § 1334; 10104(e), 10104(q); PHSA § 1334) • **Payments to FQHCs.** Requires payments by Qualified Health Benefits Plans to FQHCs to be at least as high as payments to FQHCs under Medicaid. (PPACA § 10104(b)(2)) • **Gun Rights Protections.** Prohibits any requirements for disclosure of or collection of information on gun ownership under the bill. Prohibits insurers from using such information to increase premiums, deny coverage or reduce or withhold rewards for wellness program participation. (PPACA § 10101(e))
HEALTH INSURANCE EXCHANGES	
General Design	• **State Exchanges with Federal Fallback.** Each state must establish an Exchange that is a governmental agency or nonprofit entity by 1/1/14 to offer qualified health plans to individuals and small employers. Provides for the federal government (either directly or through an agreement with a non-profit entity) to implement an Exchange in states that either elect not to establish their own Exchange, or states for which HHS determines, by 1/1/13, that the state will not have an operational Exchange by 1/1/14. • **Voluntary Exchanges.** Exchanges will be voluntary, with insurers allowed to sell coverage, and individuals and employers allowed to purchase coverage,

	in the outside market. There is no penalty for switching to minimum essential coverage outside of an Exchange. • **Small Business Health Options (SHOP) Exchange.** Requires states to establish an Exchange for the individual market and a Small Business Health Options (SHOP) Exchange for the small group market, with flexibility to establish a single Exchange for both markets. • Each state Exchange will certify health plans as qualified health plans (QHPs). • **HHS Responsibilities.** Requires HHS to: o Establish criteria for the certification of QHPs. (PPACA § 1311(c)) o Develop a rating system to rate QHPs offered through an Exchange. (See row below) o Develop an enrollee satisfaction survey system to evaluate enrollee satisfaction with participating plans. o Continue to operate, maintain and update the Internet Portal developed by HHS by 7/1/10 and make available a model template for Internet portals that state Exchanges can use. o Require Exchanges to provide for enrollment periods. (PPACA § 1311(c)(6)) o Audit Exchanges annually; also allows HHS to investigate Exchanges and implement other financial integrity provisions. (PPACA §§ 1311(b),1312(d)(3), 1313)
Tax Credits Tied to Exchange	Ties premium tax credits and cost-sharing subsidies to coverage purchased exclusively through the Exchange. (PPACA § 1401; IRC § 36B)
Limit on Participating Plans	Allows states to exclude some plans that otherwise appear to meet the requirements of a qualified plan. o **In General**. Exchanges must determine that allowing a plan to participate is "in the interests of" eligible participants. Provides for the Exchange to also take into account any "excess of premiums growth outside the Exchange as compared to the rate of such growth inside the Exchange," including information reported by states. However, the Exchange cannot exclude a health plan on the basis that it is a FFS plan, through the implementation of premium price controls or on the basis that the plan provides treatments necessary to prevent patients' deaths in circumstances that the Exchange determines are inappropriate or too costly. o **Premium Increase Justifications**. Requires plans to submit justification for any premium increase prior to implementation, and to post such information on plan websites. Gives Exchange authority to use this information (and recommendations provided by states related to patterns of excessive or unjustified premium increases under the bill) in determining whether to make a plan available in the Exchange. Exchanges are also required to consider reasonableness of premium increase when deciding whether to allow plans to participate. (PPACA §§ 1311(e), 10104(f)(1))
Rating System	• HHS will develop a system to rate Qualified Health Plans (QHPs) in each Exchange and each benefits level, based on price and quality. • Quality ratings information will be presented in the new Internet portals. • Requires enrollee satisfaction surveys for each plan with over 500 enrollees. (PPACA § 1311(c)(2))
State/Regional Options	Provides flexibility for: • Regional or other interstate Exchanges if the state(s) involved permit such operations and HHS approves such Exchanges. • Subsidiary Exchanges, if each Exchange serves a geographically distinct area that is at least as large as a rating area (as established by a state and reviewed by HHS). (PPACA § 1311(f)(1)-(2))
Exchange Functions	Requires Exchanges to: • Offer qualified health benefits plans. Allows states to require additional benefits, but if they do so, they must assume the costs incurred by such additional benefits. • Offer limited scope pediatric dental benefit plans. • Implement certification procedures and policies. • Provide a toll-free telephone hotline for Exchange assistance. • Develop an Internet website for standardized comparative information on plans. • Provide public ratings of the participating Exchange plans (see explanation above).

	• Use a standard format for presenting health plan options in the Exchange, including the use of the uniform outline of coverage established under the new PHSA § 2715. • Inform individuals of eligibility requirements for Medicaid and CHIP, and if, through screening of Exchange applications, the Exchange identifies individuals who are eligible for such programs, to enroll such individuals in Medicaid or CHIP. • Make a calculator available to determine individuals' cost of coverage, taking into account any tax credits they may qualify for. • Grant certifications that individuals are exempt from the individual mandate requirement because there are no affordable plans available in the Exchange or the individual meets other mandate exemptions. • Grant certifications of exemptions from the individual mandate for those who meet affordability or other exemptions. • Notify employers and the Treasury of such exemptions and of information on employees who were determined eligible to enroll in the Exchange. • Establish the Navigator program (described in the "Public Education/Outreach" row below). • Be self-sustaining by 1/1/15. • Consult with stakeholders, including consumers, representatives of small business and self-employed individuals, state Medicaid offices, those with experience in facilitating health plan enrollment and advocates for enrolling hard-to-reach populations. • Publish on an Internet website the average costs of licensing, regulatory fees and other payments required by the Exchange, as well as the administrative costs of the Exchange. • Account for expenditures. (PPACA §§ 1311(d), 1313)
Standards for Participating Health Plans	• **Meet Requirements Established by HHS for Participating Plans:** o Meet marketing requirements and not employ marketing practices or benefit designs that have the effect of discouraging enrollment by those with significant health needs. o Ensure sufficient choice of providers and provide information on the availability of in- and out-of-network providers. o Include "essential community providers" who serve low-income and underserved communities in plan networks. o Be accredited for clinical quality measures such as HEDIS and patient experience ratings by CAHPS surveys as well as consumer access, UM, quality assurance, provider credentialing, complaints and appeals, network adequacy and access and patient information programs by an accreditation entity recognized by HHS. o Implement and report on a quality improvement strategy described as a payment structure that provides increased payment or other incentives for the following kinds of activities (to be described in further detail in HHS guidelines): ▪ Improving health outcomes; ▪ Preventing hospital readmissions; ▪ Improving patient safety and reducing medical errors; ▪ Implementing wellness and health promotion activities; and ▪ Reducing health care disparities through language services, community outreach and cultural competency training. o Utilize uniform enrollment forms for qualified individuals and employers, that takes into account NAIC criteria for paper and electronic forms. o Utilize a standardized format for explanation to customers of health benefits and plan options. o Provide information to enrollees and Exchanges on any quality measures for health plan performance endorsed under PPACA § 3015. (PPACA § 1311(b), (g)) • **Meet Mental Health Parity Requirements.** (PPACA § 1311(j)) • **Justify Rates.** Any Exchange plan must, before raising premiums, submit justification to the Exchange and post such justification on their websites. Exchanges can consider such information in determining Exchange participation status for health plans. (PPACA § 1311(e)) • **Meet Provider Contracting Requirements.** Starting 1/1/15, also prohibits plans from contracting with: o Hospitals with >50 beds unless such hospitals use a patient safety evaluation system as described in the Medicare Advantage statute and implement a

	mechanism to ensure that each patient receives a comprehensive program for hospital discharge that includes patient-centered education and counseling, comprehensive discharge planning and post-discharge reinforcement by an appropriate health care professional. o Providers, unless they implement "such mechanisms to improve health care quality" as HHS requires by regulation. (PPACA § 1311(h)) • **Meet Transparency/Disclosure Requirements.** See above "Uniform Explanation of Coverage and Transparency Requirements" under the Near-Term Reforms section.
Benefits Requirements	Participating plans must agree to offer at least one QHP in the Silver level and at least one plan in the Gold level in each Exchange in which it operates. (PPACA § 1301(a)(1)(C)(ii))
Public Education/ Outreach	• **Open Enrollment.** Requires Exchanges to provide for: o An initial open enrollment period (requires HHS to make a determination as to the date of the initial OEP by 7/1/12) o Annual open enrollment periods (for years following the initial OEP) o Special enrollment periods under HIPAA (IRC § 9801) and other SEPs "under circumstances similar to SEPs under Medicare Part D." [Note: These SEPs are different from those required in the general guaranteed issue requirement, which provide for SEPs provided under ERISA § 603 (COBRA)]. o Special monthly enrollment periods for Indians. (PPACA § 1311(c)(6)) • **Role of Agents/Brokers.** States can allow, under HHS procedures, insurance agents and brokers to help individuals and employers enroll and apply for tax credits. (PPACA § 1312(e)) • **Navigators.** Exchanges will award grants to entities to increase public awareness and education about QHP choices, with impartial information and services. o Such entities could include trade/industry/professional associations, fishing/ranching/farming organizations, community groups, chambers of commerce, unions, resource partners of the Small Business Administration and other licensed insurance agents and brokers that demonstrate they have existing relationships (or could readily establish relationships) with employers, employees, consumers or self-employed individuals likely to be qualified for Exchange coverage. No health insurer or entity receiving direct consideration from a QHP-offering insurer is eligible to be a Navigator. o Duties for Navigators include: conducting public education activities; distributing fair and impartial information about QHPs and subsidy availability; facilitating Exchange enrollment; referring individuals to offices of health insurance consumer assistance or other appropriate state agencies regarding grievances, complaints or questions about their health plans, coverage, and providing culturally and linguistically appropriate information. (PPACA §§ 1311(i), 10104(h)) • **Coordination with Medicaid and CHIP.** By an unspecified date, requires HHS to develop a single form that will allow individuals to apply for enrollment in Medicaid, CHIP or Exchange subsidies and receive a determination of eligibility. Exchanges are required to inform individuals of eligibility requirements for Medicaid and CHIP. If an Exchange determines that such individuals are eligible for any such program, Exchanges are required to enroll such individuals in such program. (PPACA §§ 1311, 1413)
Exchange Eligibility	
- Individuals	• Any legal resident not incarcerated. (PPACA § 1312(f))
- Employers	• Available to small group market, which the bill defines as 1-100 workers, with the option for states to define the market as 1-50 until 1/1/16, at which time employers with up to 100 employees must be allowed to purchase coverage through the Exchange. (PPACA § 1304(b)) • Starting in 2017, states may allow employers with >100 employees to participate in the Exchange at the discretion of HHS. (PPACA § 1312(f)) • Employees will have a choice of carriers within a level of coverage (Bronze, Silver, Gold or Platinum) chosen by the employer. (PPACA § 1312(a)(2)) • Members of Congress and congressional staff may only be offered health plans created by the PPACA or offered through an Exchange. (PPACA § 1312(d))
- Medicaid/ CHIP Enrollees	See Medicaid and CHIP sections below.

Accreditation	Be accredited for clinical quality measures such as HEDIS and patient experience ratings by CAHPS surveys. (PPACA § 1311(c))
Treatment of State Benefit Mandates	States may require additional benefits, but must assume the costs of providing those benefits. (PPACA §§ 1311(d)(3), 10104(e))
Oversight and Enforcement	• **HHS Role.** If a state does not establish an Exchange by 2014 or, in 2013, it appears the state will not meet the 2014 deadline, HHS will (either directly or through a nonprofit entity) establish an Exchange in that state. (PPACA § 1312(c)) • **Deeming of Existing Exchanges.** Requires HHS to "presume" that Exchanges in existence before 1/1/10 that insure a percentage of the population that is at least as high as the percentage projected to be covered nationally after the implementation of this law, meet the standards for Exchanges, unless HHS determines that the Exchange does not comply with such standards. (PPACA § 1321(e))
Grants	Not later than 1 year after date of enactment, HHS will give states grants to establish Exchanges. (PPACA § 1311(a))
State Basic Plan Option	• **State Option.** States and/or "regional compacts" of states may seek HHS approval to establish a federally-funded, non-Medicaid program to cover persons between 133-200% FPL. • **In Lieu of Exchanges.** The program would be in lieu of enrolling eligible individuals in Exchanges. Specifically precludes eligible individuals from enrolling in an Exchange plan (and therefore not able to receive Exchange subsidies). • **Funding.** Federal funds to the state would be capped. Formula for state funding is equal to 95% of the subsidies and cost-sharing reduction that would have been provided over a fiscal year through an Exchange for enrollees in the state basic plan option • **Eligibility.** Eligible individuals must be under 65 and not eligible for employer coverage, Medicaid or other minimum essential coverage. • **Coverage.** Must be equal to at least the essential health benefits inside an Exchange. • **Contracting** o Required 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." o Participating plans would have to maintain an MLR of 85%. The state program is required to have a competitive process for entering into contracts with "standard health plans," including negotiation of: ▪ Premiums and cost-sharing. ▪ Benefits in addition to the essential benefit requirements. ▪ Inclusion of innovative features such as care coordination and care management for enrollees, especially for those with chronic health conditions. ▪ Incentives for use of preventive services and the establishment of relationships between providers and patients that maximize patient involvement in health care decision-making, including providing incentives for appropriate utilization under the plan. ▪ Suitable allowances for differences in health care needs of enrollees and differences in local availability of, and access to, health care providers. • **Regional Compact.** A state may negotiate a regional compact with other states to include coverage of eligible individuals in all such states in agreements with contracted entities offering the coverage. • **Effective Date.** Unspecified, but presumably 2014 when subsidies begin. (PPACA § 1331)
Other	• **Direct Payment of Premiums.** Allows enrollees to pay premiums directly to their health plans. (PPACA § 1312(b)) • **GAO Study.** Requires GAO to conduct an ongoing study of Exchange activities and enrollees, including a review of Exchange operations and administration (including surveys and reports of QHPs, as well as their claims statistics and complaints data, and Exchange expenses). Also requires the study to include a survey of the cost of coverage provided to small employers inside and outside of Exchanges. (PPACA §§ 1313(b), 10104(k)) • **Consultation with Consumers.** Exchanges must consult with "educated health care consumers," defined as "an individual who is knowledgeable about the health care system and has background or experience in making informed decisions regarding health, medical, and scientific matters," as well as persons or entities with enrollment experience, representatives of small businesses and the self-employed, state Medicaid offices and advocates for enrolling hard-to-reach populations. (PPACA §§ 1304, 10104(d), 10104(e))

QUALIFIED HEALTH PLANS	
Qualified Health Plan (QHP) Requirements	• A QHP must be certified by each Exchange in which it operates. • A QHP must provide the essential benefits package, including providing essential benefits and meeting cost-sharing and actuarial value requirements. • A QHP must be offered by a health insurer that: o Is licensed and in good standing. o Agrees to offer at least one QHP in the Silver level and at least one plan in the Gold level in each Exchange in which it operates. o Agrees to charge the same premium for the same plan whether offered in or out of an Exchange. • Complies with regulations HHS establishes under PPACA § 1311(d) and any other requirements an Exchange may establish.
Benefit Design Essential Benefits Package	• **Essential Benefits Package.** Services must include: o Ambulatory patient services; o Emergency services; o Hospitalization; o Maternity and newborn care; o Mental health and substance abuse disorder services "including behavioral health treatments"; o Prescription drugs; o Rehabilitative and habilitative services and devices; o Laboratory services; o Preventive and wellness services and chronic disease management; and o Pediatric services, including oral and vision care. • Must meet emergency coverage requirements (e.g., does not require prior authorization and charges the same cost-sharing for out-of-network emergency services as in-network). • **Scope Equal to "Typical Employer Plan."** The scope of these essential benefits will be equal to the scope of benefits provided under a "typical employer plan" – according to HHS. To inform the decision, DOL will conduct a survey of employer plans, including multiemployer plans. Certification will be conducted by the CMS Actuary. • **Definition of Benefits.** In defining the essential benefits, requires HHS to: o Make sure all benefits are given equal importance and emphasis. o Not make coverage decisions, rate determinations or incentive programs or structure benefits that discriminate against anyone based on age, disability or expected lifespan. o Take into account the diverse health care needs of the population. o Make sure that essential benefits are not involuntarily denied to anyone on the basis of age or expected lifespan or disability, medical dependency or quality of life. o Periodically review and update essential health benefits. • **Cost-Sharing** o Limits cost-sharing (deductible, coinsurance, copayments, etc.) to Health Savings Account (HSA) cost-sharing limits in 2014 and then indexed annually to per capita premium increases measured after 2013. o *Small group employer plans*. Limits deductibles to $2,000/single, $4000/family. o *Indexing* ▪ These limits can be raised by the maximum amount of reimbursement which is reasonably available to a participant under a flexible spending arrangement (FSA).

	▪ Indexes the individual limits annually to per capita premium increases measured after 2013. For any other plans, the limits will be indexed to double the individual increase. (PPACA § 1302)
Levels of Coverage	• Qualified Health Plans (QHP) must meet one of the 4 specified actuarial value tiers (determined by standard population, not plan's actual population): o **Bronze.** Coverage of 60% actuarial value o **Silver.** Coverage of 70% actuarial value o **Gold.** Coverage of 80% actuarial value o **Platinum.** Coverage of 90% actuarial value • Requires Exchange-participating plans to offer at least one QHP in the Silver level and at least one plan in the Gold level. • Employer HSA contributions may be taken into account when determining actuarial value. • **Catastrophic Plans.** QHP may also be a catastrophic plan under certain circumstances. o *Eligibility.* Makes this plan available only in the individual market to individuals under age 30 and individuals who have received certification that they are exempt from the coverage mandate by reason of affordability or hardship. o *Benefit Design* ▪ Covers 3 primary care visits regardless of deductible. ▪ Covers essential health benefits after deductible is met. ▪ Sets deductible at HDHP limit indexed to per capita premium increases after 2013. • Requires all QHPs to offer the same plans to children only (under 21). (PPACA § 1302(d))
INTERSTATE COMPACTS, COOPERATIVES AND MULTI-STATE PLANS	
Interstate Compacts	• Requires HHS, in consultation with NAIC, to issue regulations for the creation of "Health Care Choice Compacts," to provide for the sale of individual insurance across state borders. Subjects insurers selling coverage through these compacts only to the laws and regulations of the state where the policy is written or issued, with the following exceptions: insurance rules related to market conduct, unfair trade, network adequacy, consumer protections (including rating rules) and contract disputes, which will still be enforced in the state where the consumer lives. • **State and Federal Approval** o Requires all participating states to enact a law specifically authorizing the compact. o Requires HHS to approve such compacts based on factors such as coverage comprehensiveness, coverage, affordability, deficit neutrality and whether the compacts would weaken enforcement of state law. • **Requirements for Insurers**. Insurers offering coverage through these compacts must: o Be licensed in all states, or submit to the jurisdiction of each state with respect to the non-exempted state requirements. o Disclose that the policies being sold may not be subject to all the laws and regulations of the state where the consumer lives. • Requires HHS to issue regulations by 7/1/13 and for compacts to be in effect no earlier than 1/1/16. (PPACA § 1333(a))
CO-OPs	Requires HHS to establish the Consumer Operated and Oriented Plans (CO-OPs) program, which will provide loans and grants to foster the creation of qualified non-profit health plans to offer coverage in the individual and small group markets. • **Funding.** Provides up to $6 billion in loans for start-up assistance and grants to help meet state solvency requirements, to be made available no later than 7/1/13. • **Criteria for Awarding Funds** o Creates an advisory board to help HHS make grant/loan award decisions. ▪ Provides for the Comptroller General to appoint the 15 members of the advisory board, with initial appointments made within 3 months of enactment (by 6/23/10). ▪ Uses the same qualifications for members as MedPAC (namely: individuals with national recognition for their expertise in health finance and

economics, actuarial science, health facility management, health plans and integrated delivery systems, reimbursement of health facilities, allopathic and osteopathic physicians and other providers of health services and other related fields, who provide a mix of different professionals, broad geographic representation and a balance between urban and rural representatives).

- Gives priority to applicants that will offer statewide coverage, will use integrated care models and have significant private support.
- Requires HHS to ensure sufficient funding for establishment of at least one plan in each state. (If no issuers apply in a state, allows HHS to award grants to encourage establishment of a qualified nonprofit issuer within the state or the expansion of a qualified issuer from another state.)
- Prohibits funds from being used to influence legislation or for marketing.

- **Requirements for CO-OP Participating Plans.** Qualified plans must:
  - Be not-for-profit.
  - Have substantially all their activities involve providing health insurance coverage in the individual and small group markets.
  - Not be "sponsored" by a state government.
  - Not be an existing organization that provides insurance as of 7/16/09, nor an affiliate or successor to any such company.
  - *Governance Requirements.* Will not treat an organization as a qualified nonprofit issuer unless:
    - Its governance is subject to a majority vote of its members.
    - Its governing documents incorporate ethics and conflict of interest standards protecting against insurance industry involvement and interference.
    - It operates with a strong consumer focus (according to HHS regulations), including timeliness, responsiveness and accountability to members.

    Also prohibits representatives of any health insurer in existence as of 7/16/09, or of any federal, state or local government to serve on the entity's board of directors.
  - *Compliance with State Insurance Laws.* Must meet all the requirements that other QHPs must meet in any state, including state requirements for: licensure; solvency; provider payment; network adequacy; rate and form filing; and state premium assessments. Also requires compliance with state laws described in PPACA § 1324(b): guaranteed renewal; rating; preexisting conditions; nondiscrimination; quality improvement and reporting; fraud and abuse; market conduct; appeals and grievances; privacy and confidentiality; and benefit plan material or information.
  - Offer coverage only after this law's market reforms are in effect in the state.
  - Use any profits to lower premiums, improve benefits or for other programs intended to improve the quality of health care delivered to members.
- **Grant/Loan Repayment**
  - Requires HHS to issue regulations on the repayment of loans and grants no later than 7/1/13, and prior to the awarding of any monies. Provides for loans to be repaid within 5 years and grants to be repaid within 15 years.
  - Requires grant/loan recipients who fail to meet the requirements of this provision to repay 110% of the amount received plus interest.
- **Collective Purchasing/Rate Setting.**
  - Allows participating plans to establish a private purchasing council to enter into collective purchasing arrangements for services that increase administrative and other cost efficiencies (e.g., claims administration, HIT, actuarial services). Prohibits such councils from setting payment rates and clarifies that antitrust laws will continue to apply to such councils. Prohibits representatives of existing health insurers or of federal, state or local governments from serving on the council.
  - Prohibits HHS from participating in any negotiations between participating plans and providers.
  - Prohibits HHS from establishing or maintaining a price structure for reimbursement of covered benefits.
- **Tax Exemption.** Grants a federal income tax exemption (IRC § 501(c)(29)) to entities receiving grants or loans, if in compliance with CO-OP and grant agreement requirements.
- **Health Insurance Provider Tax.** Subject to annual fee on health insurers; however, only 50% of premium arising from tax-exempt business is considered in calculating their market share, which in turn determines their share of the annual tax. (HCERA § 1406 (a)(2)(B))
- **GAO Study.** Requires GAO to conduct an ongoing study, beginning in 2014, on competition and market concentration in the health insurance market in

	the U.S. after implementation of reforms, including an analysis of new health insurance issuers. Requires such reports to be submitted to Congress by 12/31 of each even-numbered year. (PPACA §§ 1322, 10104(l))
Multi-State Plans	Requires the Office of Personnel Management (OPM) to contract with at least 2 private plans (including at least one non-profit) to offer multi-state plans through Exchanges in each state. Allows participation by a group of health insurance issuers affiliated either by common ownership and control or by the common use of a nationally licensed service mark. • **Administration** o Requires OPM to administer the program in a manner similar to FEHBP with regard to negotiation of loss ratios, profit margins, premiums and other terms and conditions of coverage "as are in the interests of enrollees," but does not require plans in the FEHBP to participate. o Treats enrollees in the new plans as a separate risk pool from the FEHBP. o Requires OPM to establish an advisory board (with a significant percentage of members composed of enrollees in multi-state plans or their representatives) to provide recommendations on this program. o Requires OPM to ensure that at least one of the multistate plans offered in an Exchange does not provide coverage of abortion services for which public funding is prohibited. • **Requirements for Insurers.** Insurers offering such coverage must: o Be licensed in each state and subject to all state law requirements not inconsistent with this provision. Allows states to apply age rating limits stricter than the bill's 3:1 requirement. o Offer a uniform benefit package consisting of the essential benefits package. (The provision exempts plans from state benefit mandates that exceed requirements for federal essential benefits package unless a state agrees to assume the cost of these mandates for ALL state enrollees.) o Meet all requirements for QHPs, including offering of different levels of coverage in each Exchange. (The provision deems plans qualified to offer coverage under this provision to be certified as QHPs.) o Comply with minimum standards for FEHBP plans. o Agree to offer coverage in each Exchange in each state (see phase-in schedule below). • **Phase-In.** Requires coverage to be offered in all states (through state Exchanges) on a phased-in basis, with coverage offered in 60% of states in the 1st year; 70% in the 2nd year; 85% in the 3rd year and all states in later years. • **Availability of Tax Credits.** Makes individuals enrolled in coverage under this provision eligible for premium credits. • **Contract Terms.** One-year, annually renewable contracts, which may be made automatically renewable in the absence of notice of termination by either party. Permits approval of contracts to be withdrawn only after notice and opportunity for a hearing. • **Funding.** Provides for OPM to be appropriated funds to support these new duties. (PPACA §§ 1334, 10104(q))
INDIVIDUAL AND EMPLOYER MANDATES	
Individual Mandate	
- Coverage Requirements	Non-exempt U.S. citizens and legal residents are required to maintain "minimum essential coverage" which includes the following: • Individual market plans offered within a state • Eligible employer-sponsored plans including the following: governmental plans, church plans, grandfathered group health plans and other group health plans offered in the small or large group market within a state • Grandfathered individual or group coverage • Government sponsored programs including: Medicare, Medicaid, CHIP, Department of Defense health benefit programs including TRICARE and the Nonappropriated Fund Health Benefits Program, VA and Health Care for Peace Corps volunteers • Other coverage deemed acceptable by HHS in coordination with Treasury

	Minimum essential coverage does not include certain HIPAA excepted benefits. (PPACA § 1501; TAA § 2; IRC § 5000A)
- Penalty	• Starting in 2014, annual penalty for not having insurance would be the greater of a flat dollar amount per person or a percentage of the individual's income. Specifically, the penalty would be equal to the greater of the following amounts: o Flat Dollar Amount: $695 (in 2016) per person failing to buy coverage (phased in at $95 in 2014; $325 in 2015; $695 in 2016). Total family flat dollar amount capped at 300% of the applicable per person adult amount (e.g., in 2016, $695 x 300% = $2,085); or o Percentage of Taxable Income: An amount equal to a percentage of a household's income that is in excess of the applicable tax filing threshold (Applicable percentage phased in at 1.0% in 2014; 2.0% in 2015; 2.5% in 2016) (Generally, for 2010, the filing threshold is $9,350 for singles and $18,700 for married, filing jointly) • In any event, the penalty is capped at the national average Bronze premium in the Exchange for the family size involved. • For any dependent under age 18, per person amount for calculating flat dollar amount is one half the adult individual amount. • If the individual is a dependent of another taxpayer, the other taxpayer is liable for any penalty payment with respect to the individual. • Flat dollar penalties are indexed to cost of living (based on CPI-U) after 2016. • Penalty is calculated on a monthly basis; i.e., penalty is prorated for partial coverage during the year. (PPACA §§ 1501, 10106; HCERA § 1002; IRC § 5000A)
- Exemptions to Individual Mandate	• Affordable coverage not available (cost exceeds 8% of household income). o In the case of those enrolled in an employer plan, insurance cost is the portion of the premium paid by the individual (including through salary reduction). Household income for this purpose is increased by any salary reduction contribution through a cafeteria plan. o In the case of those only eligible for individual market coverage, insurance cost is the premium for the lowest cost Bronze plan available through the Exchange and reduced by any premium subsidy that is allowable under PPACA. o 8% of household income threshold is indexed after 2014 by the amount by which premium growth exceeds income growth • Individuals with a coverage gap of less than 3 months. o Coverage gap is determined without regard to the calendar years in which gap occurs. o If coverage gap is 3 months or greater, then no exemption is provided for any months (including the initial period without coverage). o If there is more than one period with a coverage gap, this exemption only applies to the months in the first period without coverage. • Hardship situation (as determined by HHS) • Religious exemption (certain faiths). Those exempt due to religious reasons must be members of a recognized religious sect exempting them from self employment taxes and adhere to tenets of the sect. • Illegal aliens • Individuals living outside the U.S. or residents of territories • Those with incomes below tax filing threshold. (In 2010 the threshold for taxpayers under age 65 was $9,350 for singles and $18,700 for couples). • Members of Indian Tribes • Incarcerated individuals (PPACA §§ 1501, 10106; HCERA § 1002; IRC § 5000A)
- Enforcement & Verification	• Penalty is assessed through the tax code and counted as an additional amount of federal tax owed. • Criminal and civil penalties are waived for any failure to pay the tax penalty. In addition, Treasury shall not file notice of lien or levy with respect to any property of a taxpayer. (PPACA § 1501; IRC § 5000A) • IRS Notice of Nonenrollment. Not later than 6/30, the IRS, in consultation with HHS, is required to send a notification to each individual who files an income tax return and who is not enrolled in minimum essential coverage. Notification will include information on services available through the state Exchange. (PPACA § 1502; IRC § 6055)

- Reporting	**Insurer & Employer Reporting (Effective 2014)** • Requires insurers (and employers who self-insure) providing minimum essential coverage to report the following information to Treasury: o Name, address and taxpayer identification number of each enrolled member. o Dates of coverage for such individual(s) during the calendar year. o Whether coverage is a qualified health plan offered through an Exchange; if yes, the amount, if any, of advance payment for premium credits and cost-sharing subsidies. o Treasury may prescribe additional reporting requirements. • In the case of health insurance through an employer-sponsored group health plan, the insurer is also required to report the following information to Treasury: o Name, address and employer identification number of the employer maintaining the plan. o Portion of the premium, if any, required to be paid by the employer. o If coverage is a qualified health plan in the small group market and offered through the Exchange, such information as Treasury may require for administering the small employer tax credit. • Requires insurers (and employers that provide minimum essential coverage) to provide written statements with similar information to each covered individual. Statements are to be given to individuals on or before 1/31 for the previous calendar year. Required information includes: o Information required by the above bullets with respect to each individual listed in return. o Name, address and contact information of the insurer (or others that provide acceptable coverage). In case of coverage provided by any governmental unit or agency, the officer or employee who enters into agreement to provide such coverage shall make the returns and statements. (PPACA § 1502; IRC § 6055)
Employer Mandate	
- Coverage Requirements ("Play")	• Starting in 2014, employer must offer minimum essential coverage that satisfies the individual mandate. • No minimum contribution requirement. • Mandate only applies to employers with an average of at least 50 full-time employees for the prior year. o Full-time employee defined as any employee working, on average, at least 30 hours per week with respect to any month. o Seasonal workers. Employer is not considered to exceed 50 full-time employees if the workforce exceeds 50 full-time employees due to seasonal employees working for 120 days or fewer during the calendar year. "Seasonal worker" means a worker who performs labor or service on a seasonal basis as defined by DOL. This includes retail workers employed exclusively during the holiday seasons. o In situations where the employer did not exist in the preceding year, employer size is determined based on the average number of employees that it is reasonably expected to employ in the current calendar year. (PPACA §§ 1513, 10106; HCERA § 1003; IRC § 4980H)

- Free Rider Penalty ("Pay")	**Large Employers Not Offering Coverage** o Defined as employers that fail to offer "minimum essential coverage" under an employer-sponsored plan to its full-time employees and their dependents. o If employer does NOT offer coverage and at least one full-time employee receives a tax credit or cost-sharing subsidy through the Exchange, penalty is: ▪ Annual fee of $2,000 per full-time worker. ▪ Employer subtracts the first 30 full-time workers from payment calculation (e.g., firm with 51 full-time workers pays $2,000 x 21 = $42,000) ▪ Fee is calculated on a monthly basis, i.e., based on whether coverage is provided, whether one full-time employee receives a credit or subsidy through Exchange and on number of full-time employees for the month. • **Large Employers Offering Coverage** o If employer offers coverage, and at least one full-time employee receives a tax credit or cost-sharing subsidy through the Exchange, then the employer pays the lesser of: ▪ $3,000 for each full-time employee receiving a tax credit or subsidy, or ▪ $2,000 per full-time worker (Employer subtracts the first 30 full-time workers from this payment calculation). o Calculated on a monthly basis. (PPACA § 1513; HCERA § 1003; IRC § 4980H) o Employee Eligibility for Exchange premium tax credit or cost-sharing subsidy. Employees may apply for premium credits when offered employer coverage that is below 60% actuarial value or if employee premiums exceed 9.5% of household income. (PPACA §§ 1401, 10105; IRC § 36B) • **Indexing of Penalty Amounts.** Penalty amounts are indexed annually to average per capita premium increases measured after 2013 (as determined by HHS). • **Timing of Payments.** Treasury may make this payment due annually, monthly or on any other periodic basis. (PPACA § 1513; HCERA § 1003; IRC § 4980H)
- Treatment of Part-Time Employees	Part-time employees are considered solely for the purpose of determining if an employer has average of 50 or more full-time employees and is therefore subject to the employer responsibility and penalty provisions. • Employers are required to add number of hours worked by part-time employees in the month and divide by 120. This number is added to the number of full-time employees. • However, any penalties would be assessed only on behalf of full-time employees who work, on average, 30 or more hours per week with respect to the month. (PPACA § 1003)
- "Free Choice Vouchers"	Starting in 2014, employers that offer coverage and provide any contribution are required to give "vouchers" to "qualified employees," which can be used to purchase coverage through an Exchange. • Qualified employee is one whose required contribution for minimum essential coverage is between 8.0% and 9.8% of household income, whose household income is not greater than 400% of the Federal Poverty Level (FPL), and who does not participate in the employer-sponsored plan. • Amount of voucher is equal to the employer contribution for the plan where the employer pays the largest portion of the premium. • For self-insured plans, the cost is based on past experience or a reasonable estimate for the cost of providing coverage for beneficiaries. Costs shall be adjusted for age and category of enrollment in accordance to regulations established by Treasury. • Amount is equal to the premium for self-only coverage unless the employee elects family coverage. In the latter case, the voucher amount is equal to the employer contribution to family coverage. • If the voucher exceeds the cost of the Exchange-based qualified health plan, any excess amount is paid to the employee (and is includable in employee's income). • An individual receiving a voucher for a month may not receive a premium credit or cost-sharing subsidy for that month. • No employer mandate penalty will be assessed with respect to any employee that purchases Exchange-based coverage using this voucher. (PPACA § 10108)

- Automatic Enrollment for Employees	• Employers with more than 200 full-time employees and that offer employees one or more health benefit plans must automatically enroll full-time employees into one of the health plans, in accordance with DOL regulations. • Employees must be provided with adequate opportunity and notice to opt-out of any automatic enrollment. • Effective once DOL regulations are issued. (PPACA § 1511; FLSA § 18A)
- Employee Notice Requirement	• Requires employers to inform employees of their coverage options through a written notice that includes the following information: o Description of Exchange services and contact information for requesting assistance o That the employee may be eligible for a premium tax credit through the Exchange, if the employer plan is less than 60% actuarial value and the employee purchases a qualified plan through the Exchange. o That if the employee purchases a qualified plan through the Exchange, the employee may lose any employer contribution toward health benefits and such contributions may be excludable from income. • Requires employers to provide such notices at the time of hiring (or, with respect to current employees, not later than 3/1/13). (PPACA § 1512; FLSA § 18B)
- Employer Reporting Requirements	• Starting in 2014, requires large employers (those subject to the employer responsibility requirements) and "offering employers" (those required to offer a "Free Choice Voucher" to at least one employee) to report the following information to Treasury: o Name, address and employer identification number of the employer maintaining the plan o Certification as to whether the employer offers minimum essential coverage to its employees (and their dependents) o Length of any waiting period o The months during the calendar year coverage was made available to employees o Monthly premium for the lowest cost option for each enrollment category within the plan o Employer's share of the total allowed costs of benefits provided under the plan o For offering employers, the option for which employer pays the largest portion of the cost of the plan, and the portion of the cost paid by employer in each enrollment category under that option o Number of full-time employees for each month during the calendar year o Name, address and taxpayer identification number for each full-time employee during the calendar year o The months each full-time employee (and any dependents) were covered under any health benefits plan o Any other information Treasury may require (PPACA §§ 1514, 10108; IRC § 6056) • Starting in 2014, requires employers to provide each full-time employee with a written statement with the following information: o Information required by the above bullets with respect to the individual o Name, address and contact information of the employer submitting the above information to Treasury o Statements are to be provided to individuals on or before 1/31 for the previous calendar year • Provides for coordination of these requirements with the return and statement requirements in IRC § 6055 and the new W-2 requirements. See Individual Mandate section for more details on reporting requirements. Employer may enter into agreement with a health insurance carrier to coordinate information required to be reported under IRC §§ 6055 and 6056. (PPACA § 1514; IRC § 6056)
- Other	• **Waiting Periods.** Employers permitted to have waiting periods up to 90 days without being subject to penalties. (HCERA § 1003) • **W-2 Reporting.** Employers must disclose the aggregate cost of benefits provided by employers for each employee's health insurance coverage on the employee's annual Form W-2. (See Revenue Provisions below for more information.) • **Treatment of Hawaii's Prepaid Health Care Act.** Provides a rule of construction to clarify that the existing ERISA exemption for Hawaii's Prepaid Health Care Act is not affected by this bill. (PPACA § 1560) • **Study on Effect of Tax on Workers' Wages.** DOL will conduct a study to determine whether employee wages are adversely affected by the employer mandate penalties. (PPACA § 1513; IRC § 4980H)

INDIVIDUAL AND SMALL EMPLOYER SUBSIDIES	
Individual Subsidies	
- Tied to Exchange	Makes individual premium credits available only to individuals enrolled in an Exchange-participating health benefits plan. Effective in 2014. (PPACA § 1401; IRC § 36B)
- Eligibility	• **Eligible Individuals.** Makes credits available to those with household incomes up to 400% of the Federal Poverty Level (FPL) for the family size. o Married couples must file joint tax return in order to be eligible for premium subsidies. o Special rule for those aliens lawfully present in U.S. with household income below 100% FPL but not Medicaid eligible. These individuals are treated as eligible for Exchange-based subsidies with household income of 100% FPL for the family size involved. • **Ineligible Individuals** o Prohibits illegal immigrants from receiving subsidies. To receive a premium tax credit, individual must be a citizen or national of the U.S. or an alien lawfully present in the U.S. o Generally prohibits those eligible for minimum essential coverage under employer-sponsored plans, Medicare, Medicaid, CHIP, TRICARE, VA and other coverage deemed acceptable by HHS, from receiving subsidies • **Employee Eligibility.** Employees may apply for premium credits when offered employer coverage that is below 60% actuarial value or if employee premiums exceed 9.5% of household income. (PPACA §§ 1401, 10105; IRC § 36B)
- Credit Amount	• Premium credit is the lesser of the following amounts: o Total monthly premium for qualifying health plan(s) to cover taxpayer, spouse and any dependents; or o The excess of the "adjusted monthly premium" for the applicable second-lowest-cost Silver plan, over a defined percentage of household income. • Defined percentage of household income is a sliding scale determined by the Federal Poverty Level (FPL) of the family involved: o Up to 133% FPL: 2.0% of income o 133-150% FPL: 3.0% – 4.0% of income o 150-200% FPL: 4.0% – 6.3% of income o 200-250% FPL: 6.3% – 8.05% of income o 250-300% FPL: 8.05% – 9.5% of income o 300-400% FPL: Capped to 9.5% of income (PPACA §§ 1401, 10105; HCERA § 1001; IRC § 36B) • "Adjusted monthly premium" is for the second-lowest-cost Silver plan for the rating area where the taxpayer resides. The premium is adjusted for age as allowed under PPACA. If a state is participating in a wellness discount pilot project, the premium, for purposes of determining the tax credit, is determined without regard to any of the discounts for this pilot program. (See "Qualified Health Plans" above for more details on the Silver plan.) • Indexing o Starting in 2015, percentage of income caps are adjusted to reflect the excess rate of premium growth over the rate of income growth for the preceding year. Net effect is that the income caps are expected to increase if premiums grow faster than the rate of income growth. (PPACA § 1401; IRC § 36B) o Starting in 2019, a "failsafe mechanism" is applied if the aggregate amount of premium tax credits and cost-sharing reductions exceeds 0.504% of GDP for the preceding year. Mechanism, if applied, further adjusts income caps to reflect excess rate of premium growth over growth in CPI for the preceding year. (HCERA § 1001) • Benefits offered, in addition to the required "essential health benefits," are excluded from the portion of the premium used to determine the tax credit amount. Any state mandated benefits, beyond the "essential health benefits" package, are also excluded from the portion of the premium used to determine the tax credit amount. (See "Qualified Health Plans" above for more details on "essential health benefits.") o Special rule for pediatric dental coverage. In the case of individuals enrolling in both a qualified health plan and a standalone plan providing for

	pediatric dental coverage (as part of the "essential health benefits" package), amounts allocable to pediatric dental coverage will be included in the premium for calculating the premium tax credit, under regulations prescribed by HHS. (PPACA § 1401; IRC § 36B)
- Use of Premium Credits	Premium credit cannot be used for catastrophic plans. Appears that eligible individuals can use credit for any other level of coverage inside Exchange; however, cost-sharing subsidies are tied to enrollment in the Silver level of coverage. (PPACA §§ 1401-1402)
- Cost-Sharing Subsidy	• Eligible individuals must be enrolled in a Silver plan. • **Maximum Out-of-Pocket (OOP) Limits.** As a first order, cost-sharing subsides reduce OOP limits set at IRC levels for HSA-eligible plans ($5,950 for individuals; $11,900 for families in 2010): o Between 100%-200% of the Federal Poverty Level (FPL): OOP limits reduced by 2/3 o Between 200%-300% FPL: OOP limits reduced by 1/2 o Between 300%-400% FPL: OOP limits reduced by 1/3 • **Coordination with Actuarial Value Limits.** HHS will adjust OOP limits, if necessary, to ensure reduced OOP limits do not result in actuarial values (AV) that exceed the following AV limits: o 94% AV for between 100%-150% FPL o 87% AV for between 150%-200% FPL o 73% AV for between 200%-250% FPL o 70% AV for between 250%-400% FPL • **Additional Cost-Sharing Reduction for Lower Income Enrollees.** HHS will establish procedures for insurers to further reduce cost-sharing to meet the following AVs: o 94% AV for between 100-150% FPL o 87% AV for between 150-200% FPL o 73% AV for between 200-250% FPL • **Treatment of Indians.** No cost-sharing for Indians under 300% FPL enrolled in individual market coverage through an Exchange. • **Additional Benefits.** Benefits offered, in addition to the required "essential health benefits," are excluded from any cost-sharing reductions. Any state mandated benefits, beyond the "essential health benefits" package, are also excluded from any cost-sharing reductions. (See "Qualified Health Plans" above for more details on "essential health benefits.") o Special rule for pediatric dental coverage. In the case of individuals enrolled in both a qualified health plan and a stand-alone dental plan, cost-sharing reductions do not apply to the portion of premiums that, under regulations prescribed by HHS, are properly allocable to pediatric dental benefits. (PPACA § 1402; HCERA § 1001)
- Advance Payment of Premium Tax Credit and Cost-Sharing Subsidies	• **Advance Determination** o HHS shall establish a program for determining eligibility and amount for premium tax credits and cost-sharing subsidies. In most cases, advance determination is based on latest tax return (2012 for 2014). Taxpayer advance payments are later reconciled on applicable year's tax return. (PPACA § 1411) o In case of excess advance payments, the taxpayer's tax liability increases by the amount of any excess payment made by the federal government. ▪ Limitation on tax increase for lower-income families whose household income is less than 400% FPL. Increase in tax liability cannot exceed $400 for families or $250 for individuals. Indexed by cost-of-living adjustment after 2014. (PPACA §§ 1411-1413) • **Premium Tax Credit Payment** o Premium tax credit is paid directly and in advance to the insurer by Treasury to cover a portion of monthly insurance premiums. o Insurers must reflect payment on member bill and notify the Exchange and HHS of such reduction. (PPACA §§ 1401, 1412) • **Cost-Sharing Subsidy Payment** o HHS shall notify insurers if enrollee in a qualified health plan is eligible for cost-sharing subsidies.

	o Insurers shall then notify HHS of any cost-sharing reductions and HHS will make periodic and timely payments to plans. HHS may establish a capitated payment system to take into account the cost-sharing subsidies with appropriate risk adjustments. (PPACA §§ 1402, 1412)
- Study on Affordability	Not later than 5 years after date of PPACA enactment, the Comptroller General will conduct a study on the affordability of health insurance. This includes: (1) Impact of tax credit through Exchanges; (2) Availability of affordable health benefit plans including whether the threshold for affordable employer coverage is appropriate and may be lowered without significantly increasing the federal government's costs; and (3) The ability of individuals to maintain "essential health benefits" coverage. (PPACA § 1401)
- Grace Period for Non-Payment	Grants subsidy-eligible individuals failing to pay any remaining premiums a 3-month mandatory grace period prior to any termination of a policy by an insurer. Insurer shall also notify HHS of any nonpayment. (PPACA § 1412)
Small Employer Tax Credit	
- Eligibility	• Small employers: less than 25 full-time equivalent (FTE) employees, with less than $50K in average annual wages. • Employer must make a nonelective contribution on behalf of each employee enrolled in a qualified health plan in an amount equal to a uniform percentage. Amount must be at least 50% of the premium. • Tax credit is part of the "general business credit" (a nonrefundable credit) as provided for in IRC § 38(b). (PPACA §§ 1421, 10105; IRC § 45R)
- Credit Amount	**Phase I (2010-2013)** • Credit amount is up to 35% of employer costs (25% if tax exempt) with sliding scale for firm size and wages. • Employer costs are lesser of: o Nonelective employer contributions to health insurance coverage, or o Aggregate amount of nonelective contributions an employer would have made if employees enrolled in a health plan that had a premium equal to the average small group premium (as determined by HHS) for the small group market in a given state. • Tax-exempt employer credits are the lesser of: o Credit allowed as defined by general rules above, or o Total amount of income and Medicare (i.e., Hospital Insurance) tax the employer is required to withhold from employees' wages for the year and the employer share of Medicare tax on employees' wages. **Phase II (2014 and beyond)** • Credit amount is up to 50% of employer costs (35% if tax-exempt) with sliding scale for firm size and wages o Only qualified health plans offered through the Exchange are eligible for the tax credit o Tax credit is limited to first 2 consecutive years of coverage (not taking into account years before 2014) • Employer costs are lesser of: o Employer contributions to selected qualified health plan, or o Aggregate amount of contributions an employer would have made if employees enrolled in a qualified health plan that had a premium equal to the average small group premium (as determined by HHS) for the small group market in the rating area in which the employee enrolls for coverage. • Tax-exempt employer credits are the lesser of: o Credit allowed as defined by general rules above, or o Amount of payroll taxes during the calendar year in which the taxable year begins (PPACA §§ 1421, 10105; IRC § 45R)
- Phase Out Schedule	• **Eligibility for Full Small Employer Tax Credit** o 10 or less full-time equivalent (FTE) employees; and o $25K or less in average annual wages.

	o Indexing. After 2013, $25K limit is indexed by the cost of living adjustment. • **Phase Out in the Amount of Credit.** (Credit (before any reduction) is multiplied by following to get reduction amount) o In the case of more than 10 FTEs, the number of FTEs in excess of 10 divided by 15; plus o In the case of average annual wages in excess of $25K, such excess divided by $25K. (PPACA §§ 1421,10105; IRC § 45R) o (Note, if employer has both more than 10 FTEs and average annual wages over $25,000, reduction is sum of amount of 2 reductions.)
- Qualified Coverage	**Phase I (2010-2013).** Eligible "health insurance coverage" consists of products that provide medical care coverage for hospital and medical services as defined by IRC § 9832(b)(1). Generally, this includes health insurance coverage purchased from an insurance company licensed under state law. This does NOT include excepted benefits such as coverage for accident only, disability income insurance, coverage for onsite medical clinics, etc. **Phase II (2014 and beyond).** Only qualified health plans offered through the Exchange are eligible for the tax credit.
- Calculating Wages and Full - Time Equivalent (FTE) Employees	• Full-time equivalent (FTE) employees are determined by dividing total number of hours of service for which wages are paid by the employer for the taxable year by 2,080. Number is rounded down to next lowest whole number. o If an employee works in excess of 2,080 hours, then any such excess is not taken into account for calculating FTEs. o Leased employees are included in FTE and wage calculations • Average annual wages are determined by dividing the aggregate amount of wages paid by the employer during the taxable year by number of FTEs. Number is rounded to the next lowest multiple of $1,000. • Ineligible employees for FTE and wage calculations: o Seasonal employees working for 120 days or less o Self-employed individuals o Any 2% shareholders of an S corporation o Any 5% owner of an eligible small business o Family members with certain relationships to above bullets (e.g., dependent, sister, brother). (PPACA §§ 1421, 10105; IRC § 45R)
OTHER EMPLOYER PROVISIONS	
Part D Tax Exclusion	• **Repeal Business Deduction in Retiree Part D Subsidy Program.** Beginning 2011, eliminates the tax exclusion for subsidy payments made when employers offer retiree prescription drug coverage that is as good or better than Medicare Part D. (PPACA § 9012)
Workplace Wellness	• **Technical Assistance for Employer-Based Wellness Programs.** Requires CDC to provide employers with technical assistance in evaluating worksite wellness programs. (PPACA § 4303) • **National Worksite Health Policies and Program Study.** Within 2 years of enactment, and at regular intervals thereafter, requires CDC to conduct a national survey to assess employer-based wellness programs and make recommendations to Congress based on the findings. o Requires evaluations of all programs funded through the CDC before evaluations are conducted on privately funded programs, unless such a program requests an evaluation. (PPACA §4303) • **Grants to Small Employers.** Provides for grants to small employers to provide comprehensive worksite wellness programs. (PPACA § 10408) • **Break Times for Nursing Mothers.** Requires employers to provide a reasonable break time for working mothers to express breast milk for one year after a child's birth, and to provide a private place for such activities. Exempts employers with fewer than 50 employees if this requirement would impose an undue hardship. (PPACA § 4207)
MEDICAID AND CHIP PROVISIONS	
Medicaid Expansion	Effective 1/1/14, expands mandatory Medicaid eligibility to non-elderly, non-pregnant individuals (generally parents and childless adults) at or below 133% Federal Poverty Level (FPL) who are not entitled to or enrolled for Medicare benefits or otherwise eligible for Medicaid. Specifically, "newly eligible individuals" are defined as those who are not children and who, as of 12/1/2009, were not eligible for full Medicaid benefits, benchmark benefits or benchmark equivalent coverage, or were eligible but not enrolled due to a capped or limited enrollment that was full. (PPACA § 2001)

	• **Additional Federal Funding for Expansion.** Beginning in 2014, additional federal funding is provided to states for the newly eligible population. States that already expanded also receive enhanced federal funding for individuals who are not newly eligible but otherwise fit the definition of the expansion population. In later years, generally no state would receive less than 93% in 2019 and 90% in 2020 and beyond. Specific matching rates are as follows: o ***Enhanced Funding for Newly Eligible Population.*** From 1/1/14 through 12/31/16, states receive 100% federal funding for the newly eligible population. (PPACA § 2001) Federal government pays 95% of the cost in 2017, 94% in 2018, 93% in 2019, and 90% in 2020 and beyond. (HCERA § 1201) o ***Enhanced Funding for Expansion States*** ▪ "Expansion states" are states that before 3/23/10 offered statewide coverage to parents and nonpregnant, childless adults up to 100% FPL that is not dependent on access to employer coverage or employment, and is not limited to premium assistance, hospital-only benefits, a high-deductible health plan purchased through an HSA or a health opportunity account demonstration program. A state which offers coverage to only parents or nonpregnant childless adults shall not be considered an expansion state. (PPACA § 2001) ▪ Federal match increases by 2.2 percentage points in CY 2014 for individuals who are not newly eligible in any state that is an "expansion state" (as defined in preceding bullet), (HCERA, §1201), and HHS determines will not receive any additional federal payments for newly eligible individuals and has not been approved by HHS to divert a portion of disproportionate share hospital (DSH) allotments to the cost of providing Medicaid coverage under a waiver that is in effect in 7/09. (PPACA § 10201). ▪ In addition, the matching rates for expansion states for nonpregnant childless adults are increased by an amount that consists of a transition percentage of the amount by which the federal matching rate for the state is less than the matching rate provided for newly eligible individuals. The transition percentage is 50% for 2014, 60% for 2015, 70% for 2016, 80% for 2017, 90% for 2018 and 100% for 2019 and thereafter. For example, in 2017, a state that has a 50% FMAP would get an additional 80% of the difference between 95 and 50, (0.8 x 45=36) for a total matching rate of 86%, with the state share 14%. (HCERA § 1201). • **Benefits.** Expansion population required to receive benchmark-equivalent benefit packages under SSA § 1937 (PPACA § 2001), modified as follows: o **New Benchmark Benefit Requirements.** Effective 1/1/14, benchmark benefit requirements are modified, requiring such packages to be at least the essential health benefits offered through Exchanges. Modified upon enactment to include coverage of prescription drugs and mental health services, family planning services and parity with mental health services if offered by an entity that is not a Medicaid MCO and such entity provides both medical/surgical benefits and mental health/substance use disorder benefits. (PPACA §2001) Note the Mental Health Parity and Equality Act requirements already apply to Medicaid only insofar as a State's Medicaid agency contracts with one or more managed care organizations (MCOs) or Prepaid Inpatient Health Plans (PIHPs), to provide medical/surgical benefits as well as mental health or substance use disorder benefits. • **Requirement to Not Lower Eligibility.** Effective 3/23/10, maintenance of effort requirement precludes a state from lowering Medicaid eligibility levels before HHS has determined state exchange is fully operational and before FY 2020 for all children currently in Medicaid. Exempts states over the period 1/1/11 through 12/31/13 if state has or is projected to have budget deficits during that period, allowing such states to alter eligibility for non-pregnant, non-disabled adults whose income exceeds 133% FPL. (PPACA § 2001) • **New State Options** o **Earlier Expansion.** Effective 4/1/10, states have a new option to provide Medicaid coverage to the expansion population through 12/31/13 and can phase in coverage by making lower income individuals eligible first. (PPACA § 2001) Federal funds would be provided under current law Medicaid match rates, which are 57% on average. o **Expansion above 133% FPL.** Effective 1/1/14, states also have a new option to expand Medicaid to non-elderly *above* 133% FPL. (PPACA § 2001) Federal funds would be provided under current law Medicaid match rates, which are 57% on average. o **Presumptive Eligibility.** States that provide presumptive eligibility to pregnant women or children may also do so for individuals meeting expansion eligibility requirements. Presumptive eligibility period not to exceed 2 months. (PPACA § 2001) • **Requirement to Cover Kids Before Parents.** Individuals newly eligible as of 1/1/14 or between 4/1/10 and 1/1/14 (for states that elect the option to expand early) who are parents of children under the age 19 (or such higher age a state may have elected) must not be enrolled in Medicaid unless the child is enrolled in Medicaid or other coverage. (PPACA § 2001)
CHIP	**Reauthorizes CHIP** through 2015, 2 years beyond 2013 (when current law authorization expires) and increases state funding as follows: • **Federal Allotment.** $19 billion in FY 2014 and $21 billion in FY 2015. FY 2015 includes 2 semiannual allotments of $2.85 billion and a one-time allotment

	of $15.4 billion. (PPACA § 10203) • **Matching Funds.** Effective 10/1/15 through 9/30/19 increases current law state matching rates by 23 percentage points up to 100%, excluding children in families with incomes above 300% FPL. (PPACA § 2101) • **Eligibility.** Effective 3/23/10, requires states to maintain CHIP eligibility through 9/30/19. (PPACA § 2101) **Technical Changes** • In FY 2010, the enhanced federal matching rate is provided (instead of the regular federal match) to any state that has an approved state plan amendment effective 1/1/06 to provide child health assistance through Medicaid for children up to age 5 whose family income does not exceed 200% FPL. (PPACA § 2102) • Makes other technical changes related to the CHIPRA enrollment and citizenship verification process, altering funds available for state performance payments by removing certain unexpended grants for coverage of childless adults from the available bonus pool, and other minor technical changes. (PPACA § 2102)
Medicaid/CHIP and Exchanges	• **HHS Requirements.** By an unspecified date, HHS is required to develop a single form that will allow individuals to apply for enrollment in Medicaid, CHIP or Exchange subsidies and receive a determination of eligibility. Exchanges are required to inform individuals of eligibility requirements for Medicaid and CHIP. If an Exchange determines that such individuals are eligible for any such program, Exchanges are required to enroll such individuals in such program. (PPACA §§ 1311, 1413) • **State Requirements for Web-Based Enrollment in Medicaid or CHIP.** Effective 1/1/14, states are required to develop an Internet site and procedures for individuals to enroll through the Internet in Medicaid or CHIP. Website must allow individuals to enroll or reenroll in Medicaid with an electronic signature. Must also allow for enrollment in Medicaid or CHIP without any further determination by a state if an Exchange identifies the individual as eligible for Medicaid or CHIP. Website must also be linked to any website of an Exchange established by the state and allow an individual to compare the Medicaid and CHIP benefits, premiums and cost-sharing with those of an Exchange plan. (PPACA § 2201) • **Additional State Requirements.** Effective 1/1/14, states are required to ensure individuals determined ineligible for Medicaid or CHIP are screened for eligibility in an Exchange plan and subsidies. States must also coordinate coverage for individuals enrolled in Medicaid or CHIP and an Exchange plan. States can use Medicaid and CHIP agencies to determine Exchange subsidy eligibility if such agencies enter into an agreement with an Exchange and the agreement complies with Treasury's conditions for reducing administrative costs. (PPACA § 2201) • **CHIP Enrollment in Exchange.** Effective 10/1/15, states can enroll CHIP-eligible children in Exchange plans. States must certify with HHS that such coverage is comparable in benefit and cost-sharing levels to CHIP coverage in the state. (PPACA § 10203) CHIP-eligible children who cannot enroll in CHIP because of federal allotment caps are deemed ineligible for CHIP and eligible for federal tax credits in Exchanges. (PPACA § 2101)
Medicaid/CHIP Income Determinations	• Effective 1/1/14, requires states to use modified adjusted gross income (MAGI) and household income to determine eligibility for CHIP and Medicaid non-elderly individuals. Generally removes state ability to disregard income and expenses, and removes asset and resource tests, except that in determining eligibility using MAGI, states are to disregard income equal to 5% of the upper income limit that applies to the individual. Definition of MAGI is same as income measure used to determine eligibility for Exchange subsidies. MAGI is adjusted gross income increased by any amount of interest received or accrued by the taxpayer during the taxable year which is exempt from tax and foreign earned income excluded from gross income. The new IRC § 36B(d)(2) defines MAGI and household income. Children no longer eligible for Medicaid as a result of the elimination of disregards are eligible for CHIP. (PPACA §§ 1401, 2001, 2002, 2101; HCERA § 1004)
Medicaid Payment to PCPs	• Effective 1/1/13 through 12/31/14, requires Medicaid payments to primary care providers to be no less than Medicare rates. Requires Medicaid MCO payment rates to be consistent with the mandated minimum payment rates. Provides 100% federal funding to meet this requirement. (HCERA § 1202)
Medicaid Payments to Hospitals	• **Reductions in Disproportionate Share Hospital (DSH) Payments.** Reduces aggregate Medicaid DSH allotments by $0.5 billion in 2014, $0.6 billion in 2015, $0.6 billion in 2016, $1.8 billion in 2017, $5 billion in 2018, $5.6 billion in 2019 and $4 billion in 2020. Requires HHS to develop methodology for reducing state allotments that reduces most states that have low rates of uninsured and do not target DSH payments to hospitals based on volume of Medicaid and uncompensated care. (PPACA §§ 2551, 10201) • **Hospital Presumptive Eligibility.** Effective 1/1/14, subject to HHS guidance, hospitals that are participating Medicaid providers may elect to presume individuals are Medicaid eligible for up to 2 months and provide Medicaid coverage regardless of whether the state has elected a presumptive eligibility option for the expansion population, women screened for breast and cervical cancer, family planning services, pregnant women or children. Payments to

	such hospitals would not be considered erroneous payments for purposes of states receiving matching payments. (PPACA § 2202)
Medicaid/CHIP Premium Assistance	• Effective 1/1/14, expands the state Medicaid option regarding premium assistance for qualified employer sponsored coverage as a voluntary alternative to traditional Medicaid for all enrollees (not only children), amending § 1906A of the Social Security Act (SSA) enacted in CHIPRA for children. Precludes states from requiring individuals to apply for employer coverage as a condition of Medicaid eligibility. (PPACA § 2003) • Applies to Medicaid premium assistance offered under § 1906 and § 1906A of the SSA, the CHIPRA requirements related to determining cost-effectiveness that allow the measurement to be determined on a case-by-case or aggregate basis. Repeals CHIPRA provision deeming qualified employer coverage as meeting the cost-effectiveness requirement. Effective as if included in CHIPRA, effective 2/4/09. (PPACA § 10203(b)(1),(2)(A), and (3)) • Although PPACA § 2003 is labeled as requiring states to implement Medicaid premium assistance, PPACA § 10203(b)(2)(B) declares the requirement null and void which appears to maintain premium assistance as optional.
Medicaid Drug Provisions	• **Drug Rebates for Medicaid MCO Enrollees.** Effective 3/23/10, requires drug manufacturers with Medicaid rebate agreements to pay rebates to states for outpatient drugs provided to Medicaid managed care plan enrollees. Requires Medicaid MCOs to report to the state, on a periodic basis to be specified by HHS, information required by HHS to determine rebate amounts including the total number of units of each dosage form and strength and package size by National Drug Code of each covered outpatient drug dispensed to Medicaid enrollees and for which the entity is responsible for coverage. Capitation rates paid to Medicaid MCOs required to be based on actual cost experience related to rebates and subject to federal regulations requiring actuarially sound rates. Exempts covered outpatient drugs dispensed by HMOs and drugs subject to discounts under the 340B program (for public hospitals and community health centers) from the new requirements. (PPACA § 2501(c)) • **Increased Drug Rebates.** Effective 1/1/10, increases the minimum manufacturer rebates as follows: o **Brand Name Drugs.** Increase from 15.1% of average manufacturer price to 23.1%. (PPACA § 2501) o **Generic Drugs.** Increase from 11% of average manufacturer price to 13%. (PPACA § 2501) o **Exceptions.** From 14.1 to 17.1% for certain brand name or generic drugs that have a clotting factor with a separate payment under Medicare or are approved exclusively for pediatric indications. (PPACA § 2501) • **HHS "Clawback" of Rebate Savings.** Effective 1/1/10, directs HHS to reduce payments to states in the amount of the state share for rebates attributable to the increase in the minimum rebate percentage for brand name and generic drugs, taking into account the drugs provided by Medicaid MCOs. (PPACA § 2501) • **Generic Drug Payments to Pharmacists.** Effective 10/1/10, calculates Medicaid payments to pharmacists for such drugs to 175% of the weighted average manufacturer price (AMP). Excludes from AMP in this calculation certain price concessions, including those provided to pharmacy benefit managers and MCOs. (PPACA § 2503) • **Rebates for New Formulations.** Effective 1/1/14, applies additional Medicaid rebate to new formulations of brand name drugs, including new formulations of orphan drugs. Removes loophole that allowed manufacturers to provide lower rebates for new formulations of existing drugs. Now requires rebate to be the greater of the new rebate level or the product of the AMP, the highest additional rebate (compared to the original drug's rebate as a percentage of AMP) and the total number or units of each dosage form and strength. (PPACA § 2501; HCERA § 1206) • **Requirement to Cover Certain Drugs.** Effective 1/1/14, does not permit Medicaid coverage exclusions of smoking cessation drugs, barbiturates and benzodiazepines. (PPACA § 2502)
Medicaid Prevention	• **Public Awareness of Preventive and Obesity-Related Services under Medicaid.** By an unspecified date, requires HHS guidance and information to states and health care providers regarding Medicaid's coverage for obesity-related services and preventive services. Requires states to design a public awareness campaign to educate Medicaid enrollees regarding the availability and coverage of such services. Requires HHS report to Congress by 1/1/11, 1/1/14 and 1/1/17 on status and effectiveness of outreach. (PPACA § 4004) • **Improved Access to Preventive Services for Eligible Adults.** Effective 1/1/13, increases state matching rate by 1 percentage points for prevention services provided to eligible Medicaid adults. States must provide, with no cost-sharing, coverage for all USPSTF services graded A or B and certain vaccines to Medicaid adults. (PPACA § 4106) • **Tobacco Cessation Coverage.** Effective 10/1/10, requires state coverage of tobacco cessation services, including with no cost-sharing for pregnant women in Medicaid. (PPACA § 4107)

	• **Incentives for Chronic Disease Prevention.** By at least 1/1/11, requires HHS to award grants to states to implement an evidence-based program that has been proven successful in helping individuals modify their lifestyle and improve their health status. Appropriates $100 million over 5 years and requires reports to Congress on 1/1/14 and 7/1/16. A state must participate for 3 years. (PPACA § 4108)
Medicaid Quality	• **Adult Health Quality Measures.** HHS recommends core set of quality measures for Medicaid-eligible adults by 1/1/2011. HHS will encourage states to report core measures by 1/1/2013. (PPACA § 2701) • **Payment Adjustment for Health Care-Acquired Conditions.** HHS incorporates state practices preventing payment for health care-acquired conditions into regulations, effective 7/1/2011, that prohibit paying states for providing medical assistance for health care-acquired conditions. Uses Medicare as a guide to defining conditions. (PPACA § 2702) • **Home Health Option for Chronically Ill.** Effective 1/1/11, permits states to provide health home (a provider or a health team designated by the beneficiary that provides health home services) for individuals with chronic conditions. (PPACA § 2703) Requires community health teams to support primary care practices that serve as patient-centered medical homes for Medicaid patients with chronic conditions. (PPACA §§ 3502, 10321) • **Integrated Care Around Hospitalizations.** Effective 1/1/12 to 12/31/16, HHS demonstration in up to 8 states of bundled hospital and physician Medicaid payments for episodes of care that include hospitalizations. Does not appropriate funds. (PPACA § 2704) • **Medicaid Global Payment System Demonstration.** Effective FY 2010 through FY 2012 for demo project period, HHS and Center for Medicare and Medicaid Innovation establish a project where a state adjusts payments to large safety net hospitals or networks from FFS to a global capitated payment model. Authorizes such sums as are necessary for project and limits demo to 5 states. (PPACA § 2705) • **Pediatric ACO Demonstration.** Effective 1/1/12 through 12/31/16, allows pediatric providers meeting specified requirements to be recognized as ACOs and share in any savings if the ACO meets a state-established threshold of savings for Medicaid and CHIP covered services. Authorizes such sums as are necessary for project, with no limit on states; states must participate for 3 years. (PPACA § 2706) • **Medicaid Emergency Psychiatric Demonstration.** 3-year demonstration under which a state could pay a private institution for mental diseases to stabilize emergency conditions for adult beneficiaries under age 65. Appropriates $75 million for FY 2011, available through FY 2015. (PPACA § 2707)
Medicaid and CHIP Program Integrity	**Requirements for Medicaid and CHIP that also apply to Medicare (Medicare-related provisions are also in the Medicare section of the chart):** • **Provider Screening and Other Enrollment Requirements.** HHS must establish pre- screening and other fraud control requirements for providers and suppliers enrolling in Medicare, Medicaid and CHIP. Adds new authority for HHS and states to control enrollment and implement compliance programs and to disclose the identity of terminated providers and suppliers. Gives HHS the authority to adjust payments to providers and suppliers to satisfy any past-due obligations. Effective 9/19/10. (PPACA §§ 6401, 10603) • **Enhanced Funding.** Authorizes substantial new funding for enhanced Medicare and Medicaid Program integrity operations FYs 2011-2020. Effective date of enactment. Extends funding for Medicaid program integrity indefinitely after FY 2010, indexed at CPI. (PPACA § 6402; HCERA § 1304) • **Eliminating Duplication between Data Banks.** HHS shall stop operating the Healthcare Integrity and Protection Data Bank and shall transfer all information to the National Practitioner Data Bank. HHS shall issue regulations to maintain a program to collect and furnish information about certain final adverse fraud-related penalty and sanction actions to the National Practitioner Data Bank. States shall create and maintain systems for reporting, licensing, certification and other adverse actions to the Data Bank. Adverse action information in the Data Bank shall be available for a disclosure fee. No person or entity shall be civilly liable for the reporting or disclosure of this information. Effective on date of enactment. (PPACA § 6403) • **Face-to-Face Encounter Prior to Ordering Home Health Services.** Physicians or covered nurse practitioner specialists must document that there has been a face-to-face encounter with a Medicaid eligible patient prior to ordering DME or home health services. Effective 1/1/10. (PPACA §§ 6407, 10605) • **Expansion of Recovery Audit Contractor Program.** Expands federal Recovery Audit Contractor (RAC) program to Medicaid and Medicare Parts C and D. Effective 12/31/10. (PPACA § 6411) **Provisions specific to Medicaid (and programs that use CHIP funding to expand Medicaid):** • **Termination of Provider Participation.** Providers terminated under Medicare or any federally funded state health programs are also terminated under Medicaid and CHIP. (PPACA § 6501) • **Exclusion from Participation.** Medicaid shall exclude any provider that owns, controls, manages or is affiliated with any entity or individual that has been suspended, terminated or excluded or has unpaid overpayments. (PPACA § 6502)

	• **Registration Requirements for Medicaid Claims Submitters.** Medicaid program billing agents, clearinghouses or other alternate payees are required to register with HHS and the state. (PPACA § 6503) • **Fraud and Abuse Reporting Requirements.** States are required to provide HHS-specified data through MMIS that is necessary for program integrity, oversight and administration, and Medicaid managed care organizations are required to provide patient encounter data to HHS at a frequency that HHS shall set. Effective 1/1/10. (PPACA § 6504) • **No Payment to Entities Outside of U.S.** States shall not make Medicaid payments to financial institutions or entities located outside the United States. (PPACA § 6505) • **Overpayments.** For purposes of the federal Medicaid matching payment to states, extends to one year the time a state has to retrieve overpayments before the federal payment to the state can be adjusted by the unrecovered overpayment amount. Also bars such adjustments until such time as any final determination of the overpayment is made, including a determination on appeal. Effective on date of enactment. (PPACA § 6506) • **Mandating Medicaid Apply the National Correct Coding Initiative (NCCI)** o HHS must identify and notify states of the NCCI methodologies (or other correct coding methodologies) applicable to Medicaid and CHIP claims by 9/1/10. (PPACA § 6507(2)(A)) o States must apply HHS-identified NCCI methodologies to their Medicaid automated claims systems. Effective 10/1/10. (PPACA § 6507(1)) o HHS must file a report with Congress on the identified coding methodologies and notice to states by 3/1/11. (PPACA § 6507(2)(B)) • **General Effective Date and Delay for State Legislation.** Except as otherwise specifically provided, amendments in PPACA §§ 6501 through 6508 are effective on 1/1/11 unless HHS determines state legislation is required to give them effect. Under such circumstance, Medicaid and CHIP programs will not be regarded as out of compliance until the first day of the first calendar quarter following the close of the first regular session of the state legislature following passage of this Act. Effective 1/1/11 (with exceptions). (PPACA § 6508)
MACPAC Reports	**Expanded Scope for MACPAC.** By 6/15/10, the Medicaid and CHIP Payment and Access Commission (MACPAC) is required to publish its first report. Although CHIPRA established MACPAC, no funding was provided. $11 million is authorized in FY 2010. Required report dates are changed from 3/1 and 6/1 each year to 3/15 and 6/15. Mission of MACPAC is broadened to include an assessment of payment policies to Medicaid MCOs. Scope of assessment is expanded to include review of issues related to eligibility, enrollment and retention, benefits and coverage, quality and Medicare-Medicaid interactions. (PPACA § 2801)
Puerto Rico and State Specific Provisions	• **Puerto Rico and Territories.** Effective 7/1/11 through 9/30/19, an additional $6.3 billion is available for payments to territories. Payments increase in proportion to the amounts that are applicable to such territories on the date of enactment. Beginning 7/1/11, increases FMAP applicable to territories from 50% to 55%. With respect to Exchange coverage, permits territories to elect whether to establish an Exchange, with funds available for premium and cost-sharing assistance. Territories that elect not to have an Exchange are entitled to an increase in Medicaid funding. Puerto Rico to receive $925 million of the $1 billion allotted to all territories over the 5-year period 2014-2019 for that purpose. (HCERA § 1204) • **Hawaii.** Provides a disproportionate share hospital (DSH) allotment to Hawaii for the second, third and fourth quarters of 2012 of $7.5 million. Specifies that Hawaii will be treated as a low DSH state for purposes of calculating the annual DSH allotment for fiscal year 2013 and succeeding years. (PPACA § 10201) • **Tennessee.** Allots $100 million in DSH funds over FY 2012 and FY 2013. (HCERA § 1201) • **Louisiana.** Effective 1/1/11, prevents reductions in federal matching rate. (PPACA § 2006)
Other Medicaid	• **Outreach and Enrollment.** Grants for community health workers, among other requirements, require such workers to educate and provide outreach regarding enrollment in health insurance including Medicaid and CHIP. (PPACA § 5313) • **Public Review of Medicaid Waivers.** Before roughly 9/19/10 (180 days from enactment), HHS must issue regulations requiring public review and input on section 1115 waiver applications and renewals. (PPACA § 10201) • **New Community Choice LTC Option.** Effective 10/1/11, allows states to provide home and community-based support services to individuals below 150% FPL or with higher incomes if the individual requires a nursing home level of care. Increases state federal matching rate by 6 percentage points for services provided under such option. (PPACA § 2401; HCERA § 1205) • **Changes to Existing HCBS LTC Payment**

	o Allows states to target coverage to certain groups and removes ability of states to place enrollment caps on home and community based services (HCBS) provided. Requires HHS to issue guidance for states to improve coordination and funding to encourage provision of HCBS. (PPACA §2402) o Extends for an additional 5 years, a demonstration, "Money Follows the Person," that provides extra federal funding to states for moving individuals from nursing homes to HCBS settings. (PPACA § 2403) o Applies certain exceptions for counting spousal income for Medicaid nursing home eligibility to HCBS eligibility. (PPACA § 2404) o Makes additional funding available for state Aging and Disability Resource Centers that help individuals become aware of HCBS options. (PPACA § 2403) o Provides no more than $3 billion over FY 2012 through FY 2015 to encourage states to increase the proportion of long-term care funding for HCBS as opposed to nursing home care. (PPACA § 10202) • **Medicare-Medicaid Dual Eligibles** • **5-Year Demonstration Projects.** Clarifies that state waivers for coordinating care for the dual eligible population may conducted for 5 years and renewed an additional 5 years. (PPACA § 2601) • **Federal Coverage and Payment Coordination.** Effective no later than 3/1/10, requires HHS to establish a new CMS office for dual eligibles. Responsibilities of the office include providing states, SNP MA plans, physicians and others with the education and tools necessary to align benefits for the duals. (PPACA § 2602) • **Foster Care Children.** Effective 1/1/14, requires individuals below the age of 26 who were formerly in foster care under the responsibility of the state to be eligible for Medicaid. May not be required to enroll in benchmark or benchmark-equivalent coverage. Creates a state option to provide presumptive eligibility for this population. (PPACA §§ 2004, 10201) • **Eliminates Medicaid Improvement Fund.** Rescinds $160 million that would have otherwise been available over the period FY 2014 through FY 2018. Fund was intended to improve Medicaid project management, oversight and evaluation within CMS. (PPACA § 2007) • **Coverage for Freestanding Birth Center Services.** Effective 3/23/10 (unless state legislative action is necessary), requires states to reimburse providers at freestanding birth centers for Medicaid covered services provided to Medicaid eligible individuals. (PPACA § 2301) • **Concurrent Care for Children.** Effective 3/23/10, clarifies that children electing to receive Medicaid hospice services are not waiving rights to be provided or have payment made for other Medicaid or CHIP services. (PPACA § 2302) • **Family Planning Option.** Effective 3/23/10, allows states to provide family planning services and supplies to non-pregnant women and other individuals without a waiver. Benefits can be provided solely based on income, removing requirement that individuals be of childbearing age. Benefits include medical diagnosis and treatment services in a family planning setting. Requires benchmark benefit packages for expansion population to include family planning services. Creates a new 2-month presumptive eligibility period for such services. (PPACA § 2303) • **Clarification of Definition.** Clarifies that the term "medical assistance" used in the Medicaid title of the Social Security Act and elsewhere refers to both the services and payment for such services. (PPACA § 2304)
Provisions Related to Native Americans	• **Special Rules for Indians.** Prohibits cost-sharing for Indians with income at or below 300% of FPL who are enrolled in coverage through an Exchange. Establishes that health programs operated by the Indian Health Service, Indian tribes, tribal organizations and Urban Indian organizations shall be the payer of last resort for services, notwithstanding other provisions to the contrary. Facilitates enrollment of Indians under the Medicaid Express Lane enrollment option. (PPACA § 2901) • **Reimbursement of Medicare Part B Services by Indian Facilities.** Effective 1/1/10, removes the sunset provision in current law to allow Indian tribes, tribal organizations and urban Indian organizations to continue to receive reimbursement for Medicare Part B services furnished by certain Indian hospitals and clinics. (PPACA § 2902)
TRADITIONAL MEDICARE PROVISIONS	
Medicare Physician Care and Other Services	• **Physician Payment Update.** The 0.5% update for 2010 included in the underlying Senate bill was repealed by the Manager's Amendment. (PPACA §§ 3101, 10310) • **Primary Care.** Establishes a 10% Medicare bonus payment for certain primary care providers (PCPs) for select codes. Provides a 10% bonus for general surgeons providing major surgical procedures in health professional shortage areas. Effective 1/1/11 through 12/31/15. (PPACA §§ 5501,

	10501(h)) • **FQHCs.** Establishes a Medicare prospective payment system for FQHCs, effective 10/1/14. (PPACA § 5502, which was replaced by §10501(i)) • **Adjustments to Physician Fee Schedule.** Extends, through 2010, the work GCPI floor. Limits variation in practice expense GCPI with a hold harmless for current values. Requires analysis of current methods of establishing practice expense geographic adjustments; the feasibility of using actual or survey data; the office expense portion of the geographic adjustment; and the weights assigned each category. Adjustments are to be incorporated based on the analysis starting 2012. (PPACA § 3102) • **Medicare Therapy Caps.** Extends the therapy cap exceptions process from 12/31/09 through 12/31/10. (PPACA § 3103) • **Physician Pathology Services.** Extends the technical component for certain pathology services through 2010. (PPACA§ 3104) • **Ambulance Add-on Extension.** Extends, through 1/1/11, the ground ambulance add-on; air ambulance add-on; and super rural ambulance add-on. (PPACA §§ 3105, 10311) • **LTC Hospital Payment Rules.** Extends certain payment rules for LTC hospitals and the moratorium from establishing certain hospitals from 3 years to 5 years. (PPACA §§ 3106, 10312) • **Mental Health Add-On.** Extends, from 12/31/09 to 12/31/10, the Part B mental health add-on. (PPACA § 3107) • **Physician Assistants.** Effective 2011, permits physician assistants to order post-hospital extended care services. (PPACA § 3108) • **Pharmacy Accreditation Exemption.** Beginning 2011, exempts from pharmacy accreditation requirements pharmacies with less than 5% total Medicare sales based on the average sales the 3 previous years; the pharmacy is enrolled as a Medicare DME supplier, has had a Medicare provider number for at least 5 years and has had no adverse actions against them in the past 5 years; the pharmacy submits attestation to these 2 categories; and the pharmacy submits materials or to an audit to verify that it meets the criteria of the 2 first categories. (PPACA § 3109) • **SEPs for Disabled TRICARE Beneficiaries.** Establishes a 12-month Part B special election period for disabled TRICARE beneficiaries. (PPACA § 3110) • **Bone Density Tests.** Establishes payment for dual-energy X-ray absorptiometry for bone density testing and requests an IOM study. (PPACA § 3111) • **Medicare Improvement Fund.** Eliminates the remaining $22.29 billion in the Medicare Improvement Fund. (PPACA § 3112) • **Complex Lab Tests.** Establishes a 2-year demonstration project starting 7/1/11 to evaluate payment rules for complex lab tests including those that: analyze gene protein expression, topographic genotyping, or cancer chemotherapy sensitivity assay; HHS determines does not have an equivalent; is billed using a Health Care Procedure Coding System code other than a not otherwise classified code; is approved by the FDA or covered under Medicaid; ***and*** is a diagnostic test under section 354 of the PHSA, diagnostic lab test or other diagnostic test. Payments under the demo may not exceed $100 million. HHS is required to report to Congress not later than 2 years after the conclusion of the demonstration project. (PPACA § 3113) • **Certified Nurse Midwife Services.** Increases reimbursement for certified nurse-wife services starting in 2011. (PPACA § 3114)
Improved Medicare Payment Accuracy	• **Home Health Care.** Makes a number of changes in payments for home health care, including: phased-in rebasing home health prospective payments to reflect the number and mix of services, level and intensity of services and the average cost of providing care; revisions to the HH outlier cap; and a 3% add-on payment for HH providers serving rural areas during 2010-2015. (PPACA §§ 3131, 10315) • **Hospice Payment Reform.** Requires HHS to revise payments to hospices after collecting additional data and consulting with hospice providers and MedPAC. (PPACA § 3132) • **Medicare DSH.** Beginning in 2015, reduces Disproportionate Share Hospital (DSH) payments by 75%. A portion of these savings are returned to hospitals as additional payments to reflect uncompensated care costs. Aggregate amount of additional payments is determined by percent reduction in the national uninsured population. E.g., if uninsured rate falls by 20%, 80% of the 75% reduction would be returned to hospitals based on each hospital's share of total uncompensated care provided by all hospitals. (PPACA §§ 3133, 10316) • **Misvalued Physician Codes.** Beginning 2013, requires HHS periodically to identify physician services as being potentially misvalued and make appropriate adjustments under the physician fee schedule in a budget neutral manner. (PPACA § 3134) • **Imaging Services.** Beginning in 2011, sets the equipment utilization assumption in the physician fee schedule equal to 75% for expensive equipment (>$1 million). Beginning in 2011, increases the multiple imaging discount for certain procedures involving contiguous body parts from 25% to 50%. Excludes reduced expenditures from calculation of budget neutrality. (PPACA § 3135) • **Power Wheelchairs.** Adjusts payments for power-driven wheelchairs, effective 1/1/11. (PPACA § 3136)

	• **Hospital Wage Index.** Extends the hospital reclassifications authorized by Section 508 of the MMA until 9/30/10 and generally requires use of the wage index promulgated 8/27/09. Requires HHS to report to Congress by 12/31/11 with a plan, developed with stakeholder consultation, to comprehensively reform the Medicare inpatient hospital wage index system taking into account the goals set forth in the June 2007 MedPAC report. (PPACA §§ 3137, 3141, 10317) • **Cancer Hospitals.** Requires HHS to study if the outpatient costs of PPS-exempt cancer hospitals with respect to Medicare's APCs exceed costs incurred by hospitals reimbursed under Outpatient Prospective Payment System (OPPS). Requires HHS to adjust payments if such costs are found to be excessive, effective 1/1/11. (PPACA § 3138) • **Hospice Demonstration.** Creates a Medicare Hospice Concurrent Care 3-year demonstration program. (PPACA § 3140) • **Study on Urban Medicare-Dependent Hospitals.** Requires HHS study on the need for additional payment for urban Medicare dependent hospitals for inpatient hospital services. (PPACA § 3142) • **Revision to SNF PPS.** Delays implementation of certain skilled nursing facility "RUGs-IV" payment system changes by one year to 10/1/11. (PPACA § 10325)
Improved Access to Preventive Services	• **Coverage of Annual Wellness Visit.** Starting 1/1/11, requires Medicare coverage of an annual wellness visit with no cost-sharing, including creation of a personalized prevention plan that includes a health risk assessment. Requires such risk assessments be completed prior to or as part of the annual wellness visit. Requires HHS to develop guidelines and a model for health risk assessments. (PPACA § 4103) • **Removal of Barriers to Preventive Services.** Starting 1/1/11, removes cost-sharing for specified preventive services and waives the deductible for colorectal cancer screening tests, effective 1/1/11. (PPACA §§ 4104, 10406) • **Evidence-Based Coverage of Preventive Services.** Allows HHS to modify coverage of any preventive services to the extent consistent with USPSTF recommendations, including services included in the initial physical exam. Allows HHS to withdraw coverage for services not rated A, B, C, or I. (PPACA § 4105)
Medicare Rural Access	• **Program Extensions** o *Outpatient Hold Harmless*. Extends for services rendered by 1/1/11 the outpatient hold harmless provision and includes sole community hospitals regardless of bed size. (PPACA § 3121) o *Reasonable Cost Payments for Certain Lab Tests*. Extends, through 7/1/11, the reasonable cost payment provision for certain clinical diagnostic lab tests furnished in certain rural hospital areas. (PPACA § 3122) o *Rural Community Hospital Demonstration*. Extends, for 5 years, the rural community hospital demonstration program, expands the number of states to 20 and increases the maximum number of hospitals to 30. (PPACA §§ 3123, 10313) o *Medicare-Dependent Hospital Program*. Extends, through 10/1/12, the Medicare-dependent hospital program. (PPACA § 3124) o *Medicare Rural Hospital Flexibility Program*. (PPACA § 3129) • **Temporary Improvements to Payments for Low-Volume Hospitals.** Temporarily improves Medicare payments to low-volume hospitals for FY 2011 and 2012 and increases the threshold to 1,600 discharges. (PPACA §§ 3125, 10314) • **Demonstration Improvements.** Makes improvements to the demonstration project on community health integration models in certain rural counties. (PPACA § 3126) • **MedPAC Study on Payment Adequacy.** Requires MedPAC study on the adequacy of Medicare payment for services and supplies in rural areas. Report due no later than 1/1/11. (PPACA § 3127) • **Technical Corrections for Critical Access Hospitals.** Provides for critical access hospital services to be reimbursed at 101% of reasonable costs – retroactively effective as if included in the MMA. (PPACA § 3128) • **Frontier States Provision.** Provides a floor on the hospital and outpatient wage index and physician practice expense index for "frontier states," defined as states where at least half of the counties have a population per square mile of less than 6 (i.e., Montana, North Dakota, South Dakota, Utah and Wyoming). (PPACA § 10324)
Medicare Sustainability	• **Market Basket Updates and Productivity Improvements.** Reduces annual market basket updates for inpatient and outpatient hospitals, home health, SNF (productivity reductions), hospice and other providers, in addition to productivity adjustments. (PPACA §§ 3401, 10319)

	• **Part B Premium Adjustment.** Freezes income thresholds related to Part B premium subsidies for the period 2011-2019. (PPACA § 3402)
Other	• **New Standards for Certain Medigap Plans.** Directs the NAIC to develop revised standard Plans C and F to include requirements for nominal cost-sharing to encourage the use of appropriate physician services under Medicare Part B. Effective for benefit packages as of 1/1/15. (PPACA § 3210) • **Senior Housing Facility Demonstration.** Beginning 2010, makes the MA senior housing demonstration permanent and permits the plan to limit their service area to the geographic area of the housing facility. (PPACA § 3208) • **Coverage for Individuals Exposed to Environmental Health Hazards in Montana.** Establishes Medicare eligibility for individuals exposed to environmental health hazards who resided in or around the Libby, Montana, geographic area as of 6/17/09. Individuals eligible are diagnosed with one or more of asbestos poisoning, mesothelioma or other condition deemed necessary by HHS. Coverage could be extended to individuals in other areas for which a future public health emergency declaration is made under the Comprehensive Environmental Response, Compensation and Liability Act of 1980. (PPACA § 10323)
PAYMENT ADVISORY BOARD	
Independent Payment Advisory Board	• Establishes an "Independent Payment Advisory Board" that would annually, beginning in 2014, develop a proposal that includes recommendations to reduce the rate of Medicare spending growth to meet specific targets. o Prior to 2018, the target rate is the average of the urban CPI and urban medical care component of the CPI; beginning 2018, the target rate is GDP + 1%. o Hospitals and many types of providers of services and suppliers are excluded from recommendations that would take effect prior to 2020. o Specifically directs that the Board may look at reductions in MA and Part D payments to account for administrative costs and profit, deny high bids and/or reduce/eliminate performance bonuses to bring down the overall rate of growth for the Medicare program. o Proposals are not permitted to include any revenue raised from beneficiary premiums or cost-sharing, benefit or eligibility restrictions. o Directs the President to send the proposal to Congress within 2 days, which is directed to introduce it in both Senate and House with provisions for automatic, expedited consideration with limited debate. o If no proposal is sent in a required year, HHS is directed to develop a proposal based on the Board's recommendations. o If no bill is enacted by 8/15 in a year when a Board proposal is required and transmitted, HHS is directed to implement the Board's recommendations administratively. o Includes annual public report on system-wide health care costs, patient access to care, utilization and quality of care that allows for comparisons by region, types of services, types of providers and both private and Medicare. o Beginning 2015 and every 2 years thereafter, Board makes nonbinding recommendations on ways to slow national health spending (excluding recommendations for Medicare and other federal health programs). (PPACA §§ 3403, 10320)
MEDICARE ADVANTAGE PROVISIONS	
Medicare Advantage Payments	The final bill reduces MA funding by a total of $206 billion over 10 years - $66.7 billion more than the underlying Senate bill. Direct cuts account for $136 billion and interactions with other cuts in the FFS Medicare program account for an additional $70 billion.
- MA Benchmark Cuts	• **Changes to MA Benchmarks.** MA Benchmarks generally will be phased-down to a level of county FFS spending based on a complicated formula: o *Intermediate Update.* In 2011, MA rates do not receive an update and have been set at the 2010 levels. o *Phase-down to 100% FFS benchmark.* In 2012: ½ current benchmark and ½ local FFS; in 2013 and beyond, benchmark equals 100% local FFS (adjusted by county rank described below) unless county qualifies for alternate phase-down schedule. • **Alternate Phase-Down to 100% FFS** o *4-year:* if the reduction between the current 2010 benchmark and one projected for 2010, with ½ FFS and ½ current benchmark, is between $30 and $50, the phase-down to 100% FFS would take 4 years, until 2015. o *6-year:* if the reduction between the current 2010 benchmark and one projected for 2010, with ½ FFS and ½ current benchmark, is $50 or more, the phase-down to 100% FFS would take 6 years, until 2017.

	• **100% FFS Benchmark Adjustment Based on Rank of County in U.S.** County benchmarks will be further adjusted based on the comparison of local FFS spending to the national average and divided into quartiles. o Counties in first quartile of FFS spending (highest), benchmark is adjusted to 95% FFS o Second quartile to 100% FFS o Third quartile to 107.5% FFS o Fourth (lowest) quartile to 115% FFS • At no point can a benchmark exceed what would otherwise apply had the law not been enacted. (HCERA § 1102(b))
- MA Coding Intensity	• Requires HHS to adjust MA rates for coding pattern differences between MA and FFS (i.e., coding intensity adjustment) until HHS implements MA risk adjustment using MA "diagnostic, cost and use data." Previous law sunset this adjustment after 2010. • Beginning in 2011, requires HHS to produce an annual analysis of coding differences. • Mandates a minimum coding intensity adjustment of 5.7% annually beginning in 2019. • Requires 2014 coding intensity adjustment to be no less than 2010 plus 1.3%. • In 2015-2019, requires the adjustment to be no less than the previous year plus 0.25%. (HCERA § 1102(e))
Medicare Advantage Quality Bonus Provisions	Makes quality/performance bonus payments available for both "Qualifying Plans" and "Qualifying Plans in Qualifying Counties" • **Qualifying Plans.** Bonuses result in increased benchmarks for "qualifying plans." Qualifying plans achieve scores of 4 stars or higher on a 5-star rating system developed by HHS based on data from the quality improvement program. • **Benchmark Increases for Qualifying Plans** o 2012: 1.5% increase o 2013: 3.0% o 2014 and beyond: 5.0% o These amounts are *doubled* for qualifying plans in qualifying counties. • **Qualifying Counties.** Defined as historical "urban floor" counties as of 2004; had MA penetration of 25% or greater as of 12/09; *and* county that has FFS spending below the national average for the year involved. • **Low Enrollment Plans.** In 2012, plans with low enrollment that would not qualify for a star rating are treated as qualifying plans. HHS is directed to develop a method to compute quality of low enrollment plans for 2013 and subsequent years. • **New Plans.** Organizations that have not had a contract with HHS for the previous 3 consecutive years are treated as qualifying plans with the following benchmark increases: • 2012: 1.5% increase • 2013: 2.5% • 2014 and beyond: 3.5% (HCERA § 1102(c)) • **Rebate dollars** are tied to an HHS developed 5-star rating system. For plans that bid below the benchmark: o Plans with 4.5 stars or higher receive a rebate equal to 70% of the difference between bid and benchmark (previous law provided for 75%). o Plans with 3.5 to 4.5 stars receive a rebate of 65%. o Plans with fewer than 3.5 stars receive a rebate of 50%. o New plans are treated as having 3.5 stars. o In 2012, low enrollment plans are treated as having 4.5 stars. o Phased-in from 2012 to 2014. (HCERA § 1102(d))

Retroactive Enhanced Penalties	**False Claims.** Expands the use of civil monetary penalties (CMPs) for making false statements or delaying inspections and increases the penalty to $50,000 per statement and $15,000 per day delay. Effective 1/1/10. (PPACA § 6408(a)) • Ensures that audits and inspections of Medicare Advantage plans will be "timely." Effective 1/1/10. (PPACA § 6408(b)(1)) • Adds new types of marketing violations for which sanctions and penalties can be applied, including enrolling or transferring an individual between plans without their consent or transferring an individual solely for the purpose of earning a commission. Extends such prohibition to all employees, contractors, providers or suppliers that contract with the MA plan. Effective 1/1/10. (PPACA § 6408(b)(2)). • Sets the CMP amount for a MA plan providing false information or misrepresentations to HHS at not more than the amount claimed by such plan or plan sponsor based upon the misrepresentation of false information. Effective 1/1/10. (PPACA § 6408(b)(3)) • Extends HHS' permissive exclusion authority to include individuals convicted of interfering with or obstructing an audit related to federally funded health care programs. Effective 1/1/10. (PPACA § 6408(c)) • Applies to both MA and Part D plans.
Other Medicare Advantage Provisions	• **Minimum Medical Loss Ratio (MLR)** o Starting in 2014, requires 85% MLR. o Plans failing the MLR test must remit to HHS "total revenue of the MA plan under this part" for the year multiplied by the amount under the 85% MLR requirement (e.g. $100 revenue with 80% MLR owes $5 = $100 x 5%). o After 3 consecutive years of failing the MLR requirement, plans are prohibited from new enrollment. o After 5 consecutive years, plans will be terminated. (HCERA § 1103) • **Limits on OOP Costs for Individual Health Services.** Beginning in 2011, reduces the flexibility to design benefit packages that meet beneficiary needs by prohibiting MA plans from charging higher cost-sharing greater than that in traditional Medicare for chemotherapy, dialysis, skilled nursing care and such other services CMS deems appropriate. (PPACA § 3202(a)) • **Simplification of Election Periods.** For plan years 2012 and beyond, establishes the open enrollment period as 10/15 through 12/ 7 to help ensure enrollment processing by January; the statute is silent on the open enrollment period for 2011 but the agency has indicated it will continue the current open enrollment period for CY 2011 as 11/15/10 through 12/31/10 . Beginning in 2011, permits MA enrollees to disenroll and return to traditional Medicare at any time within the first 45 days of the year and enroll in a Part D plan. (PPACA § 3204) • **Special Needs Plans** o Extends, to 2013, authority for MA Special Needs Plans (SNPs) for beneficiaries with chronic conditions. o Requires HHS to transition enrollees without applicable chronic conditions to which the SNP is restricted to a non-SNP MA plan or traditional Medicare by no later than 1/1/13. o Extends, through 2012, SNPs for dual eligible enrollees with restriction on service area expansions. o Beginning 2012, requires that all SNPs be NCQA approved. (PPACA § 3205) • **Authority to Deny Bids.** Provides authority for CMS to deny MA and PDP bids for a plan if it proposes "significant increases in cost-sharing or decreases in benefits." Effective for plan years 2011. (PPACA § 3209) • **Cost Contracts.** Extends, through 2013, Medicare Cost contracts. Effective upon enactment. (PPACA § 3206) • **PFFS Plans.** Extends the employer waiver of PFFS network requirements to employers that contract directly with HHS as a PFFS plan. Effective 2011. (PPACA § 3207) • **Comparative Cost Adjustment (CCA).** Repeals the CCA program. CCA was part of the MMA and was designed as a demonstration program where MA and FFS Medicare would directly compete in 6 metropolitan areas. (HCERA § 1102(f)) • **Expansion of Recovery Audit Contractor Program.** Expands federal Recovery Audit Contractor (RAC) program to Medicaid and Medicare Parts C and D. Effective 12/31/10. (PPACA § 6411)

MEDICARE PART D PROVISIONS	
Coverage Gap	• **Reduction in Coverage Gap.** New provision provides a $250 government-issued rebate to all beneficiaries that reach the coverage gap in 2010. o Implements a 93% coinsurance rate for generics in 2011 in the coverage gap (down from 100% today) and phases it down to 25% in 2020. o Similarly phases-down the coinsurance for brand name drugs to 25%. o Reduces growth rate of the amount of expenditures it takes for beneficiaries to reach the catastrophic out-of-pocket cap, above which the government pays 95% of drug costs. o In 2014 and 2015, reduces the growth rate of the catastrophic limit by 0.25%. o In 2016-2019, the rate of growth is the lesser of the urban CPI+2% or the average increase in drug costs. (HCERA § 1101(b), (c)) • **Brand Drug Discounts in Coverage Gap.** Beginning with drugs dispensed after 1/1/11, incorporates voluntary PhRMA agreement to provide discounts of 50% for brand-name drugs used by Part D enrollees in the Part D donut hole. Discounts paid by the manufacturer are counted as incurred drug expenses toward the catastrophic limit, beyond which Medicare pays 95% of drug costs. (PPACA § 3301)
Taxes	• **Repeal Business Deduction in Retiree Part D Subsidy Program.** Beginning 2011, eliminates the tax exclusion for subsidy payments made when employers offer retiree prescription drug coverage that is as good or better than Medicare Part D. (PPACA § 9012)
Low-Income Provisions	• **Determination of Low-Income Benchmark Premium.** Beginning in 2011, the Part D low income premium subsidy benchmarks are calculated to exclude any beneficiary rebate in MA-PDs that bid below the benchmark or MA performance quality bonus payments. (PPACA § 3302) • **De Minimis Policy for Subsidy-Eligible Individuals.** Directs HHS to develop a de minimis policy to permit a Part D plan to waive the monthly premium for a LIS eligible individual. Beginning in 2011, the policy of auto enrolling LIS eligible beneficiaries shall include MA-PD and PDPs that have waived the monthly premium for LIS individuals. (PPACA § 3303) • **Special Rule for Widow(er)s.** Beginning in 2011, extends for one year the LIS determination period for individuals whose spouse dies. (PPACA § 3304) • **Improved Information for Certain Subsidy-Eligible Individuals.** Beginning 2011, for LIS eligible individuals that are reassigned to another plan (because their previous plan no longer qualifies for LIS enrollments), within 30 days HHS is required to provide the beneficiary with information on formulary differences between plans and a description of the individual's right to request a coverage determination, exception or reconsideration. (PPACA § 3305) • **Outreach and Assistance Funding.** Provides $7.5 million for FY 2009 and $15 million for FY 2010 through 2012 for state health insurance programs; the same amounts and periods for Area Agencies on Aging; $5 million in FY 2009 and $10 million for FY 2010 through 2012 for Aging and Disability resource centers; and $5 million in FY 2009 and $5 million for 2010 through 2012 for contract with the National Center for Benefits and Outreach and Enrollment. (PPACA § 3306) • **Cost-Sharing Elimination for Certain Individuals.** Eliminates cost-sharing for an individual receiving services through a home and community based waiver who would otherwise be institutionalized, not earlier than 2012. (PPACA § 3309)
Other Part D Provisions	• **Protected Classes.** CMS shall designate the classes of medications that should be included in the "protected" classes in Part D, and in the interim, prior to a rule regarding these classes, the current 6 classes will be codified. Beginning 2011, requires all Part D sponsors to cover **all** drugs in the 6 protected classes (currently they have to cover "all or substantially all"). (PPACA § 3307) • **Means-Test Part D.** Medicare Part D subsidies would be reduced for higher-income beneficiaries in a similar manner as Medicare Part B premium subsidies through Social Security withholding. (PPACA § 3308) • **Free Generic Fill.** Not earlier than 1/1/11, provides for MA-PD and PDP sponsors to waive cost-sharing for the first fill of a generic medication in order to promote greater use of generic substitution. (PPACA § 6402(d)(2)(B)) • **Reducing Waste in Long-Term Care Pharmacies.** Beginning 2012, requires MA-PD plans and PDPs to utilize specific, uniform dispensing techniques developed by HHS (such as daily, weekly or automated dose) when dispensing covered Part D drugs to institutionalized enrollees to reduce the waste associated with 30-day fills. (PPACA § 3310) • **Improved Complaint System.** Requires HHS to develop a complaint system to collect complaints against MA-PD plans and PDPs and to annually report to Congress on the number and types of complaints. Directs HHS to develop a model electronic complaint form and "prominently" display on the front page of Medicare.gov. (PPACA § 3311)

	• **Uniform Exceptions and Appeals Process.** Requires all Part D sponsors to use a single, uniform exceptions process for the determination of drug coverage and provide instant access by means of a toll-free phone number and the Internet by 2012. (PPACA § 3312) • **OIG Studies and Reports.** Requires HHS IG to study and report by 7/1/11 (and annually thereafter) on the extent that formularies include drugs commonly used by full-benefit dual eligible individuals. Additionally requires, by 10/1/11, a report on the prices for covered Part D drugs and covered outpatient drugs including the 200 most frequently dispensed drugs and an assessment of the financial impact of any discrepancies in prices on the federal government and state governments under Medicaid. (PPACA § 3313) • **Costs Counted toward OOP Threshold.** Includes drug costs incurred by AIDS drug assistance programs and Indian Health Service, an Indian tribe or organization on behalf of Part D enrollees toward the annual out-of-pocket cap. (PPACA § 3314) • **Improvement in MTM Systems.** For plan years beginning at least 2 years from enactment, requires Part D sponsors to include medication therapy management (MTM) services to targeted beneficiaries that include an annual, comprehensive, person-to-person medication review and a process for auto-enrollment with the ability to opt-out. Sponsors must also have in place a process to quarterly assess the medication use of individuals who are at risk but not enrolled in a MTM program. (PPACA § 10328) • **MTM Grants.** Requires HHS to award grants to implement medication therapy management (MTM) services for specified individuals (e.g., those who take 4 or more medications, high-risk medications or have 2 or more chronic diseases). Specifies requirements for grant entities. Requires MTM services to include a list of specified services (e.g., assessments of health and functional status, medication treatment plans and medication therapy, etc.). Permits HHS to award grants for the development of performance measures that assess the use and effectiveness of medication therapy management services. (PPACA § 3503) • **Marketing Prohibitions.** Adds new types of marketing violations for which sanctions and penalties can be applied, including enrolling or transferring an individual between plans without their consent or transferring an individual solely for the purpose of earning a commission. Extends such prohibition to all employees, contractors, providers or suppliers that contract with the PDP or MA-PD plan. Effective retroactively to 1/1/10. (PPACA § 6408(b)(2)) • **Expansion of Recovery Audit Contractor Program.** Expands federal Recovery Audit Contractor (RAC) program to Medicaid and Medicare Parts C and D. Effective 12/31/10. (PPACA § 6411)
ADMINISTRATIVE SIMPLIFICATION	
Rule Development	**Rulemaking to Support Standards and Operating Rule Requirements.** Instructs HHS to issue rules to implement new and amended standards and operating rules for electronic administrative and financial transactions. • Adopts Operating Rules – to create as much uniformity as possible in implementing electronic standards – for each individual standard transaction. (PPACA § 1104) • Establishes a unique health plan identifier, effective 10/1/12. (PPACA § 1104) • Establishes a standard and associated operating rules for health claims attachments, effective 1/1/16. (PPACA § 1104) • Establishes a standard for electronic funds transfers, effective 1/1/14. (PPACA § 1104)
Compliance Process	**Compliance Process for Health Plans.** New compliance process establishes a requirement for health plans and their associated service contractors and business associates to document to HHS their compliance with standards and operating rules. • Health plans must certify that their data and information systems are in compliance with standards and operating rules. (PPACA § 1104) • Compliance will be based on the effective date of applicable standards and operating rules. (PPACA § 1104) • Health plans must be able to document end to end testing with trading partners. (PPACA § 1104) • Health plans must ensure entities that provide services under contract with the plan are in compliance. (PPACA § 1104) • Requires periodic audits to ensure health plan compliance. (PPACA § 1104)
Standardization	**Transaction Standardization.** Specifies the new or revised standards that must be used for the electronic exchange of administrative and financial transactions. • References all existing HIPAA transactions. (PPACA § 1104) • Adds standard for claims attachments. (PPACA § 1104)

	• Adds standard for electronic funds transfers. (PPACA § 1104) • Refers to ICD 9 to ICD 10 crosswalk posted on CMS website as a standard. (PPACA § 10109)
Penalties	**Penalties for Health Plans.** Establishes new health plan penalties against plans that fail to provide sufficient documentation showing they are certified to be in compliance. • Establishes penalties for failure to meet requirements. (PPACA § 1104) • Penalty amount is $1 per covered life for each day not in compliance. (PPACA § 1104) • Additional penalties apply for misrepresentation. (PPACA § 1104) • Maximum penalties $20 per covered life or $40 per covered life if misrepresentation determined. (PPACA § 1104)
Adoption Requirements	**Timeframe for Adoption.** Specifies the timeframes for the adoption of the new health plan identifier and for both new and revised standards and operating rules. • Adopts operating rules for eligibility and claim status transactions by 7/1/11. (PPACA § 1104) • Adopts operating rules for electronic payment and remittance advice by 7/1/12. (PPACA § 1104) • Adopts operating rules for claims, enrollment, premium payments and referral transactions by 7/1/14. (PPACA § 1104) • Adopts a standard for electronic funds transfers by 1/1/14. (PPACA § 1104) • Adopts standard and associated operating rules for claims attachments by 1/1/14. (PPACA § 1104) • Establishes a unique health plan identifier by 10/1/12. (PPACA § 1104)
Additional Requirements	**Additional Requirements.** Instructs HHS to establish requirements for both HHS and various entities involved in processes related to the creation and maintenance of standards and operating rules. • Specifies the qualification requirements for entities that develop operating rules. (PPACA § 1104) • Identifies actions to be taken by the National Committee on Vital and Health Statistics (NCVHS) related to operating rules development. (PPACA § 1104) • Establishes an operating rules review committee by 4/1/14. Could include NCVHS. (PPACA § 1104) • Instructs HHS to solicit industry input on the need for greater uniformity in financial and administrative transactions every 3 years, starting 1/1/12. (PPACA § 10109)
HHS QUALITY/SAFETY IMPROVEMENTS	
National Strategy for Quality Improvement	• **National Strategy.** Directs HHS to establish a national strategy to improve the delivery of health services, patient outcomes and population health and identify national priorities for such improvement (taking into consideration recommendations of the entity under contract with Medicare (under SSA § 1890(a)) regarding a national strategy and priorities for health care performance as well as input from other stakeholders). Directs HHS to identify national priorities for such improvement. Requires such priorities to: o Have the greatest potential for improving outcomes, efficiency and patient-centeredness of care for all populations. o Identify areas in the delivery of health services that have the potential for rapid improvements in quality and efficiency. o Address gaps in quality, efficiency, comparative effectiveness information, health outcomes measures and data aggregation techniques (taking into account the limits on the use of evidence or findings from comparative effectiveness research specified under new SSA § 1182, as added by PPACA § 6301). o Improve federal payment policy to emphasize quality and efficiency. o Enhance the use of health care data to improve quality, efficiency, transparency and outcomes. o Address health care provided to patients with high-cost chronic diseases. o Improve research and dissemination of strategies and best practices to improve patient safety and reduce medical errors, preventable admissions and readmissions and health care-associated infections. o Reduce health disparities.

	• **Coordination with States.** Requires HHS to coordinate and consult with state Medicaid and CHIP agencies in developing and disseminating strategies, goals, models and timetables consistent with the national priorities. • **Strategic Plan.** Requires national strategy to include a comprehensive strategic plan that must be updated at least annually. Requires the strategy to achieve the identified priorities that addresses at minimum: o Coordination among agencies within HHS, including use of common quality measures, where available. Specifies that quality measures used be those identified by HHS under SSA § 1139A (child health quality measures for Medicaid and CHIP), SSA § 1139B (a new provision under this bill adding adult health quality measures under Medicaid – see PPACA § 2701) or endorsed under SSA § 1890 (the Medicare performance measurement provision noted earlier). o Agency-specific strategic plans and annual benchmarks for each agency. o Regular reporting by the agencies on the implementation of the strategic plan. o Strategies to align public and private payers regarding quality and safety efforts. o Incorporating quality improvement and measurement into the strategic plan for HIT required by the ARRA of 2009. • **Initial and Updated Strategies.** Requires HHS to submit its initial recommended strategy to Congress by 1/1/11 and to submit annual updates to that strategy thereafter. Requires each update to include: o A review of the short- and long-term goals of the national strategy and any gaps in such strategy. o An analysis of the progress in meeting such goals and any barriers to such progress. o Information reported under current child health quality measures for Medicaid and CHIP (under SSA § 1139A); and, after 1/1/14, the new adult health quality measures under Medicaid under new SSA § 1139B (as created by PPACA § 2701). • **Quality Internet Website.** Requires HHS to create an Internet website by 1/1/11 to make public information regarding the national priorities, the agency-specific strategic plans and other information HHS determines to be appropriate. (PPACA §§ 3011, 10302)
Interagency Working Group on Quality	Requires the President to convene an Interagency Working Group on Health Care Quality. • **Goals.** Sets the following goals for the Working Group: o Collaboration, cooperating and consultation between federal departments and agencies re: developing and disseminating strategies, goals, models and timetables consistent with the national priorities developed under PPACA § 3011. o Avoidance of duplication of quality improvement efforts and resources and a streamlined process for quality reporting and compliance requirements. o Assessment of the alignment of quality efforts in the public and private sectors. • **Composition.** Specifies that the Working Group will be composed of senior level representatives of HHS, CMS, NIH, CMC, FDA, HRSA, AHRQ, the Office of the National Coordinator for HIT, SAMSA, the Administration for Children and Families, the Departments of Commerce, Labor, Defense, Education, and Veterans Affairs, OMB, the U.S. Coast Guard, the Federal Bureau of Prisons, NHTSA, the FTC, the SSA, OPM, the Veterans Health Administration and any other federal agencies and departments with activities relating to improving health care quality and safety, as determined by the President. Specifies that HHS will chair the group, with other members serving as Vice Chair on a rotating basis. • **Report.** Requires the group to make an initial report to Congress by 12/31/10 and annually thereafter, and to make this report available on a public website. (PPACA § 3012)
Development of Quality and Outcome Measures	• **Identification of Quality Measures.** Requires HHS, in consultation with AHRQ and CMS, to identify, not less often than every 3 years, gaps where no quality measures exist and existing quality measures that need improvement, updating or expansion, consistent with the national strategy under PPACA § 3011, for use in federal health programs. Directs HHS to consider, in identifying such gaps: o Any gaps identified by the entity under contract with HHS under SSA § 1890(a) and other stakeholders. o Current child health quality measures for Medicaid and CHIP (under SSA § 1139A) o New adult health quality measures under Medicaid under new SSA § 1139B (as created by PPACA § 2701)

	• **Quality Measure Development Grants** o Directs HHS to award grants, contracts or intergovernmental agreements to eligible entities to develop, improve or update such quality measures. Sets standards for entities to be eligible for such grants. Gives priority to development of measures that allow assessment of: ▪ Health outcomes and functional status of patients. ▪ Management and coordination of care across episodes of care and care transitions across the continuum of providers, settings and health plans. ▪ Experience, quality and use of information provided to and used by patients and caregivers to inform decision-making about treatment options. ▪ Meaningful use of HIT. ▪ Safety, effectiveness, patient-centeredness, appropriateness and timeliness of care. ▪ Efficiency of care. ▪ Equity of health services and health disparities. ▪ Patient experience and satisfaction. ▪ Use of innovative strategies and methodologies identified under new PHSA § 933 (as added by PPACA § 3501). ▪ Other areas determined appropriate by HHS. o Quality measures developed by grantees must address the gaps identified by HHS, support other measures required to reported under the SSA, and: 1) to the extent practicable, be able to be collected using HIT; 2) be free of charge to users of such measures; and 3) be publicly available on an Internet website. o Requires HHS to ensure that grants or contracts are coordinated with those awarded under SSA §§ 1139A and 1139B. • **Quality Measures under CMS.** Amends SSA § 1890A (added by the bill) to direct CMS, in consultation with AHRQ, to develop quality measures for use under the Social Security Act. Requires that at least half of the $375 million appropriated for this provision ($75 million for each of FYs 2010-2014) be spent on this subsection. • "**Quality Measure."** Defines this term as a standard for measuring the performance and improvement of population health or of health plans, providers and other clinicians in the delivery of health care services. • **Outcomes Measure Development.** Requires HHS to develop and update (not less than every 3 years) provider-level outcome measures for physicians, hospitals and other providers determined appropriate by HHS. Requires such measures to include outcome measures for 1) acute and chronic diseases, including, as feasible, the 5 most prevalent and resource-intensive acute and chronic medical conditions; and 2) primary and preventive care, including, as feasible, measures for care of distinct patient populations. o *Goals.* Such measures are intended to address issues regarding risk adjustment, accountability and sample size; include the full scope of services in a cycle of care; and include multiple dimensions. o *Timing.* Requires HHS to develop at least 10 measures for acute and chronic disease by 24 months after enactment and at least 10 measures for primary and preventive care by 36 months after enactment. • **Hospital-Acquired Conditions.** Requires HHS, to the extent practicable, to publicly report on measures for hospital-acquired conditions currently used by CMS for adjusting hospital payments. (PPACA §§ 3013, 10303)
Quality and Efficiency Measures	• **New Duties for Consensus-Based Entity.** Gives new duties to the consensus-based entity under contract with Medicare (under SSA § 1890(a)) to make recommendations on a national strategy and priorities for health care performance and endorse measures for standardized health care performance. These new duties include: o *Identifying Gaps in Quality and Efficiency Measures*. Requires the consensus-based entity to provide a report identifying gaps in endorsed quality and efficiency measures and areas in which evidence is insufficient to support endorsement of quality/efficiency measures and where targeted research may address such gaps. o *Selection of Quality and Efficiency Measures*. Requires the entity to convene a multi-stakeholder group to provide input on the selection of quality and

	efficiency measures endorsed by the entity as well as measures used or proposed to be used by HHS and on national priorities for performance improvement developed under PPACA § 3011. Establishes transparency requirements for the multi-stakeholder group. Requires the consensus-based entity to report the input of the group to HHS annually, beginning 2/1/12, and HHS to determine to use recommended quality and efficiency measures only after taking into account this input. Requires HHS, no later than 12/1 of each year (starting with 12/1/11), to make the list of quality and efficiency measures under consideration by HHS available to the public. • **Impact Assessment.** Requires HHS to assess the quality impact of the use of endorsed measures no later than 3/1/12 and at least once every 3 years thereafter, and make such assessment available to the public. • **Dissemination.** Requires HHS to establish a process for disseminating endorsed quality and efficiency measures. • **Periodic Review of Measures.** Requires HHS to periodically (no less than once every 3 years) review the quality measures in use and determine whether to continue using them or to phase them out. • **Funding.** Provides for the transfer from the Medicare trust funds to CMS of $20 million for each of FYs 2010-2014. (PPACA §§ 3014, 10304)
Data Collection and Reporting	• **Data Collection and Analysis** o Requires HHS to collect data on quality and resource use measures from information systems used to support health care delivery to implement the public reporting of performance information. o Permits HHS to award grants to entities that enable summary data that can be integrated and compared across multiple sources. Eligible entities must: ▪ Be: 1) a multi-stakeholder group that coordinates the development of methods and implementation plans for consistent reporting of summary quality and cost information; 2) an entity capable of submitting summary data for particular populations; or 3) a federal Indian Health Service program. ▪ Promote the use of systems that provide data to improve and coordinate patient care. ▪ Support the provision of timely, consistent quality and resource use information to health care providers, and other groups, with an opportunity for providers to correct inaccurate measures. ▪ Agree to report measures on quality and resource use to the public. ▪ Match funds with $1 for each $5 of federal funds provided under the grant. • **Public Reporting.** Requires HHS to make available to the public, through standardized Internet websites, performance information summarizing data on quality measures. Such information shall include information on clinical conditions and, where appropriate, shall be provider-specific and disaggregated and specific enough to meet the needs of patients with different conditions. o Requires information to be tailored to the different needs of providers, practitioners, patients, consumers, researchers, and other stakeholders. o Requires HHS to consult with the consensus-based entity under SSA § 1890(a) and other entities as appropriate to determine the type of information that is useful to stakeholders and the format that will best facilitate use of the reports. Requires the entity to convene a multi-stakeholder group to provide input on the design and format of the website. • **Funding.** Appropriates funds as necessary for FYs 2010 through 2014. (PPACA §§ 3015, 10305)
Clinical Practice Guidelines	Amends MIPPA § 304(b) (which requires HHS to contract with the Institute of Medicine to study and report on the best methods for developing clinical practice guidelines) to use the results of that study to identify existing and new clinical practice guidelines developed using such best methods. (PPACA § 10303(c))
Quality Reporting	• **Availability of Medicare Data for Performance Measurement.** Starting 1/1/2012, HHS may give (for a fee) standardized extracts of Medicare claims data for specified geographic areas to qualified public and private entities to evaluate provider performance. (PPACA § 10332) • **"Physician Compare" Website.** No later than 1/1/2011, HHS will develop a website on Medicare physicians participating in the PQRI program, and by 1/1/13, implement a plan to publicly report information on physician performance. To the extent practicable, HHS will include data reflecting care to all patients seen by physicians, and appropriately attribute care when multiple providers are involved in caring for a patient. Report to Congress due 1/1/15. (PPACA § 10331)

	• **Better Diabetes Care.** HHS and CDC will issue biennial national and (if possible) state diabetes report cards showing aggregate health outcomes (PPACA § 10407).
Consumer Education	• **Facilitating Shared Decision-Making.** Establishes standards and certification of patient-decision aids for "preference sensitive care" – where clinical evidence does not clearly support one treatment option – and grants for their implementation. (PPACA § 3506) • **Rx Drug Benefit and Risk Information.** FDA determines whether to add standardized summaries of benefits and risks to Rx drug labels. (PPACA § 3507) • **Improving Women's Health.** Establishes an Office of Women's Health and a National Women's Health Information Center to facilitate sharing information regarding health promotion, preventive services, research advances and education in appropriate use of health care services. (PPACA § 3509) • **Young Women's Breast Cancer.** CDC conducts national education campaign to increase awareness of breast health issues. (PPACA § 10413)
Comparative Effectiveness Research	**Comparative Effectiveness Research (CER).** Establishes a private, nonprofit Patient-Centered Outcomes Research Institute to identify national priorities for research and carry out research projects to evaluate and compare health outcomes and clinical effectiveness, risks and benefits of 2 or more medical treatments/services/items. Governed by a Board consisting of AHRQ and NIH Directors and 19 members (appointed by the Comptroller General) representing consumers, providers, payers, drug/device makers, researchers and federal and state health programs. Funded by the Patient-Centered Outcomes Research Trust Fund that collects $1 multiplied by the number of lives covered under each health insurance policy or self-insured health plan, and Medicare Part A and B in FY 2013, and $2 (growing at the rate of per capita growth in health expenditures) in 2014-19. (PPACA §§ 6301, 10602) • *Limits*. Places conditions on HHS uses of CER, including that HHS may not deny coverage of items/services under Medicare solely on the basis of CER, or use CER that values older, disabled or terminally ill lives lower than younger, non-disabled or not terminally ill lives. The Institute may not establish cost-effectiveness based on dollars-per-quality adjusted life year or similar measures. • *Office of Communication and Knowledge Transfer within AHRQ*. Creates tools to broadly disseminate CER findings to providers, patients, payers and policy makers. (PPACA § 6301)
Other Quality Improvement	• **Center of Excellence for Depression.** HHS awards grants to educational or research institutions to establish national centers of excellence for depression to develop and carry out innovative treatments. (PPACA § 10410) • **Programs for Congenital Heart Disease.** CDC establishes a National Congenital Heart Disease Surveillance System, made available to public and researchers. (PPACA § 10411) • **Clinical Education Demonstration.** HHS matching grants (5:1) to institutions of higher education to develop curricula integrating quality improvement and patient safety in the education of health professionals. (PPACA § 3508) • **Patient Navigator Program.** Extends existing Navigator program indefinitely, and requires that entities receiving grants to provide patient navigator services meet minimum core proficiencies. (PPACA § 3510) • **Public Access Defibrillation Programs.** Adds requirements that current program be administered by an organization with expertise in pediatric education/medicine, electrophysiology and sudden death. Extends authorization of appropriations through 2014. (PPACA § 10412) • **Key National Indicators.** Establishes a Commission on Key National Indicators that will work with the National Academy of Sciences to determine how best to establish a key national indicator system for the U.S. (PPACA § 5605)
Nursing Home Transparency	**Improving Transparency of Information.** New disclosure requirements regarding the ownership of a facility and accountability requirements for SNFs and a new compliance and ethics program to prevent/detect violations and promote quality. (PPACA §§ 6101, 6102)
HHS DELIVERY SYSTEM REFORMS/COST CONTAINMENT FOR MEDICARE AND MEDICAID	
Medicare Facilities Payment Reforms	• **Hospital Value Based Purchasing (VBP).** Establishes budget-neutral VBP for hospitals in Medicare for discharges on or after 10/1/12 (FY 2013). Applies to 1% of base DRG payments in FY 2013 increasing to 2% in future years. (PPACA § 3001(a)) • **Other VBP.** Develop plans to implement VBP programs for skilled nursing facilities, home health agencies and ambulatory surgical centers (Reports to Congress due 1/1/11). (PPACA §§ 3006, 10301) • **VBP Pilots.** Pilot test VBP program for psychiatric hospitals, long-term care hospitals, rehabilitation hospitals, PPS-exempt cancer hospitals and hospice programs not later than 1/1/16; if successful, HHS may expand after 1/1/18. (PPACA § 10326) • **Pay for Reporting.** Starting in rate year 2014, LTC and inpatient rehabilitation, psychiatric hospitals and hospice programs that do not submit data on

	quality measures to CMS will have their annual update reduced by 2%. Exempt cancer hospitals must submit quality data as a condition of participation. CMS will make quality measures public. In addition, HHS will collect additional data from hospice programs to revise payment rates for certain services not earlier than 10/1/13. (PPACA §§ 3005, 3132, 10322) • **"Efficiency" Payments.** HHS will make $400 million in special payments available in FYs 2011 and 2012 to hospitals in counties with age-sex-race adjusted spending per beneficiary in the lowest quartile of all counties. (HCERA § 1109) • **Hospital-Acquired Conditions Payment Adjustment.** Starting in FY 2015, applies a 1% payment reduction to all discharges for hospitals in top quartile of hospitals with respect to their rates of risk-adjusted hospital-acquired conditions. (PPACA § 3008) • **Hospital Readmissions Reduction Program.** Starting in FY 2013, reduction in payment for hospitals based on their levels of excess preventable readmission: up to 1% in 2013, up to 2% in 2014, up to 3% in 2015 and thereafter. (PPACA §§ 3025, 10309) • **Medicare Shared Savings Program (ACOs).** Creates Accountable Care Organizations (ACO) / Shared Savings payment model within FFS Medicare to allow groups of providers working together (the ACO) that reduce costs for assigned Medicare FFS beneficiaries relative to a spending benchmark and meet quality targets to share in a portion of the Medicare savings. Allows different payment models: FFS, partial capitation, any other payment models. HHS may give preference to ACO involved with other payers. (PPACA §§ 3022, 10307) • **Voluntary Payment Bundling Pilot.** Establishes a national voluntary pilot program starting 1/1/13 for 10 conditions (to be identified by HHS) to bundle payments for episodes of care (defined as 3 days prior to admission, hospital stay and 30 days post-discharge). Bundled services include inpatient and outpatient hospital services, post-acute care services, physicians, post-acute providers such as SNFs and other services. May be expanded and extended after 2016 if there are certified savings. (PPACA §§ 3023, 10308) • **Gainsharing Demonstration Extension.** Extends the gainsharing demonstration until 9/30/11, and extends the relevant reporting requirements. Appropriates an additional $1.6 million in FY 2010, available through FY 2014. (PPACA § 3027)
Medicare Physician Payment Reforms	• **Physician Quality Reporting Initiative.** Extends incentives for reporting to 2014, but lowers them (1.5% in 2011, 1% after). In 2015, incentives end and penalties for non-reporting begin (-1.5% in 2015, -2% after). As an alternative to submitting data to CMS, physicians may submit data to a Maintenance of Certification (MOC) program run by a medical specialty body, which will submit data to CMS on behalf of its participants. Moreover, physicians submitting data to an MOC receive an additional 0.5% incentive if they complete a MOC practice assessment. (PPACA §§ 3002, 10327) • Begins phasing in **physician payment modifier** based on composite of quality and efficiency measures under the physician fee schedule. (PPACA § 3007) (Actual payment starts 1/1/15 for some physicians; phases in for all physicians by 1/1/17).
Medicare Physician Feedback Program	HHS will use claims data to give physicians confidential reports that measure each physician's resource use. HHS will develop an "episode grouper" to aggregate claims for separate but clinically related items and services and by 1/1/12 give reports to physicians that benchmark their patterns of resource use by episodes of care. (PPACA § 3003)
Other New Medicare Delivery Models/ Reforms	• **New Center for Medicare and Medicaid Innovation (CMI)** to test and evaluate different payment structures and methods to reduce spending and improve quality. HHS may expand projects in Medicare, Medicaid and CHIP that improve quality of care without increasing spending or reduce spending without reducing quality. Potential models for testing include allowing states to test all-payer payment reform and contracting directly with groups of providers and suppliers, such as through risk-based comprehensive payment or salary-based payment. Provides a direct appropriation of $10 billion in aggregate for FYs 2011-2019. (PPACA §§ 3021, 10306) • **Community-Based Care Transitions Program.** HHS funds hospitals with high readmission rates or community-based organizations with arrangements with hospitals to manage transition of chronically ill "high-risk" beneficiaries from inpatient to outpatient settings. Starting 2011 for 5 years, though HHS may expand the program if HHS determines it will reduce spending without reducing quality. (PPACA § 3026) • **Minority Health.** Establishes the Office of Minority Health in Office of the Secretary that will award grants/contracts to public and nonprofit private entities to assure improved health status of racial and ethnic minorities through such activities as community outreach, language services, workforce cultural competence, etc. (PPACA § 10334) • **Independence at Home Demonstration.** Beginning no later than 1/1/12, HHS tests payment incentive and delivery model using primary care teams to deliver home-based care for high-need population (2 or more chronic illnesses) and coordinate health care across all settings. Must use electronic health systems, remote monitoring and mobile diagnostic technology. Spending targets determined on a per capita basis with a risk corridor. (PPACA § 3024)

Other Medicare Initiatives	• **Modernizing CMS Computer and Data Systems.** HHS develops plan/budget to improve providers' access to data for care management and coordination, and support evaluations of delivery/payment system reforms. (PPACA § 10330) • **GAO Study on Beneficiary Access to Dialysis.** GAO to study including oral drugs in bundled payments for treating ESRD and report to Congress within one year. (PPACA § 10336) • **GAO Study on Causes of Action.** GAO to report within 2 years on whether various new delivery system reforms and quality improvement provisions would establish new causes of action (right to sue). (PPACA § 3512)
Federal Delivery Innovations	• **Community-Based Collaborative Care Networks.** HHS grants (through HRSA) to consortia of providers with a joint governance structure that provide comprehensive and integrated health care services for low-income populations. Grantees may help low-income individuals access services and health coverage programs, obtain a regular primary care provider, provide case and care management, perform health outreach and provide transportation. (PPACA § 10333) • **Regionalized Systems for Emergency Care.** HHS awards at least 4 grants for pilot projects to state/local government partnerships or Indian tribes to test innovative models of regionalized emergency/trauma care. (PPACA § 3504) • **Trauma Care Centers and Service Availability.** HHS awards grants to Indian trauma centers to defray uncompensated costs and improve services. (PPACA § 3505)
HHS PREVENTION AND WELLNESS	
Modernizing Disease Prevention & Public Health Systems	• **National Prevention, Health Promotion and Public Health Council** o *New Council.* Requires the President to establish within HHS a National Prevention, Health Promotion and Public Health Council, to be composed of representatives from designated federal agencies, to: ▪ Provide coordination and leadership with respect to prevention, wellness, health promotion practices and the public health system. ▪ Develop a strategy to improve health status and reduce preventable illness. ▪ Make recommendations to the President and Congress concerning the country's most pressing health challenges. ▪ Consider and propose evidence-based and innovative approaches to promote new models of prevention, integrative health and public health on individual and community levels. The President shall establish an Advisory Group to the Council, composed of 25 non-federal members (including a diverse group of licensed health professionals). o *National strategy.* Within one year of enactment, requires the council to recommend a national prevention, health promotion and public health strategy that sets specific goals for improving health in the United States, establishes specific and measureable actions and timelines to carry out the strategy and makes recommendations to improve federal efforts. o *Reports.* Requires the Council, by 7/1/10 (and annually thereafter through 1/1/15), to report on the Council's prevention and health promotion efforts and national progress in meeting specific goals, with lists of national priorities, and including specific plans for meeting goals. No less than every 5 years, requires joint reviews and evaluations by HHS and GAO of every Federal disease prevention and health promotion initiative, program and agency. (PPACA § 4001) • **Prevention and Public Health Fund.** Establishes a new Prevention and Public Health Investment Fund for prevention and public health programs. Appropriates $500 million for FY 2010; $750 million for FY 2011; $1 billion for FY 2012; $1.25 billion for FY 2013; $1.5 billion for FY 2014 and $2 billion for each of FYs 2015 and beyond. (PPACA § 4002) • **Clinical and Community Preventive Services.** Requires AHRQ and CDC to convene an independent Prevention Services Task Force (to review and make recommendations on clinical preventive services) and a Community Preventive Services Task Force (to review and make recommendations on population-based preventive services). Duties of the Task Forces to include: o Develop additional topic areas for recommendation. o Review interventions and update recommendations (at least once every 5 years). o Improve integration with federal health objectives and related target setting for health improvement. o Enhance dissemination of recommendations. o Report annually to identify gaps in research and recommend areas deserving further examination. Directs the task forces to coordinate their work. (PPACA § 4003)

	• **Education and Outreach** o *Public-Private Partnership.* Requires HHS to implement a national public-private partnership for a prevention and health promotion outreach and education campaign to raise public awareness of health improvement across the life-span. o *Media Campaign*. By one year after enactment, requires the CDC to implement a national science-based media campaign on health promotion and disease prevention to address nutrition, exercise, smoking cessation, obesity reduction, the 5 leading disease killers in the country and disease screening. Requires HHS to evaluate the campaign every 2 years. Requires creation of an Internet website with science-based information on these topics. o *Provider Focus.* Requires dissemination of information to providers who participate in federal programs. o *Personalized Prevention Plans*. Requires development and operation of a federal Internet website that provides a personalized prevention plan tool that will allow individuals to determine their risk of disease and obtain personalized suggestions for preventing such diseases. o *Internet Portal*. Requires establishment of an Internet portal for accessing risk assessment tools developed and maintained by private and academic entities. o *State Guidance*. Requires HHS to provide information to states and providers regarding preventive and obesity-related services available to Medicaid enrollees and requires states to design public awareness campaigns regarding the availability and coverage of such services. Requires HHS to report to Congress on these efforts by 1/1/11 and every 3 years thereafter though 1/1/17. (PPACA § 4004)
Improved Access to Preventive Services	• **School-Based Health Centers.** Appropriates $50 million for each of FYs 2010-2013 to provide grants to states to support the operation of school-based clinics. (PPACA §§ 4101, 10402) • **Health Care Prevention.** Provides for a national 5-year public education campaign focusing on oral health care prevention and education. Also provides for demonstration grants on the effectiveness of dental caries disease management activities. (PPACA § 4102)
HHS Prevention and Wellness Initiatives	• **Community Transformation Grants.** Provides for grants to state and local government agencies and community-based organizations for evidence-based community preventive health activities to reduce chronic disease rates, address health disparities and develop a stronger evidence-base of effective prevention programming. Examples of activities to be funded include programs to create healthier school environments; highlight healthy food options; assess and implement worksite wellness programs; and promote programs to improve nutrition, physical activities and smoking cessation. (PPACA §§ 4201, 10403) • **Community-Based Prevention and Wellness Programs for Medicare Beneficiaries** o *Grants.* Provides for grants to state or local health departments and Indian tribes to carry out 5-year pilot programs to provide public health community interventions, screenings and clinical referrals for individuals between 55 and 64 years of age. Examples of activities to be funded include public health intervention activities (e.g., improving nutrition); health screenings; and measuring changes in the prevalence of risk factors among participants. o *Evaluation and Plan for Medicare.* Allocates $50 million from the Medicare Trust Fund for HHS to evaluate community-based prevention and wellness programs and develop a plan for promoting healthy lifestyles and chronic disease self-management for Medicare beneficiaries. (PPACA § 4202) • **Improved Access for Disabled Individuals.** Within 24 months of enactment, requires federal standards for medical diagnostic equipment (e.g., exam tables and chairs, scales, mammography equipment and radiologic equipment) used in physicians' offices, hospitals and other settings to ensure its usability for disabled individuals. (PPACA § 4203) • **Immunizations.** Allows HHS to negotiate with vaccine manufacturers to purchase certain vaccines for adults, and allows states to obtain additional quantities of such vaccines at a price negotiated by HHS. Establishes a demonstration program to improve immunization rates of high-risk populations. Requires GAO report to Congress on the impact of coverage of adult immunizations under Part D on access to those immunizations by Medicare beneficiaries. (PPACA § 4204) • **Nutrition Labeling at Chain Restaurants.** Requires restaurants that are part of a chain with 20 or more locations to disclose nutritional content and calorie information on its standard menu items, as well as information on suggested daily caloric intake as specified by the FDA. Includes exceptions to such requirements. Establishes similar requirements for packaging on vending machine items. (PPACA § 4205) • **Individualized Wellness Plan Demonstration.** Requires HHS to establish a pilot program to test the impact of providing at-risk populations who use community health centers an individualized wellness plan designed to reduce their risk factors for preventable conditions. (PPACA § 4206)

HHS Prevention and Wellness Research	• **Research on Optimizing Delivery of Public Health Services.** Requires HHS to fund research in the following areas: o Examining evidence-based practices relating to prevention, and comparing community-based public health interventions in terms of effectiveness and cost. o Analyzing the translation of interventions from academic settings to real world settings. o Identifying effective strategies for organizing, financing or delivering public health services. (PPACA § 4301) • **Health Disparities Research** o *Data Collection, Analysis, Reporting and Dissemination.* Within 2 years after enactment, requires HHS to ensure that federally supported health care or public programs collect data on race, ethnicity, gender, geographic location, socioeconomic status, primary language, disability status and any other demographic data deemed appropriate. Requires HHS to develop national standards for various measures and for the management of data collected and develop interoperability and security systems for data management. Requires HHS to disseminate its analyses to various federal agencies, publish the analysis on the HHS website and make data available for research. Requires HIPAA privacy protections be used with respect to such data. o *Standardized Data Collection in Medicaid and CHIP.* Requires that any data collected under Medicaid and CHIP programs meet the requirements above. Requires HHS to evaluate approaches for collecting health disparities data under these programs, and to implement such approaches within 24 months of enactment. (PPACA § 4302) • **Epidemiology Lab Capacity Grants.** Provides grants to assist public health agencies in improving surveillance for, and response to infectious disease and other conditions of public health importance. (PPACA § 4304) • **Research and Treatment for Pain Care Management.** Takes multiple steps to address pain care, including: o Convening an Institute of Medicine conference on pain. o Encouraging the NIH to continue and expand an aggressive program of basic and clinical research on the causes and potential treatments for pain. o Establishing an Interagency Pain Research Coordinating Committee to coordinate all efforts among federal agencies relating to pain research. o Supporting programs to educate and train providers in pain care. (PPACA § 4305) • **Funding for Childhood Obesity Demonstration.** Appropriates $25 million for these demonstrations for FYs 2010-2014. (PPACA § 4306) • **Evaluation of Federal Health and Wellness Initiatives.** Requires HHS to evaluate whether existing federal health and wellness initiatives are achieving their stated goals. (PPACA § 4402) • **Cures Acceleration Network.** Requires the NIH to establish a Cures Acceleration Network to award grants and contracts to develop cures and treatments of diseases. Grants will be awarded to accelerate the development of "high need cures" through the development of medical products and behavioral therapies. Defines "high need cures" as a drug or device that is a priority to diagnose, mitigate, prevent or treat harm from a disease or condition, for which private market incentives are unlikely to result in its adequate or timely development. (PPACA § 10409)
Diabetes Care	• **Better Diabetes Care.** Directs HHS to develop a national report card on diabetes to be updated every 2 years and to work with health professionals and states to improve data collection related to diabetes and other chronic diseases. Provides for an Institute of Medicine study on the impact of diabetes on medical care. (PPACA § 10407) • **National Diabetes Prevention Program.** Establishes a national diabetes prevention program at the CDC. State, local and tribal public health departments and non-profit entities can use funds for community-based prevention activities, training and outreach and evaluation. (PPACA § 10501(g))
TRANSPARENCY	
HHS Transparency	• **Physician Self-Referral Exceptions.** Adds requirements for rural hospitals to qualify for the rural provider exception to the prohibition on certain physician self-referrals due to ownership or investment. Beginning not later than 9/23/11, only hospitals with physician ownership or investment and a provider agreement in operation on 12/31/10 and that meet numerous specified requirements are exempt from the prohibition on self-referral. Limits such hospitals from expanding their facilities, with a process for appeal. Places requirements on the physician-hospital relationship. (PPACA §§ 6001, 10601) • **Reporting of Physician Ownership/Investment Interests.** Manufacturers of drugs, biologicals, medical devices and supplies must file public reports with HHS on payments or value transfers to physicians and/or physician ownership interests. Effective 3/31/13. (PPACA § 6002) • **Disclosure Requirements.** Disclosure requirements for certain, previously exempt, in-office ancillary imaging services under the prohibition on physician

	self-referral (Stark). Effective 1/1/10. (PPACA § 6003) • **Rx Drug Sample Transparency.** Drug manufacturers and distributors must report to HHS the drug samples requested and distributed and the identity of the requesting practitioner. Effective 4/1/12. (PPACA § 6004) • **PBM Transparency Requirements.** For purposes of Medicare Part D and plans offered through state Exchanges, PBMs must report to HHS, at a time and in a manner to be specified by HHS, the generic dispensing rate payments by pharmacy type, aggregate amounts and types of rebates, discounts or price concessions based on patient utilization negotiated and passed on to plan sponsors, the total number of prescriptions dispensed and the aggregate difference between the amount the plan pays the PBM and the PBM pays the pharmacies. HHS must keep the information confidential except for specified purposes. Effective on date of enactment (requires HHS regulation). (PPACA § 6005)
FRAUD AND ABUSE	
Medicare, Medicaid and CHIP Programs Integrity	• **Provider Screening and Other Enrollment Requirements.** HHS must establish pre-screening and other fraud control requirements for providers and suppliers enrolling in Medicare, Medicaid and CHIP. Adds new authority for HHS and states to control enrollment and implement compliance programs and to disclose the identity of terminated providers and suppliers. Gives HHS the authority to adjust payments to providers and suppliers to satisfy any past-due obligations. Effective 9/19/10. (PPACA §§ 6401, 10603) • **90-Day DME Payment Hold.** HHS must hold Medicare payment of a durable medical equipment (DME) supplier's claims for 90 days if there is a significant risk of fraudulent activity among DME suppliers in a geographic area or within a category of DME. Effective 1/1/11. (HCERA § 1304) • **Enhanced Program Integrity Funding Provisions.** Authorizes substantial new funding for enhanced Medicare and Medicaid Program integrity operations FYs 2011-2020. Effective date of enactment. Adds $250 million to the HHS Medicare Health Care Fraud and Abuse Account in Treasury over the period FY 2011 through FY 2016. (PPACA § 6402; HCERA § 1303) • **Eliminating Duplication between Data Banks.** HHS shall stop operating the Healthcare Integrity and Protection Data Bank and shall transfer all information to the National Practitioner Data Bank. HHS shall issue regulations to maintain a program to collect and furnish information about certain final adverse fraud-related penalty and sanction actions to the National Practitioner Data Bank. States shall create and maintain systems for reporting licensing, certification and other adverse actions to the Data Bank. Adverse action information in the Data Bank shall be available for a disclosure fee. No person or entity shall be civilly liable for the reporting or disclosure of this information. Effective on date of enactment. (PPACA § 6403) • **Maximum Period for Submission of Medicare Claims.** Maximum time for Medicare providers to submit claims reduced to not more than 12 months. Effective for services furnished on or after 1/1/10 (with claims for services provided before 1/1/10 to be submitted by 12/31/10). (PPACA § 6404) • **Physicians Ordering DME or HH Services.** Physicians who order home health or DME are required to be enrolled in Medicare. HHS may extend requirement to other categories of items or services. Effective 7/1/10. (PPACA §§ 6405, 10604) • **Documentation on Referrals to Programs at High Risk of Waste and Abuse.** Physicians ordering DME and home health services must produce supporting documentation upon request of HHS or face disenrollment from Medicare for up to a year. Effective 1/1/10. (PPACA § 6406) • **Face-to-Face Encounter Prior to Ordering Home Health / DME.** Physicians or covered nurse practitioner specialists must document that there has been a face-to-face encounter with a Medicare eligible patient prior to ordering DME or home health services. HHS may extend the face-to-face encounter requirement to other Medicare covered items and services. Effective 1/1/10. (PPACA §§ 6407, 10605) • **Medicare Self-Referral Disclosure Protocol.** Directs HHS to develop, not later than 9/23/10, a self-referral disclosure protocol (SRDP) for violations of the physician self-referral prohibition (Stark) and permits HHS to reduce a provider's penalties for the use of such SRDP. (PPACA §6409) • **Adjustments to DME Competitive Bidding Program** o Increases the expansion of phase 2 DME competitive bidding areas from 70 to 91 new metropolitan areas. (PPACA § 6410(a)) o HHS shall competitively bid DME covered by Medicare or use competitive bid prices in paying for DME in all remaining areas. Effective 1/1/16. (PPACA § 6410(b)) • **Expansion of Recovery Audit Contractor Program.** Expands federal Recovery Audit Contractor (RAC) program to Medicaid and Medicare Parts C and D. Effective 12/31/10. (PPACA § 6411) • **Oversight of Community Mental Health Centers.** Redefines the term "community mental health center" (for purposes of Medicare coverage of partial hospitalization services) to require that at least 40% of services must be furnished to individuals not eligible for Medicare, and specifies that a program of partial hospitalization services is one that does not offer services in the patient's home or in an inpatient or residential setting. Effective 4/1/11. (HCERA §

	1301) • **Contractor Random Prepayment Review.** Repeals current statutory limits on contractor use of random and non-random prepayment review (i.e., a contractor's demand for records and documentation does not have to be related to a specific claim). (HCERA § 1302).
Additional Program Integrity Provisions	• **Clarifying Definition.** Expands the definition of "federal health care offense" to include ERISA-related convictions and other criminal violations by benefit plan personnel. Effective upon enactment. (PPACA § 6602) • **Model Uniform Report Form.** Directs NAIC to develop a model fraud and abuse reporting form and submit reporting standards recommendations to HHS. Effective upon enactment. (PPACA § 6603) • **Evidentiary Privilege and Confidential Communications.** Permits DOL to establish, by regulation, a confidentiality of communications and evidentiary privilege between DOL, DOT, DOJ, HHS and a state AG or insurance agency, and the NAIC related to any investigation, audit, examination or inquiry conducted by these agencies. Effective upon enactment. (PPACA § 6607) • **Fraud Enforcement.** Directs the development of higher penalties in the federal sentencing guidelines for federal health care crimes. Grants administrative subpoena power for health care records related to HIPAA and institutionalized person civil rights cases. Effective upon enactment. (PPACA § 10606)
MULTI-EMPLOYER WELFARE ARRANGEMENT (MEWA) PROVISIONS	
Additional Program Integrity Provisions	• **Prohibition on False Statements.** Making certain false statements in the marketing of multiple employer welfare arrangements (MEWA) regarding financial conditions or solvency, benefits or state or federal regulatory status is a crime punishable by fines and up to 10 years in prison. Effective upon enactment. (PPACA § 6601) • **Applicability of State Law.** DOL may adopt regulations to set standards, or issue an order, to establish that state fraud and abuse laws will apply to persons providing insurance through a MEWA. Effective upon enactment. (PPACA § 6604) • **Cease and Desist Orders.** DOL may issue administrative cease and desist and seizure orders for MEWA plans that are fraudulent or in hazardous financial condition. Provides for an administrative appeals hearing. Effective upon enactment. (PPACA § 6605) • **MEWA Registration.** Requires MEWAs to register with DOL prior to operating in a state. Effective upon enactment. (PPACA § 6606)
CLASS ACT PROVISIONS	
New Federal LTC Program	Creates new, voluntary national insurance program (Community Living Assistance Services and Supports or "CLASS" program) financed through payroll deductions to provide a cash benefit to individuals who require community living assistance services and support. • **Enrollment.** Provides for auto-enrollment of all working individuals over age 18, but permits them to opt out of the program. Allows employers to provide payroll deduction for premium costs. Prohibits underwriting to prevent individuals from enrolling in the program to determine their premiums. • **Premiums.** Requires individuals to contribute monthly premiums (set by HHS based on an actuarial analysis of the 75-year costs of the program). Premiums to remain the same for as long as an individual is an active enrollee in the program, although premiums can be increased if HHS determines that such increase is necessary to ensure program solvency. Individuals age 65 or older, who have paid premiums for at least 20 years and are not actively employed are exempt from such increases. Permits higher age-adjusted premiums for individuals who reenroll after more than a 3-month lapse in coverage. Charges only a nominal premium ($5/month) for individuals with incomes below 100% FPL and full-time students under age 22. • **Eligibility for Benefits.** Vesting period of 5 years. Benefits are triggered when an individual experiences a functional limitation that is expected to last more than 90 days. Provides tiered benefits to individuals unable to perform a minimum number (which may be 2 or 3) "activities of daily living." • **Benefits.** Eligible beneficiaries would receive not less than $50 per day (increased annually by the increase in the CPI), scaled to the level of functional ability. The benefit would not be subject to any lifetime or aggregate limit. Payment of the cash benefit would go into a beneficiary's Life Independence Account for the purchase of nonmedical services and supports (personal assistance, transportation, assistive technologies, etc.) needed to maintain independence at home or in another residential setting of their choice in the community. o Beneficiaries enrolled in Medicaid and receiving services in an institution would retain 5% of the daily or weekly cash benefit and the remainder would be applied toward the institution's cost of providing care. Medicaid would provide secondary coverage for such care. o Beneficiaries enrolled in Medicaid and receiving home and community-based services would retain 50% of the daily or weekly cash benefit and the

	remainder would be applied toward the cost to the state of providing such assistance. Medicaid would provide secondary coverage for the remainder of any costs incurred. • **Eligibility for Other Benefits.** Benefits paid under the CLASS program are to be disregarded for purposes of determining that individual's eligibility for any other Federal, state or local assistance program (i.e., Social Security, Medicare, Medicaid, low-income housing assistance, etc.) (PPACA § 8002)
Other LTC Provisions	• **LTC Insurance Tax Treatment.** Treats CLASS program in same manner as LTC insurance for tax purposes. (PPACA § 8002) • **Medicaid Incentives for HCBS.** Provides FMAP increases of 2-5% to encourage states to shift Medicaid beneficiaries out of nursing homes and into home and community based services (HCBS). (PPACA § 10202)
WORKFORCE IMPROVEMENT PROVISIONS	
Innovations in the Health Care Workforce	• **National Health Care Workforce Commission.** Establishes a new Commission to review health care workforce supply and demand and make recommendations on priorities and goals, to oversee and report on the operation of state health care workforce development grants, study effective mechanisms for financing education and training for health care careers, submit recommendations on improving workplace safety, and assess reports from the National Center for Health Care Workforce Analysis. (PPACA §§ 5101, 10501(a)) • **State Workforce Development Grants.** Provides for planning and implementation grants to enable state partnerships to complete comprehensive planning and carry out workforce strategies at the state and local levels. (PPACA § 5102) • **National and State Centers for Workforce Analysis.** Provides for the National Center, together with the Commission, to develop information on health care workforce issues, evaluate program effectiveness, develop performance benchmarks and establish a national health workforce database. Awards grants to state and regional centers to collect, analyze and report on workforce data at the state and local level. (PPACA § 5103) • **Alaska Task Force.** Establishes a temporary task force to assess health care access and develop a strategy to improve health care delivery in Alaska. (PPACA § 10501(b))
Increasing Workforce Supply	• **Loan Programs.** Increases interest rates for students failing to comply with the terms of medical school and primary care federally supported loans. Amends loan agreements under the Nursing Student Loan Program. Creates a pediatric specialty loan repayment program to increase the supply of pediatric providers. (PPACA §§ 5201-5203) • **Recruitment and Retention Programs.** Establishes a Public Health Workforce Loan Repayment Program and recruitment and retention programs for allied health professionals to ensure an adequate supply of public health professionals to eliminate critical shortages in federal, state, local and tribal public health agencies. (PPACA §§ 5204, 5205) • **Grants for State and Local Programs.** Provides grants for scholarships to eligible individuals to enroll in degree or professional training programs to enable mid-career professionals in the public health and allied health workforce to receive additional training. (PPACA § 5206) • Provides funding for the National Health Service Corps. (PPACA § 5207) • Provides grants for the cost of operating nurse-managed health clinics. (PPACA § 5208) • Establishes a commissioned Regular Corps and a Ready Reserve Corps for service in time of national emergency and eliminates the cap on the commissioned corps. (PPACA §§ 5209, 5210)
Workforce Education and Training	• Grants or contracts to support and develop primary care training programs. (PPACA § 5301) • Grants to enable new training for direct care workers in LTC settings. (PPACA § 5302) • Grants or contracts to support and develop dental training programs. (PPACA § 5303) • Demonstration project to establish training programs for alternative dental health providers to increase access to dental care in rural and underserved communities. (PPACA § 5304) • Grants or contracts to: 1) geriatric education centers for fellowship programs and either family caregiver training or incorporation of best practices re: mental disorders in older adults; and 2) health professionals, to foster greater interest in entering the fields of geriatrics, LTC and chronic care management. (PPACA § 5305) • Grants to higher education institutions to support recruitment of students for, and education and clinical experience of students in, behavioral and mental

	health education programs as well as state-licensed mental health organizations. (PPACA § 5306) • Support for the development, evaluation and dissemination of research, demonstrations and model curricula for cultural competency, prevention and public health proficiency and aptitude for working with individuals with disabilities training. (PPACA § 5307) • Makes nurse-midwifery programs eligible for nursing education grants. (PPACA § 5308) • Grants to enhance the nursing workforce by initiating and maintaining nurse retention programs. (PPACA § 5309) • Expands the existing loan repayment and scholarship programs for nursing students. (PPACA § 5310) • Provides for repayment of education loans to increase the number of qualified nursing faculty. (PPACA § 5311) • Grants to promote positive health behaviors for populations in medically underserved areas through the use of community health workers. (PPACA § 5313) • Provides funding for fellowship programs in epidemiology training, laboratory training and Public Health Informatics as well as for expanding the Epidemic Intelligence Service. (PPACA § 5314) • Establishes a Public Health Sciences Track with authority to grant appropriate advanced degrees. (PPACA § 5315) • Establishes a training demonstration program that supports recent practitioner graduates in primary care in Federally Qualified Health Centers (FQHCs) and nurse-managed health clinics. (PPACA § 10501(e))
Support for Existing Workforce	• Establishes conditions for grants to health professions schools as "centers of excellence." (PPACA § 5401) • Increases funding for loan repayment scholarships for disadvantaged students. Provides funding to reauthorize loan repayments and fellowships for faculty positions and to reauthorize educational assistance in the health professions for individuals from disadvantaged backgrounds. (PPACA § 5402) • Provides for awards to medical schools to recruit minorities into health professions, prepare individuals to provide care in underserved areas, conduct interdisciplinary training and deliver or facilitate continuing education. (PPACA § 5403) • Expands the diversity workforce grant program to include additional scholarship services including bridge or degree completion programs and accelerated nursing degree programs. (PPACA § 5404) • Establishes a primary care extension program to provide support and assistance to PCPs to educate providers about specified topics. (PPACA § 5405)
Primary Care Workforce	• Establishes a 10% Medicare bonus payment for certain primary care providers (PCPs) for select codes. Provides a 10% bonus for general surgeons providing major surgical procedures in health professional shortage areas. Effective 1/1/11 through 12/31/15. (PPACA §§ 5501, 10501(h)) • Establishes a Medicare prospective payment system for FQHCs, effective 10/1/14. (PPACA § 5502, which was replaced by PPACA § 10501(i)) • Provides for redistribution of currently unused residency training slots to encourage increased training, especially in primary care and general surgery. (PPACA § 5503) • Provides more flexibility in the laws and regulations governing graduate medical education (GME) funding in the Medicare program. (PPACA § 5504-5506) • Creates a demonstration program to develop training and certification programs for personal and home care aides. Extends funding for family-to-family health information centers. (PPACA § 5507) • Establishes Teaching Health Centers Development Grants to establish newly accredited or expanded primary care residency programs. Provides for payments to qualified teaching health centers for expansion of existing or establishment of new approved GME residency training programs. (PPACA § 5508) • Provides for a graduate nurse education demonstration program. (PPACA § 5509) • Amends and reauthorizes the preventive medicine and public health residency program. (PPACA § 10501(m))
Improving Access to Health Services	• Appropriates additional funds for FQHCs. (PPACA § 5601) • Establishes a comprehensive methodology and criteria for designation of medically underserved populations and health professions shortage areas through negotiated rulemaking. (PPACA § 5602) • Reauthorizes and funds the Wakefield Emergency Medical Services for Children Program through FY 2014. (PPACA § 5603)

	• Provides for demonstration projects for the provision of coordinated and integrated services to special populations through the co-location of primary and specialty care in community-based mental health settings. (PPACA § 5604) • Provides for grants to providers that treat a high percentage of medically underserved and other special populations. (PPACA § 10501(k)) • Provides for grants to recruit students most likely to practice in underserved rural communities. (PPACA § 10501(l)) • Requires HHS to make annual reports to Congress on the bill's workforce provisions. (PPACA § 5701) • Improves the National Health Service Corps program by increasing loan prepayment amounts, allowing for half-time service and allowing for teaching to count for up to 20% of the corps service commitment. (PPACA § 10501(n)) • Establishes a Community Health Centers and National Health Service Corps to expand investment in CHCs. (PPACA § 10503) • **Loan Repayment Tax Relief.** Excludes from gross income payments made under any state loan repayment or loan forgiveness program that is intended to provide for the increased availability of health care services in underserved or health professional shortage areas. (PPACA § 10908)
REVENUE PROVISIONS	
Qualified Distributions	The cost of non-prescription medication cannot be paid for with income excluded through HSAs, Archer MSAs, health FSAs or HRAs. Applies to expenses incurred after 12/31/10. (PPACA § 9003)
FSA Contribution Limits	Health FSAs that are part of a cafeteria plan must limit employees' salary reduction contributions to $2,500 annually. • Applies to taxable years beginning after 12/31/12. • The $2,500 limit is subject to a cost of living adjustment for taxable years beginning after 12/31/13. o Increases not a multiple of $50 must be rounded to the next lowest multiple of $50. (PPACA §§ 9005, 10902; HCERA § 1403)
HSA/MSA Penalties for Nonqualified Distributions	The additional tax on distributions from an Archer MSA or an HSA not used for qualified medical expenses is increased to 20% of the amount of the distributions. Applies to distributions made after 12/31/10. (PPACA § 9004)
Tax on High-Cost Insurance Plans	Imposes excise tax of 40% on health insurers and self-insured plans on the aggregate value of employer-sponsored health coverage for an employee that exceeds threshold amounts, $10,200 self only, $27,500 other than self only, indexed for inflation to CPI + 1% in 2019 and to CPI for tax years beginning 2020 and after, rounded to the nearest multiple of $50. Applicable to tax years after 2017. • Insurers pay taxes on insured plans, employer pays taxes on plans under which employer makes HSA or MSA contributions and person administering plan pays taxes on self-insured plans. • Thresholds are adjusted by: o Multiplying by health adjustment percentage: 100% plus excess (if any) of (1) the percentage by which the per employee cost of BCBS standard plan under FEHBP for plan year 2018 (determined using benefit package for coverage in 2010) exceeds the cost for plan year 2010, over (2) 55%; o Adding an age and gender adjustment percentage: Thresholds calculated with health adjustment percentage are increased by the excess (if any) of (1) the premium cost of BCBS standard benefit plan under FEHBP for the type of coverage provided an individual in a taxable period, if priced for the age and gender characteristics of all employees of the individual's employer, over (2) that premium cost for the provision of coverage under this option in the taxable period if priced for the age and gender characteristics of the national workforce. • Thresholds increased by $1,650 (self only) and $3,450 (other than self only) for certain occupations identified as high risk, indexed for inflation at the same rates that apply to the general thresholds. o High risk professions mean: Law enforcement officers (as defined in 42 U.S.C. § 3796b), employees in fire protection activities (as defined in 29 U.S.C. § 203(y)), individuals who provide out-of-hospital emergency medical care (including emergency medical technicians, paramedics and first-responders), individuals whose primary work is longshore work (as defined in 8 U.S.C. § 1288(b), determined without regard to paragraph (2) thereof) and individuals engaged in the construction, mining, agriculture (not including food processing), forestry and fishing industries; this includes retirees from a high-risk profession if the employees met the definition for a period of not less than 20 years during the employee's employment.

	• Exceptions: o Accident only; o Disability; o Liability; o Workers' compensation; o Automobile medical payment insurance, o Credit only; o Long-term care; o Stand-alone dental and vision; and o Specified disease or indemnity if purchased on an after-tax basis. • Determination of plan cost used as aggregate value of employer-sponsored coverage: o Cost of employer-sponsored coverage is determined using rules used to calculate premium for purposes of COBRA continuation coverage (except that the new high value plan tax is not considered in the calculation). o For an employer that covers active employees and retirees, the employer has the option to combine pre-65 and post-65 retiree groups when calculating the value of coverage. o Salary reduction contributions to a health FSA plus any additional amounts that are reimbursed. o Employer contributions to HSA or an Archer MSA (including employee salary deferrals paid on a pre-tax basis via a cafeteria plan). • Government plans are included. o JCT states that the government plans that are included are those primarily for civilian employees. (JCT, Technical Explanation of the Revenue Provisions of the "Reconciliation Act of 2010," as Amended, in Combination with the "Patient Protection and Affordable Care Act," 3/21/10, p. 62) • Self-employed individuals' coverage under a group health plan is subject to the tax if a deduction is permitted for any or all of the coverage. • Failure to pay subject to penalty equal to amount due plus interest, except if the failure to pay not discovered using reasonable diligence or is corrected within 30 days. • Tax is nondeductible. (PPACA §§ 9001, 10901; HCERA § 1401)
Health Insurance Provider Tax	Imposes aggregate annual tax apportioned among health insurers of "United States health risks" based on relative market share. • "United States health risks" mean the health risk of any individual who is a U.S. citizen, a resident of the U.S. (IRC § 7701(b)(1)(A)), or located in the U.S. as to the period the individual is located in the U.S. • Insurers required to pay the tax are those providing health insurance during the calendar year in which the tax is due. • IRS will set payment date, no later than 9/30 of each year. • Annual tax burden shared by health insurers: o 2014: $8 billion; o 2015: $11.3 billion; o 2016: $11.3 billion; o 2017: $13.9 billion; and o 2018: $14.3 billion. o After 2018: The applicable tax is indexed to the rate of premium growth of the prior year's premium, defined as "the applicable amount for the preceding calendar year increased by the rate of premium growth for such preceding calendar year." • Market share is calculated based on net premiums written as reported to the IRS by insurers (reporting date to be set by IRS) or gathered by the IRS from some other source.

	o "Net premiums written" is not defined in the statute, but JCT states that it is "…intended to mean premiums written, including reinsurance premiums written, reduced by reinsurance ceded, and reduced by ceding commissions. Net written premiums do not include amounts arising under arrangements that are not treated as insurance (i.e., in the absence of sufficient risk shifting and risk distribution for the arrangement to constitute insurance)." (JCT, Technical Explanation of the Revenue Provisions of the "Reconciliation Act of 2010," as Amended, in Combination with the "Patient Protection and Affordable Care Act," 3/21/10, p. 89) o Tax exempt insurers consider only 50% of premium arising from tax-exempt business in calculating market share. The tax exempt insurers identified in the statute are those in IRC § 501(c)(3) (charitable organization), (c)(4) (civic organization), (c)(26) (high risk pools), or (c)(29) (health insurance co-ops created by PPACA). • In calculating market share, premiums less than $25 million are not taken into account, $25 million to $50 million are considered at 50% and more than $50 million are considered at 100%. • Applies to all health insurers subject to federal income tax as well as nonprofit insurers exempt from federal income taxes (except as specified). • Exemptions: o Governmental entities; o Self-insured employers; o Nonprofit corporations that receive more than 80% of gross revenues from government programs that target low income, elderly or disabled under Medicare, Medicaid or SCHIP; o Voluntary employee benefit associations established by non-employers; o Disability, accident, indemnity, specified disease; o Long term care insurance; and o Medicare supplement insurance. • Penalty for failure to report to IRS (unless reasonable cause is shown) is $10,000 plus the lesser of $1,000/day or amount of the tax. • Understatement of insurer's net premium written to IRS is also subject to a penalty of the excess of the amount of tax the IRS says is due over the amount of tax paid. • All persons treated as a single entity for purposes of the tax are jointly and severally liable for the tax. • Information submitted to the IRS by insurers for the tax is not subject to IRC § 6103 confidentiality requirements. • Tax is nondeductible. • "Anti-avoidance" regulations required to prevent "inappropriate actions taken to qualify as an exempt entity." • Applicable to calendar years beginning after 12/31/13. (PPACA §§ 9010, 10905; HCERA § 1406)
Pharmaceutical Manufacturers	Annual fee imposed on each manufacturer or importer of branded prescription drugs (including foreign corporations) for sale to specified government programs or pursuant to coverage under these programs (Medicare Parts B and D, Medicaid, VA, DoD and TRICARE). • Due date set by the IRS, but no later than 9/30 of each year. • Fee amounts are based on the ratio of each manufacturer's preceding year's branded drug sales to the preceding year's aggregate branded prescription drug sales by all manufacturers, multiplied by the annual amount due from all manufacturers as follows: o 2011: $2.5 billion; o 2012: $2.8 billion; o 2013: $2.8 billion; o 2014: $3 billion; o 2015: $3 billion; o 2016: $3 billion;

	o 2017: $4 billion; o 2018: $4.1 billion; and o 2019 and after: $2.8 billion. • In calculating each manufacturer's annual share of the tax, the branded prescription drug sales taken into account are: o 0% of sales of $5 million or less; o 10% sales of more than $5 million but not more than $125 million; o 40% of sales of more than $125 million but not more than $225 million; o 75% of sales of more than $225 million but not more than $400 million; and o 100% of sales of more than $400 million. • Fee amounts are calculated based on sales as reported to the IRS by HHS, VA and DoD (reporting date to be set by IRS) or gathered by the IRS from any other source. o HHS reports on: ▪ Medicare Part B (per unit average sales or per unit Part B payment rate for separately paid branded prescription drug without a reported average sales price and number of units paid for under Part B). CMS must establish process for determining units and allocated prices for branded prescription drugs that are not separately payable or for which National Drug Codes are not reported; ▪ Medicare Part D (per unit ingredient cost reported to HHS by prescription drug plans and Medicare Advantage prescription drug plans, minus price concessions, and number of units paid for under Part D); and ▪ Medicaid (per unit ingredient cost paid to pharmacies for branded prescription drugs dispensed to Medicaid beneficiaries, minus any per unit rebate paid by manufacturers, and number of units paid for under Medicaid). o VA reports, for each manufacturer and each branded prescription drug, the total amount paid for each branded prescription drug procured by VA. o DoD reports, for each manufacturer and each branded prescription drug, the sum of: ▪ Amount paid by DoD for each prescription drug for its beneficiaries; ▪ For each branded prescription drug dispensed under the TRICARE retail pharmacy program, per unit ingredient cost minus per unit rebate paid by the manufacturer times number of units dispensed. • Fees collected under the provision are credited to the Medicare Part B trust fund. • All persons treated as a single entity for purposes of the tax are jointly and severally liable for the tax. • Fees are nondeductible. • A "prescription drug" means any drug which is subject to the Federal Food, Drug and Cosmetic Act (21 U.S.C. § 353(b)). • A "branded prescription drug" is a prescription drug the application for which was submitted under the Federal Food, Drug and Cosmetic Act (21 U.S.C. § 355(b)), or any biological product the license for which was submitted under the Public Health Service Act (42 U.S.C. § 262(a)). o "Branded prescription drug sales" are sales of branded prescription drugs to any specified government program or sales made pursuant to any such program. o "Branded prescription drug sales" do not include sales of any drug or biological product for which the "orphan drug" credit was allowed for any taxable year under IRC § 45C, so long as the drug or biological product has not been subsequently approved by the FDA for marketing for any indication other than the treatment of the rare disease or condition with respect to which such credit was allowed. • Effective for calendar years beginning in 2011. (PPACA § 9008; HCERA § 1404)
Device Manufacturers	Imposes a tax of 2.3% on the sale of any taxable medical device sold by the manufacturer, producer or importer of the device. • Defines a "taxable medical device" as any device as defined in the Federal Food, Drug and Cosmetic Act (21 U.S.C. § 321(h)) intended for humans, but does not include:

	o Eyeglasses; o Contact lenses; o Hearing aids; and o Any other medical device determined by the IRS to be of a type which is generally purchased by the general public at retail for individual use. • Tax exemptions for sales by manufacturers for use as supplies for vessels or aircraft, and for sales to state or local governments, nonprofit educational organizations and qualified blood collector organizations are not applicable to this tax (IRC § 4221(a)(3),(4),(5), and (6) inapplicable to this new tax). • Current manufacturers excise tax exemptions for further manufacture and for export apply to this new tax (IRC § 6416(b)(2)(B), (C), (D), and (E) do not apply to this new tax). • Applies to sales after 12/31/12. • NOTE: The tax on medical devices imposed by § 9009 and amended by § 10904 of H.R. 3590 was repealed by § 1405 of H.R. 4872 effective on the date of enactment of H.R. 3590. (PPACA §§ 9009, 10904; HCERA § 1405)
Health Insurer Executive Compensation	Limits deductibility of compensation for officers, directors, employees and service providers of health insurers to $500,000. • "Covered health insurance provider" defined: o Tax years beginning after 12/31/09: "Health insurance issuers" (as defined in IRC § 9832(b)(2)) that provide "health insurance coverage" as defined in IRC § 9832(b)(1) ("…benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract offered by a health insurance issuer"). o Tax years beginning after 12/31/12: "Health insurance issuers" (as defined in IRC § 9832(b)(2)) with respect to which not less than 25% of gross premiums received is from providing "minimum essential coverage" as defined in IRC § 5000A(f) (created by H.R. 3590). • All compensation from entities within a "controlled group" is subject to the limitation: Compensation paid to the individual from any member of the controlled group of the covered health insurance provider as determined by applying rules applicable to qualified retirement plans is considered. • The deduction limits apply to both current and deferred compensation: The limit that applies to deferred compensation earned in a year is equal to the $500,000 limit for that year, reduced by the amount of current compensation paid. • NOTE: While based on existing IRC provisions limiting the deductibility of executive compensation to $1 million, there are some differences in this new provision: o No exceptions for certain performance-based compensation and commission compensation; o The limit applies to compensation to any individual service provider, including independent contractors as well as all employees, rather than just the chief executive officer and highest 3 officers, as disclosed in SEC filings; o The deduction limitations apply to "covered health insurance providers," regardless of whether the insurer is a "publicly held corporation" that is subject to SEC registration requirements; and o The limit is based on the year in which compensation is earned, rather than the year in which the deduction is claimed. A limit based on when compensation is earned requires determination of the period to which compensation is attributable, and has the effect of limiting deductions for both current and former service providers. It will also have the effect of limiting deductions for compensation earned when the company is considered a health insurance provider, even if the company ceases to be a health insurance provider by the time the compensation is paid. • Applies to current compensation paid in taxable years beginning after 12/31/12 and to deferred compensation paid in taxable years after 12/31/12 for services performed after 12/31/09. (PPACA § 9014)
Section 833	IRC § 833 deduction and other provisions would no longer be available for BCBS Plans that do not have a medical loss ratio of 85% or more. • MLR is calculated in accordance with PHSA § 2718, created by §§ 1001, 10101(f) of PPACA. o As enacted, BCBS Plans must compute an MLR for IRC § 833 status by dividing the total of "clinical services" (not taking into account activities that improve

	health care quality) by the total of premium revenue. • Applies to taxable years beginning after 12/31/09. • NOTE: o The MLR calculation for IRC § 833 purposes is a higher threshold than the standard all insurers must meet for the reporting and premium refund requirements in PHSA § 2718 because IRC § 833 does not appear to allow activities that improve health care quality to be considered part of "clinical services." o Sen. Baucus' floor statement (156 Cong. Rec. S1989 (daily ed. 3/24/10)) says that § 833 treatment is determined year to year, that activities that improve health quality are considered part of "clinical services" and that BCBS Plans are taxed as P & C stock companies. o HHS, IRS and DOL issued a request for information on implementing the MLR requirements in PHSA § 2718 and IRC § 833, with responses due 5/14/10 (75 Fed. Reg. 19297, 4/14/10). (PPACA § 9016)
W-2 Reporting	Employers must disclose the aggregate cost of benefits provided by employers for each employee's health insurance coverage on the employee's annual Form W-2. • Reporting not required: o Contributions to Archer MSAs and HSAs; and o Salary reduction contributions to FSAs as defined in IRC § 125. • How Plan Value Determined: 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, including the special rule for self-insured plans. • Applies to taxable years beginning after 12/31/10. (PPACA § 9002)
Information Reporting	Requires information reporting to the IRS (on Form 1099) for payments to any person, including any corporation that is not an exempt organization under IRC § 501(a), regardless of Treasury regulations prescribed before enactment. Clarifies that reports must be submitted for "amounts in consideration for property" and "gross proceeds." Effective for payments made after 12/31/11. (PPACA § 9006)
Simple Cafeteria Plans for Small Business	Allows small employers to adopt new "simple cafeteria plans," and by meeting minimum participation and contribution requirements, these plans will be treated as meeting the nondiscrimination requirements that would otherwise apply to the cafeteria plan. • An **"eligible employer"** is one that has an average of 100 or fewer employees on business days during either of the preceding 2 years; if an employer was not in existence during the last year, the number of employees is based on the average number of employees the employer is reasonably expected to employ on business days in the current year. o An **"eligible employer"** who establishes a simple cafeteria plan retains its status as an "eligible employer" in subsequent years unless more than 200 employees were employed on average on business days during any preceding subsequent year. o An employer is defined to include all predecessors of the employer. Additionally, persons treated as single employers for purposes of controlled group definitions (IRC § 52(a) or (b)) or the retirement plan aggregation rules in IRC § 414(n) or (o) are treated as one person. • A **"simple cafeteria plan"** is one that is established and maintained by an "eligible employer" and meets contribution and participation requirements as follows: o Contribution Requirements: Regardless of employee salary reduction contributions, the employer is required to make contributions to qualified benefits under the plan on behalf of each qualified employee (i.e., an employee who is not a highly compensated (as defined in IRC§ 414(q)) or key employee (as defined in IRC § 416(i))). The employer must contribute a uniform percentage (not less than 2%) of an employee's compensation for the plan year, or an amount equal to the lesser of 6% of an employee's compensation for the plan year or twice the amount of an employee's salary reduction contributions of each qualified employee (but the rate of an employer's contributions for highly compensated employees or key employees must not be greater than that for other employees). Subject to the preceding limitation on the rate of employer contributions, employers are permitted to make additional contributions to provide qualified benefits greater than the minimum contributions required. o Eligibility and Participation Requirements: Generally, eligibility is met if all employees with at least 1,000 hours of service may participate and all

	eligible employees may, subject to terms and conditions applicable to all participants, elect any benefit under the plan. ▪ An employer may exclude employees who: have not attained age 21 before the end of a plan year; have less than one year of service as of any day during the plan year; are covered under an agreement that the DOL finds to be a collective bargaining agreement if there is evidence that cafeteria plan benefits were the subject of good faith bargaining between employee representatives and an employer; or if the employee is a nonresident alien working outside the U.S. (see IRC § 410(b)(3)(C)). A plan may also provide for an age younger than 21 or a service period shorter than 1,000 hours. • Effective for taxable years beginning after 12/31/10. (PPACA § 9022)
Medical Expense Deduction	Increases the threshold for claiming an itemized deduction for unreimbursed medical expenses for regular tax purposes from 7.5% of a taxpayer's adjusted gross income (AGI) to 10% of AGI. Effective for taxable years beginning after 12/31/12, but for taxpayers age 65 and older or whose spouses are 65 or older, the threshold for regular tax purposes remains at 7.5% of AGI until 2017. (PPACA § 9013)
Increased Health Insurance Tax on High-Income	An additional 0.9% Medicare Hospital Insurance (HI) tax on self-employed individuals and employees as to earnings and wages received during the year above certain thresholds. • The additional tax applies to earnings of self-employed individuals or wages of an employee received in excess of $200,000, or $250,000 in the case of a joint return. • If the employer does not withhold the tax, the employee must pay the tax, but an employer is not relieved of penalties or additions to tax applicable to its failure to deduct and withhold any amount subject to employer withholding. Note that for purposes of employer's withholding obligation, only wages that the employee receives in excess of $200,000 are taken into account; the employer may disregard the amount of wages received by the employee's spouse. • For a self-employed individual, the threshold amount is reduced (but not below zero) by the amount of wages taken into account in determining the FICA tax with respect to an individual. • Self-employed individuals are not permitted to deduct any portion of the additional tax. • There is no change the employer HI tax, which remains at 1.45%. • Also adds 3.8% tax on unearned income (e.g., from interest, dividends, annuities, royalties and rents) with respect to those with income over $200,000, or $250,000 in the case of a joint return. • Effective for taxable years beginning after 12/31/12. (PPACA §§ 9015, 10906; HCERA § 1402)
Other	• **Requirements for Charitable Hospitals.** Creates 4 new requirements that a hospital must satisfy to be tax-exempt: (1) Periodic preparation of a community health needs assessment; (2) Maintenance of a qualified financial assistance policy; (3) Limitations on charges to individuals eligible for assistance; and (4) Avoidance of certain billing and collections activities. The provisions are generally effective for taxable years beginning after the date of enactment, but the community health needs assessment only applies to taxable years beginning 2 years after the date of enactment. (PPACA §§ 9007, 10903) • **Excise Tax on Cosmetic Procedures.** Dropped by Manager's Amendment to PPACA. (PPACA §§ 9017, 10907) • **Excise Tax on Indoor Tanning.** Creates a 10% tax on amounts paid for indoor tanning services, to be collected from the person receiving the service at the time the service is rendered. If that person does not pay the tax, the person providing the service remains liable for the tax. Applies to services performed on or after 7/1/10. (PPACA § 10907) • **Exclusion of Health Benefits of the Indian Health Service or Indian Tribal Governments.** Excludes from gross income the value of qualified health benefits received directly or indirectly from the Indian Health Service or from an Indian tribe or tribal organization. Effective as to benefits and coverage provided after the date of enactment. (PPACA § 9021) • **Tax Credit for Therapeutic Discovery.** Provides a credit of 50% of a qualified investment in acute and chronic disease research for businesses with 250 or fewer employees. Applicable to amounts paid or incurred after 12/31/08. (PPACA § 9023) • **Expansion of Adoption Tax Credit.** Increases the amount of child adoption tax credit and adoption assistance exclusion to $13,170 and provides for inflation

	indexing. Also extends the adoption credit through 2011 and makes the credit refundable. Generally applies to taxable years beginning after 12/31/09. (PPACA § 10909) • **Study on Impact of Taxes on Veterans' Health Care.** Study by VA includes the impact of new taxes on branded prescription drug manufacturers, medical device manufacturers and health insurance on the cost of medical care provided to veterans and veterans' access to medical devices and branded prescription drugs. VA must report to Congress by 12/31/12 (note that the annual insurance tax and tax on medical device sales will not be in effect on that date). (PPACA § 9011)
OTHER PROVISIONS	
340B Program	• **Expanded Participation in 340B Program.** Expands covered entities receiving discounted prices. Effective 1/1/10. (PPACA § 7101) • **Improvements to 340B Program Integrity.** Requires HHS to provide for improvements in compliance in order to prevent overcharges and other violations of discounted pricing requirement. Includes provisions for the resolution of claims by covered entities that they have been overcharged, and claims by manufacturers. Effective 1/1/10. Appropriates necessary funds for each FY beginning in 2010. (PPACA § 7102) • **GAO Study.** By 18 months after enactment, requires a GAO report to Congress on whether those individuals served by the covered entities under the program under section 340B are receiving optimal health care services. The report must include recommendations on whether the program should be expanded, whether mandatory sales of certain products could hinder patient access to those therapies and whether income from the program is being used by the covered entities under the program to further program objectives. (PPACA § 7103)
Biosimilars	• **Payment for Biosimilars under Medicare.** 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 6% of the ASP of the reference product. (PPACA § 3139) • **Approval Pathway for Biosimilars.** Specifies requirements for licensure of generic ("biosimilar") biological products. Provides for a period of exclusivity for the first generic biological product approved; also provides 12 years of exclusivity for the brand products. Authorizes a user fee program for generic biologic applications. Requires IOM studies of the number and importance of biological products for children. (PPACA § 7002)
Generic Drug Labeling	Modifies requirements applicable to the labeling of generic drugs. (PPACA § 10609)
Indian Health Care Improvement	Incorporates the provisions of S. 1790, the "Indian Health Care Improvement Reauthorization and Extension Act of 2009" (as reported by the Senate Committee on Indian Affairs on 12/16/09). These provisions authorize appropriations for FY 2010 and beyond, including programs to increase the Indian health care workforce, new programs for innovative care delivery models, behavioral health care services, new services for health promotion and disease prevention, efforts to improve access to health care services, construction of Indian health facilities and an Indian youth suicide prevention grant program. (PPACA § 10221)
Malpractice	• **"Sense of Senate"** encouraging states to test alternatives to the current civil litigation system. Congress should consider establishing a State demonstration program to evaluate alternatives for medical malpractice claims. (PPACA § 6801) • **Demonstration Grants.** Provides $50 million in funding over 5 years (starting in FY 2011) for state demonstration grants to encourage development of alternatives to litigation for resolving medical malpractice disputes. Requires models to emphasize patient safety, disclosure of health care errors, and the early resolution of disputes. Permits patients to opt-out of these alternatives at any time. Requires multiple evaluations of the effectiveness of the alternatives being tested, including: annual evaluations by state programs; annual assessments by HHS; an overall evaluation of the program, also conducted by HHS; and independent reviews by MedPAC and MACPAC. Requires these reports to evaluate impact of the demonstrations on quality of care, medical errors, medical resources used, time for dispute resolution and availability and price of liability insurance and to assess the overall effectiveness of the alternatives being tested. (PPACA § 10607)
Miscellaneous Access Provisions	• **Infrastructure to Expand Access.** Provides $100 million in funding for FY 2010 to be used for construction or debt service on hospital construction or renovation costs for health facilities meeting certain criteria. (PPACA § 10502) • **Demonstration to Provide Access to Affordable Care.** Establishes a 3-year demonstration project in up to 10 states to provide access to comprehensive health care services to the uninsured at reduced fees. (PPACA § 10504) • **Extension of Malpractice Coverage to Free Clinics.** Extends the protections from liability contained in the Federal Tort Claims Act to free clinics. (PPACA § 10608)

Other	• **Elder Justice** o *Elder Justice Coordinating Council.* Creates an Elder Justice Coordinating Council to make recommendation to HHS for the coordination of activities of relevant federal, state, local and private agencies and entities relating to elder abuse, neglect and exploitation and other crimes against elders. o *Advisory Board.* Establishes an Advisory Board on Elder Abuse, Neglect and Exploitation to create short- and long-term strategic plans for the development of the field of elder justice, and to make recommendations to the Council. Establishes and provides funding for the establishment and operation of elder abuse, neglect and exploitation forensic centers. o *LTC Enhancements.* Provides for a number of enhancements to long-term care, including grants and incentives for staffing and training, certified EHR technology to improve patient safety and reduce adverse events and the adoption of electronic standards for the exchange of data. o *Adult Protective Services.* Provides for grants to enhance the provision of adult protective services on the state and local levels. (PPACA §§ 6701-6703) • **Support for Pregnant and Parenting Teens and Women.** Appropriates $25 million for each of the fiscal years 2010-2019 to award grants to states to assist and provide support to pregnant and parenting teens and young women. Funds could be used for programs such as those that help pregnant or parenting teens stay in or complete high school, for assistance to states in providing intervention services and for outreach so that pregnant and parenting teens and women are aware of services available to them. (PPACA §§ 10211-10214)