Modifications to the Chairman's Mark
"America's Healthy Futures Act of 2009"
September 22, 2009

Modifications to the Chairman's Mark, Title I—Health Care Coverage

To correct a drafting error in Title I, Subtitle A: Insurance Market Reforms

On page 9 of the Mark:

– First sentence of the first full paragraph
– Add the sentence: "The Non Profit will be tax exempt for Federal tax purposes."

To correct drafting error in Title I, Subtitle A: Reinsurance

On page 9 of the Mark:

– In the paragraph beginning "Contributions collected", strike "sold in the state exchanges" in the second sentence.

To Modify the Chairman's Mark

On page 13 of the Mark:

– Change the effective date for this subtitle to July 1, 2013 unless otherwise indicated.

To Accept with Modification Kerry-Stabenow Amendment #C7:

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

To Accept with Modification Wyden Amendment #C5:

Amend **Title I, Subtitle A** to clarify that an application for unemployment insurance is to be considered as qualifying as a "change in circumstance" that allows Health Care Affordability tax credits to be reassessed.

To Accept with Modification Wyden Amendment #C8 (and related amendments Grassley Amendments #C15 and #C16; Hatch Amendment #C4; Kyl Amendment #C6 and Cornyn Amendment #C10):

Amend **Title I, Subtitle A** to allow a State to be granted a waiver if the state applies to the Secretary to provide health care coverage that is at least as comprehensive as required under the Chairman's Mark. States may seek a waiver through a process similar to Medicaid and CHIP. If the State submits a waiver to the Secretary, the Secretary must respond no later than 180 days and if the Secretary refuses to grant a waiver, the Secretary must notify the State and Congress about why the waiver was not granted.

– Insert at the end of b)(1) "and with citizen input through a referenda or similar means;"
– In b)(2) strike "a" and insert "this"
– Insert b)(4) "the State submits a ten-year budget for the plan that is budget neutral to the Federal government."
– Insert at the beginning of c)(2) GRANTING OF WAIVER.— The Secretary shall approve the plan only if it meets criteria consistent with that of the America's Healthy Future Act, including that it shall lower health care spending growth, improve the delivery system performance, provide affordable choices for all its citizens, expand protections against excessive out-of-pocket spending, provides coverage to the same number of uninsured and not increase the Federal deficit.

To Accept with Modification Wyden Amendment #C9 and Kerry Amendment #C15:

Amend **Title I, Subtitle A** to lower allowable age rating to 4:1.

To Accept with Modification Kerry-Schumer Amendment #C19, Schumer Amendment #C7, and Cantwell Amendment #C11:

Amend **Title I, Subtitle A** to amend the national plan to include the option for states to opt-out if they choose. Legislative action must be taken at the state level in order for a state to opt-out. A state that has opted-out can also take legislative action to opt back into the national plan.

To Accept with Modification Cornyn Amendment #C5:

Amend **Title I, Subtitle A** to clarify that any individual who has an existing policy equal in value to the young invincible plan can renew that policy. The policy will be considered minimum creditable coverage for purposes of meeting the personal responsibility requirement.

To Accept Bingaman Amendment #C9:

Amend **Title I, Subtitle B** to allow exchanges to enter into contracts with Medicaid agencies in determining eligibility.

To Accept Kerry Amendment #C6:

Amend **Title I, Subtitle B** to clarify that exchanges shall have the choice to enter into an agreement with a Sub-Exchange.

To Accept with Modification Kerry Amendment #C8:

Amend **Title I, Subtitle B** to add an additional function performed by the Secretary of Health and Human Services and/or States. This function would be to develop a rating system for plans entering the state exchange. Plans could be rated on their relative quality and price compared to other plans offering products in the same benefit level. The state exchange would include an indication of the plans' rating on the website.

To Accept Lincoln Amendment #C1:

Amend **Title I, Subtitle B** to strike the provision allowing for multiple exchanges.

To Accept with Modification Stabenow Amendment #C7:

Amend **Title I, Subtitle B** to allow stand-alone dental, vision and long-term care insurance plans to list their benefit on the state exchange. These plans will not be eligible to receive premium tax credits but can be listed for ease of comparison shopping by the consumer.

To Accept Carper Amendment #C5:

Amend **Title I, Subtitle B** to require the Secretary or his/her designate to conduct a study on methods that entities offering insurance plans through the exchange can use to encourage increased meaningful use of electronic health records by health care providers.

To Accept Carper Amendment #C6:

Amend **Title I, Subtitle B** to clarify that agents and brokers are allowed the immediate right to enroll individuals and employers in any health insurance option available in the state exchanges.

To Accept with Modification Grassley Amendment #C3:

Amend **Title I, Subtitle B** to require that, notwithstanding any other provision of law, beginning in 2013 elected officials and federal employees may purchase coverage through a state-based exchange, rather than using the traditional Federal Employees Health Benefits Plan (FEHBP).

To Accept with Modification Snowe-Lincoln Amendment #C3 and Snowe Amendment #C8:

Amend **Title I, Subtitle B** so that states must allow small businesses up to 100 employees, to purchase coverage through the SHOP health insurance exchange created in the Chairman's Mark beginning in 2015 and states may allow employers with more than 100 employees into the state exchange beginning in 2017.

To Accept Snowe Amendment #C10:

Amend **Title I, Subtitle B** to allow small businesses that grow beyond the upper employee limit in the SHOP exchange, to continue to purchase health insurance through the SHOP exchange.

To modify Title I, Subtitle C: Making Coverage Affordable

On page 20 of the Mark:
– Strike the last sentence of last full paragraph and replace with the following: "MAGI would be defined as an individual's (or couple's) adjusted gross income (AGI) without regard to sections 911 (regarding the exclusion from gross income for citizen or residents living abroad), 931 (regarding the exclusion for residents of specified possessions), and 933 (regarding the exclusion for residents of Puerto Rico), plus any tax-exempt interest received during the tax year, plus any income of dependents listed on the return. In addition, under the modification, deductions from gross income that are allowed in determining adjusted gross income, such as the deduction for contributions to an individual retirement arrangement, would be disregarded."

To correct a drafting error in Title I, Subtitle C: Making Coverage Affordable

On page 22 of the Mark:
– Last sentence of first full paragraph
– For clarification, the penalty would apply to individuals accessing the exchange as well as at the exchange and federal entity level. The penalty may also include a penalty applicable to someone who applies on behalf of an individual and supplies false information or documentation.

To correct a drafting error in Title I, Subtitle C: Making Coverage Affordable

On page 23 of the Mark:
– Second and third sentences of the first paragraph, for clarification, the average annual fulltime equivalent wage limitations of $40,000 and $20,000 are indexed to CPI-U for years beginning in 2014.

To Modify the Chairman's Mark

On page 25 of the Mark:

– Change the effective date for this subtitle to July 1, 2013 unless otherwise indicated.

To correct a drafting error in Title I, Subtitle C: Making Coverage Affordable

On page 26 of the Mark:

– Strike "except in those cases for which Federal funds appropriated for the Department of Health and Human Services are permitted"

To correct drafting error in Title I, Subtitle C: Personal Responsibility Requirement

On page 28 of the Mark:

– At the end of the first sentence in the first paragraph, insert "in order to meet minimum creditable coverage".

To Accept with Modification Rockefeller Amendment #C3:

Amend **Title I, Subtitle C,** beginning in 2010, this amendment would eliminate annual and lifetime limits for all plans participating in state exchanges and preclude group health plans from imposing unreasonable annual or lifetime limits on coverage.

To Accept Bingaman Amendment #C6:

Amend **Title I, Subtitle C** to clarify that the Secretary of Health and Human Services will establish alternative income documentation that may be provided to determine income eligibility for individuals and families who have not filed a tax return in the prior tax year.

To Accept with Modification Bingaman Coverage Amendment #C8, #C13 and Kerry Amendment #C12:

Amend **Title I, Subtitle C** to require the Secretary, for individually purchased plans, to define and update no less than annually the categories of covered treatments, items and services within benefit classes through a transparent and public process that allows for public input, including a public comment period. The Secretary cannot define a package that is more extensive than the typical employer plan as certified by the Office of the Actuary at the Centers for Medicare and Medicaid Services. The Secretary shall allow some flexibility in plan design but shall ensure plan design does not encourage adverse selection. The Secretary shall update or modify these definitions to account for changes in medical evidence or scientific advancement or to address any gaps in access or changes in the evidence base.

To Accept Bingaman Amendment #C11:

Amend **Title I, Subtitle C** to clarify that individuals are permitted to update eligibility information for the purposes of receiving federal healthcare tax credits or Medicaid during the year due to a change in household circumstances within the limits established by the Secretary of Health and Human Services.

To Accept with Modification Wyden Amendment #C3:

Amend **Title I, Subtitle C** to require that all states ensure that there are available in every exchange plans that are at least actuarially equivalent to the Blue Cross Blue Shield Standard Option in the Federal Employees Health Benefits Program.

To Accept with Modification Menendez-Kerry-Bingaman-Schumer Amendment #C1, Kerry-Menendez Amendment #C9, Stabenow Amendment #C1, and Carper Coverage Amendment #C8, #C9:

Amend **Title I, Subtitle C** to change the amount of the Health Care Affordability tax credits to be based on the percentage of income the cost of premiums represents, rising from two percent of income for those at 100 percent of Federal poverty level to 12 percent of income for those at 300 percent of Federal poverty level. Individuals between 300-400 percent of Federal poverty level would be eligible for a premium credit based on capping an individual's share of the premium at 12 percent of income.

To Accept Menendez Amendment #C13:

Amend **Title I, Subtitle C** for those between 300-400 percent of the Federal poverty level, within the same actuarial value, the benefit will include an out-of-pocket limit equal to two-thirds of the Health Savings Account (HSA) current law limit.

To Accept with Modification Carper Amendment #C7:

Amend **Title I, Subtitle C** to clarify that preventive services includes all USPSTF recommended preventive care services and immunizations recommended by the Advisory Committee on Immunization Practices (ACIP).

To Accept with Modification Snowe Amendment #F5:

Amend **Title I, Subtitle C** to allow individuals who would otherwise qualify for the exemption from the individual assessment (i.e., those with premiums that exceed 10% of their income) in the exchange could purchase the "young invincibles" policy, which is effectively a catastrophic with no coverage below the HSA out-of-pocket limit except for preventive benefits and services.

To Accept with Modification Snowe Amendment #C6:

Amend **Title I, Subtitle C** to require small employers to provide a plan with a deductible that does not exceed $2,000 for individuals and $4,000 for families, unless offering contributions which offset any increase in deductible above these limits. This specified deductible limit is accommodated with no change in actuarial value, including not affecting the actuarial value of Bronze plans. This amendment does not apply to "young invincible" plans.

To correct drafting error in Title I, Subtitle D: Share Responsibility

On page 31 of the Mark:

– Strike the sentence second sentence in the final paragraph and replace with "The flat dollar amount would be equal to the national average tax credit."

To correct drafting error in Title I, Subtitle D: Shared Responsibility

On page 31 of the Mark:

– Under "Employer Offer of Health Insurance Coverage", strike "employer" in the second paragraph, at the end of the fourth sentence
– Replace with "employee"

To correct drafting error in Title I, Subtitle D: Shared Responsibility

On page 32 of the Mark:

– Insert "fulltime" in the sentence at the top of the page before both references to "employees".

To Modify the Chairman's Mark

On page 32 of the Mark:

– Change the effective date for this subtitle to July 1, 2013 unless otherwise indicated.

To Accept with Modification Schumer Amendment #C6 and Snowe Amendment #F4:

Amend **Title I, Subtitle D** to lower the maximum penalty amount a family above 300 percent of Federal poverty level would pay to $1,900.

To Accept with Modification Snowe Amendment #C2:

Amend **Title I, Subtitle D** so that individuals are permitted to obtain the tax credit assistance to which they would otherwise been entitled – were it not for an offer of ESI – if the individual's cost of premiums exceeds 10 percent of income and clarify that the 10 percent is indexed to the growth in premiums.

To Accept Grassley Amendment #C2:

Amend **Title I, Subtitle E** to make more explicit the language prohibiting group purchasing councils from setting payment rates.

To Accept Hatch Amendment #C9:

Amend **Title 1, Subtitle E** to ensure a level-playing field for fair competition.

To Accept Cornyn Amendment #C14:

Amend **Title I, Subtitle E** to strike the political appointment process for the Advisory Board.

To Accept Cornyn Amendment #C15:

Amend **Title I, Subtitle E** to specify that no federal funds may be used by the CO-OPs to lobby Congress.

To Accept Cornyn Amendment #C16:

Amend **Title I, Subtitle E** to specify that no Federal funds may be used by the CO-OPs for marketing.

To Accept with Modification Cornyn Amendment #C17:

Amend **Title I, Subtitle E** to require that the CO-OPs must meet state solvency standards.

To Accept with Modification Cornyn Amendment #C18:

Amend **Title I, Subtitle E** to specify that before CO-OPs can operate, the state must have implemented all the insurance reforms required by America's Healthy Future Act.

To Accept Cornyn Amendment #C20:

Amend **Title I, Subtitle E** to clarify that CO-OPs must comply with the same state laws as private health insurers.

To Accept Kerry Amendment #C13:

Amend **Title I, Subtitle F** to clarify that certain grantee organizations can receive health insurance consumer assistance grants.

To Accept Menendez Amendment #C5:

Amend **Title I, Subtitle F** to require each health care plan and health care insurance issuer offering coverage in the exchange to provide an internal claims appeal process.

To Accept Bingaman Amendment #C5 and Menendez Amendment #C7 with Modification:

Amend **Title I, Subtitle F** to authorize a policy holder to access ombudsman services if: (1) their internal appeal lasts more than three months or (2) their appeal involves a life threatening issue.

To Accept Menendez Amendment #C8:

Amend **Title I, Subtitle F** to authorize a policy holder to access ombudsman services for assistance in resolving problems with their premium and cost-sharing credits and with assistance in filing appeals as needed.

To Accept Snowe Amendment #C9:

Amend **Title I, Subtitle F** to allow Small Business Development Centers (SBDCs) to receive grants.

To Accept with Modification Rockefeller Amendment #C12:

Amend **Title I, Subtitle F** to require the Secretary to, through regulations:

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

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

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

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

To clarify the eligibility policy in Title I, Subtitle G: Role of Public Programs.

On page 42, in the Eligibility Standards and Methodologies section

Insert "the elderly and" before "those groups" on the third line of the paragraph beginning "Effective January 1, 2014."

Replace the last sentence of the paragraph beginning "Effective January 1, 2014" with "Also, the change to MAGI would not apply to beneficiaries who were enrolled in Medicaid on January 1, 2014 until the later of March 31, 2014 or their next redetermination date."

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

To Accept with Modification Bingaman Amendment #C4:

On page 42, at the end of the Eligibility Standards and Methodologies section

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

To Accept Wyden Amendment #C11:

On page 43, in the Medicaid Program Payments

Insert "including those on waiting lists," before "as of the date of enactment" in the last line of the paragraph beginning "Under the Chairman's Mark."

To clarify the payment policy in Title I, Subtitle G: Role of Public Programs

On page 44, at the end of the Medicaid Program Payments section

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

To clarify the policy in Title I, Subtitle G: Role of Public Programs

On page 45, at the end of Part I – Medicaid Coverage for the Lowest Income Populations

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

To Accept with Modification Bingaman Amendment #C2 and Stabenow - Menendez Amendment #C9:

On page 47, at the end of Part II – Children's Health Insurance Program

Insert "The Chairman's Mark would require the Secretary to certify that (1) coverage in the state exchange is at least comparable to the level of benefits and cost-sharing in the state CHIP plan,

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

To Accept with Modification Bingaman Amendment #C1:

On page 47, in the Enrollment Coordination with the State Exchange section:

Insert "Such seamless enrollment should include systems to ensure a secure electronic interface sufficient to allow a determination of eligibility for the appropriate program." at the end of the only paragraph.

To correct an error in Title I, Subtitle G: Role of Public Programs

On page 48, in the Presumptive Eligibility section

Strike "States would decide the benefits covered during presumptive eligibility."

To Accept Stabenow Amendment #C4:

On page 49, at the end of Part III – Improvements to Medicaid

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

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

To Accept with Modification Schumer Amendment #C13:

On page 50, at the end of the Long Term Services and Supports section

Insert "The Chairman's Mark would establish the Community First Choice Option, which would create a state plan option under section 1915 of the Social Security Act to provide community based attendant supports and services to individuals with disabilities who are Medicaid eligible and who require an institutional level of care. These services and supports include assistance to

individuals with disabilities in accomplishing activities of daily living and health related tasks. States who choose the Community First Choice Option would be eligible for enhanced federal match rate of an additional six percentage points for reimbursable expenses in the program. The option would sunset after five years."

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

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

To Accept with Modification Rockefeller Amendment #D11:

On page 50, at the end of the Long Term Services and Supports section

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

To Accept with Modification Kerry Amendment #C16:

On page 50, at the end of the Long Term Services and Supports section

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

To Accept with Modification Cantwell Amendment #C1:

On page 50, at the end of the Long Term Services and Supports section

Insert "The Chairman's Mark would provide states that undertake structural reforms proven to increase nursing home diversions and access to home and community based services in their Medicaid programs a targeted increase in the federal medical assistance percentage (FMAP). The amount of the FMAP increase would be tied to the percentage of a state's long term services and supports that is offered through HCBS, with lower FMAP increases going to states that will need to make fewer reforms. States would be able to offer HCBS through a waiver or through a state plan amendment (SPA). States that choose a SPA would be able to include individuals with

incomes up to 300 percent of the maximum Supplemental Security Income payment. Funding for the nursing home diversion program would be available for five years beginning in 2011."

To Accept Rockefeller Amendment #C31:

On page 51, at the end of Part IV – Medicaid Services

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

To Accept Stabenow Amendment #C3:

On page 51, at the end of Part IV – Medicaid Services

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

"The Chairman's Mark would also allow states to make a "presumptive eligibility" determination for individuals eligible for such services through the new optional eligibility group. That is, states may enroll such individuals for a limited period of time before completed Medicaid applications are filed and processed, based on a preliminary determination by Medicaid providers of likely Medicaid eligibility. Under current law, such presumptive eligibility determinations can be made for children, pregnant women, and certain women with breast or cervical cancer. In addition, states would not be allowed to provide Medicaid coverage through benchmark or benchmark-equivalent plans, which are permissible alternatives to traditional Medicaid benefits, unless such coverage includes family planning services and supplies."

To Accept with Modification Stabenow Amendment #D11:

On page 51, at the end of Part IV – Medicaid Services

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

criteria and application procedures for the awarding of grants in this program. The Secretary would be directed to give preference in awarding grants to school-based health centers serving a large population of children eligible for Medicaid or CHIP.

To Modify the Chairman's Mark

On page 51-52 of the Mark, in Part V:

– Strike the provision "Make Prescription Drugs a Mandatory Benefit".

To Accept Bingaman Amendment #D1:

On page 54, at the end of the Extend to and Collect Rebates on Behalf of Managed Care Organizations section

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

To correct an error in Title I, Subtitle G: Role of Public Programs

On page 55, in the Changes to Medicaid Payments for Prescription Drugs section

Insert "no less than" before "175 percent".

To Accept Stabenow Amendment #D10:

On page 55, at the end of Part V – Medicaid Prescription Drug Coverage

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

To correct an error in Title I, Subtitle G: Role of Public Programs.

On page 56, in Part VI—Medicaid Disproportionate Share Payments:

Strike the word "point" both times it appears in the paragraph beginning "Each year thereafter".

To Accept Rockefeller Amendment #C25:

On page 58, in Part VII – Dual Eligibles:

Strike the Office of Coordination for Dual Eligible Beneficiaries section and insert "The Chairman's Mark would establish the Federal Coordinated Health Care Office (CHCO) within the Centers for Medicare & Medicaid Services (CMS) no later than March 1, 2010. The CHCO

would report directly to the Administrator of CMS. The purpose of the CHCO would be to bring together officials of the Medicare and Medicaid programs at CMS to (1) more effectively integrate benefits under the Medicare and Medicaid programs, and (2) improve the coordination between the Federal and state governments for individuals eligible for benefits under both such programs in order to ensure that such individuals get full access to the items and services to which they are entitled. The goals of the CHCO would be:

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

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

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

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

To Accept with Modification Kerry Amendment #C3:

On page 60, at the end of Part VIII – Medicaid Quality

Insert, "The Chairman's Mark would establish a Medicaid Global Payments demonstration project available to in up to five states from 2010 to 2012, under which a large, safety net hospital system participating in Medicaid would be permitted to alter its provider payment

system from a fee-for-service structure to a capitated, global payment structure. The CMS Innovation Center would conduct an evaluation of each demonstration project examining any changes in health care quality outcomes and spending. The Chairman's Mark would exempt the Innovation Center from the budget-neutrality requirements for an initial testing period. The Innovation Center would also be given the authority to terminate or modify the demonstration project during the testing period. The Secretary would be required to conduct and analysis of the demonstration project and report her findings to Congress."

To Accept with Modification Kerry Amendment #D4:

On page 60, at the end of Part VIII – Medicaid Quality

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

To Accept Snowe Amendment #D1:

On page 60, at the end of Part VIII – Medicaid Quality

Insert "The Chairman's Mark would establish a three-year, $75 million demonstration project for up to eight states to expand the number of emergency inpatient psychiatric care beds available in communities. This project – the Medicaid Emergency Psychiatric Care Demonstration Project – would allow states to cover patients in non-governmental freestanding psychiatric hospitals and receive federal Medicaid matching payments to demonstrate that covering patients in these hospitals will improve timely access to emergency psychiatric care, reduce the burden on overcrowded emergency rooms, and improve the efficiency and cost-effectiveness of inpatient psychiatric care.

To correct an error in Title I, Subtitle G: Role of Public Programs

On page 63, in the Eligibility Determination section

Strike "public programs and" from the last sentence of the section.

To Accept with Modification Kerry Amendment #C4:

Add a new section to **Title I, Subtitle H: Addressing Health Disparities**

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

To correct an error in Title I, Subtitle H: Addressing Health Disparities

On pages 64 through 67, in Subtitle H

– Replace the word "gender" with the word "sex" wherever the word occurs.

To correct an error in Title I, Subtitle I: Maternal, Infant and Early Childhood Visitation Program

On page 69 of the Mark:

– Funding allocations should be $100M for FY 2010, $250M for FY 2011, $350M for FY 2012, $400M for FY 2013 and $400M for FY 2014.

To Accept with Modification Menendez Amendment #C14:

Add a new section to **Title I, Subtitle I: Maternal, Infant and Early Childhood Visitation Programs**

Provide support services to women suffering from postpartum depression and psychosis and also help educate mothers and their families about these conditions. Provide support for research into the causes, diagnoses and treatments for postpartum depression and psychosis.

To Accept with Modification Hatch Amendment #C12:

Prohibits Federal funds under this Title of the Mark from being used to pay for assisted suicide and offers conscience protections to providers or plans refusing to offer assisted suicide services.

To Accept Ensign Amendment #C12:

To clarify that nothing in this Act shall prohibit or penalize veterans or their eligible family members from receiving timely access to quality health care from a VA healthcare provider or in a Department of Veterans Affairs health care delivery facility.

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

To Accept Lincoln Amendment #D5:

On page 75, at the end of Title I:

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

Modifications to the Chairman's Mark,
Title II—Promoting Disease Prevention and Wellness

To correct drafting errors in Title II, Subtitle A—Medicare: Annual Wellness Visit

On page 69 of the Mark:

– Strike the first sentence of the second paragraph under "Annual Wellness Visit" and replace with: "A comprehensive health risk assessment will be completed prior to or as part of the wellness visit. The Chairman's Mark would authorize Medicare payment for a visit to a primary care provider to create a personalized prevention plan, as part of this determination, the administration of the HRA will be taken into account."

On page 70 of the Mark:

– Strike "screening" in the second sentence of the first paragraph and replace with "assessment".

– Insert at the end of the first paragraph in the description of the Chairman's Mark, "During the first year of enrollment, a Medicare beneficiary may receive either the Initial Preventive Physical Examination (IPPE) or the "Annual Wellness Visit," the Secretary will not pay for the provision of both services in the same year.

To correct a drafting error in Title II, Subtitle A—Medicare: Removing Barriers to Preventive Services

On page 70 of the Mark:

– Insert at the end of the last line of the description of the Chairman's Mark "for any indication or population".

To correct drafting errors in Title II, Subtitle A—Medicare: Incentives for Health Lifestyles

On page 72 of the Mark:

– Strike "complete" in the first line of the description of the Chairman's Mark and replace with "participate"

– Insert after the second line in the description of the Chairman's Mark, "The Secretary may select sites in coordination with community-based programs conducted by other agencies such as the Administration on Aging, Centers for Disease Control and Prevention, and the Agency for Healthcare Research and Quality."

– Strike "Secretary" in the third line of the Chairman's Description of the Mark and replace with "Each participating site".

– Strike "the results, as well as set standards and health status targets" in the fourth line of the description of the Chairman's Mark and replace with "changes in health risks and outcomes, including adoption and maintenance of health behaviors"

– Strike the last sentence of the description of the Chairman's Mark and replace with "The Secretary will submit interim report to Congress after on January 1, 2014 that includes a preliminary evaluation of this project, any programs or parts of the project determined to be effective are authorized to continue for another two years. The Secretary will submit a final report to Congress on January 1, 2016."

To Accept Stabenow Amendment #D5:

On page 74 of the Mark:

Insert after the first sentence "In particular, Medicaid enrollees with at least one serious and persistent mental health condition qualify to receive services under this option."

To Accept Bingaman Amendment #D9:

On page 74 of the Mark:

– Insert "community mental health centers" in line twelve of the description of the Chairman's Mark.

– Insert after the sixth sentence in the description of the Chairman's Mark "When appropriate the state will consult and coordinate with the Substance Abuse and Mental Health Services Administration specifically in addressing the prevention and treatment of mental illness and substance abuse."

To Accept with Modification Carper Amendment #C1:

To add a new section **Title II, Subtitle—C: Grants for Small Businesses to Provide Comprehensive Workplace Wellness Programs**

This amendment provides $200 million to the Secretary of Health and Human Services for up to five years to make grants to small businesses with less than 100 employees (full and or part-time workers) to provide access to comprehensive, evidence-based workplace wellness programs. Qualifying programs will include the following components that have proven to be effective in helping employees make healthier choices: health awareness (such as health education, preventive screenings and health risk assessments), employee engagement (such as mechanisms to encourage employee participation), behavioral change (elements proven to help alter unhealthy lifestyles such as counseling, seminars, on-line programs, self help materials) and supportive environment (such as creating on-site policies that encourage health lifestyles, health eating, physical activity and mental health).

In order for a program to be a qualified wellness program, all employees would be required to be eligible to participate in the program. A qualified wellness program would be required to be consistent with evidence-based research and best practices, as determined by the Secretary, such as research and practices described in the Guide to Community Preventive Services and Guide to Clinical Preventive Services and the National Registry for Effective Programs.

Grant money from this amendment would only be available for employers that are not providing qualified wellness programs upon enactment of this Act.

To Accept Carper Amendment # C4:

Add a new section to **Title II, Subtitle—B Medicaid**

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

To add a new section **Title II, Subtitle—C: Strengthening Employer-Sponsored Wellness Programs**

This section codifies provisions of the Health Insurance Portability and Accountability Act (HIPAA) nondiscrimination regulations which allow for rewards to be provided to employees for participation in or for meeting certain health status targets related to a wellness program. A reward may be in the form of a discount or rebate of a premium or contribution, a waiver of all or part of a cost-sharing mechanism (such as deductibles, co-payments, or coinsurance), the absence of a surcharge, or the value of a benefit that would otherwise not be provided under the plan. A reward relating to programs that require participants to achieve a health status target will

not exceed 20 percent of the cost of the employee-only coverage of the plan, unless the dependents or spouse may fully participate in the wellness program, then the incentive will not exceed 20 percent of cost of coverage in which the employee and any dependents is enrolled. This section allows existing programs that have complied with the regulations to continue to operate for as long as such law and regulations remain in effect.

For a wellness program that requires enrollees to meet a standard related to a health factor (including those programs that provide a reward if certain health status targets are met) to qualify, certain standards must be met. The wellness program will be reasonably designed to promote health or prevent disease. The program is "reasonably designed" if it is not overly burdensome, is not a subterfuge for discriminating based on a health factor, and is not highly suspect in the method chosen to promote health or prevent disease. The plan or issuer must evaluate the program's reasonableness at least once each year. The plan must give individuals eligible for the program the opportunity to qualify for the reward at least once each year. The full reward must be made available to all similarly situated individuals including a reasonable alternative standard (or waiver of the otherwise applicable standard) for obtaining the reward for any individual for whom it is unreasonably difficult to satisfy the standard. The plan or issuer will bear any costs associated with the verification that any health or circumstance factor makes it unreasonably difficult or medically inadvisable for the individual to satisfy or attempt to satisfy the standard. All plan materials must state the availability of an alternative standard or waiver within the wellness program. Not later than one year after the date of enactment the Secretary of Labor, Secretary of Health and Human Services, and the Secretary of the Treasury shall issue any interim final regulations that may be necessary or appropriate to ensure that such wellness programs are reasonably designed, not overly burdensome, and not a subterfuge for discrimination based on a health factor.

In addition, this section requires the Secretary of Health and Human Services, the Secretary of Treasury and the Secretary of Labor to evaluate and submit to the appropriate committees of Congress a report exploring the following issues: effectiveness of wellness and disease prevention programs in promoting health and preventing disease, the impact of a wellness program on a participant's access to care and the affordability of coverage, and the impact of premium-based and cost-sharing incentives on employee behavior and their role in behavior change. The report will also include the determination of the Secretaries as to whether there is a threshold level of increase above which any additional increase will be punitive in nature as to other enrollees and employees, discourage non-participating employees from accepting employer coverage or lack any marginal benefit in encouraging employees to participate in the wellness program. Secretary shall require whatever information needed to complete this report and employers or issuing plans will comply with this request. The report will be due two years after the date of enactment including recommendations for any legislative or administrative action.

This section permits the Secretary of Health and Human Services, Secretary of Labor and the Secretary of the Treasury to increase the threshold of the allowance to 30 percent of the total cost of coverage under the plan if, after completing the aforementioned report, the Secretaries make a finding that such an increase is appropriate, based on empirical evidence, and that adequate safeguards exist to ensure the increased reward is likely to foster increased wellness program participation rates without becoming punitive in nature.

Not later than one year after the date of enactment of the Secretaries of Labor, Secretary of Health and Human Services, and the Secretary of the Treasury shall jointly develop model language that may be used to satisfy the requirements laid out in this section.

Modifications to the Chairman's Mark, Title III—Improving the Quality and Efficiency of Health Care

To Accept with Modification Cantwell Amendment #D1:

Add a new section to **Title III, Subtitle A, Part I**

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

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

To accept Menendez Amendment #D3:

To amend Title III, Subtitle A, on page 76, to add "and in addition would include healthcare-associated infections, as measured by the prevention metrics and targets established in the Department of Health and Human Services HHS Action Plan to Prevent Healthcare-Associated Infections or any successor plan" to line 4 after "patient perception of care".

To clarify policy in Title III, Subtitle A, Part I: Physician Quality Reporting Initiative

On page 80 of the Mark:

– Strike "Eligible professionals who successfully report in 2010 would receive a two percent bonus in 2011."
– Replace with "Eligible professionals who successfully report in 2010 would receive a one percent bonus in 2011. Eligible professionals who successfully report in 2011 would receive a 0.5 percent bonus in 2011."

– Strike "Eligible professionals who failed to participate successfully in the program would face a 1 percent payment penalty in 2012, based on their 2011 reporting period."
– Replace with "Eligible professionals who failed to participate successfully in the program would face a 1.5 percent payment penalty in 2013, based on their 2012 reporting period."

– Strike "For 2012, the applicable percent would be calculated as 99 percent of their total allowed charges. For reporting periods 2012 and in subsequent years, the penalties for non-reporting would be two percent, calculated as 98 percent of their total allowed charges."
– Replace with "For 2013, the applicable percent would be calculated as 98.5 percent of their total allowed charges. For 2014 and in subsequent years, the penalties for non-reporting would be two percent, calculated as 98 percent of their total allowed charges."

To clarify policy in Title III, Subtitle A, Part I: Expansion of Physician Feedback Program

On page 81 of the Mark:

Add "The Secretary shall coordinate the physician feedback program with other relevant value-based purchasing reforms being undertaken by CMS."

To correct drafting error in Title III, Subtitle A, Part I: Expansion of Physician Feedback Program

On page 81 of the Mark:

– Strike "2015" and replace with "2014".

To accept Rockefeller Amendment #D1:

On page 86 of the Mark:

– Add additional members to the Interagency Working Group on Health Care Quality.

To Accept with Modification Rockefeller Amendment #D3:

Add a new **Part IV – Health Information Technology** to **Title III, Subtitle A**

– Add free clinics to the list of providers eligible for Medicare and Medicaid health information technology incentives.

To Accept with Modification Kerry Amendment #D3:

On page 89 of the Mark:

– In the definition of eligible practitioners, adds "regardless of specialty" after "physicians"

To Accept with Modification Wyden Amendment #D12:

On page 89 of the Mark:

– Add the following after "coordinate care" in (8): "such as through the use of telehealth, remote patient monitoring, and other such enabling technologies."

To clarify policy in Title III, Subtitle A, Part III: CMS Innovation Center

– Add requirement that the Innovation Center be established by January 1, 2011.

To Accept Carper Amendment #D1:

On page 91 of the Mark:

– Insert "or salary-based payment" at the end of bullet 1.

– Insert "or through salary-based payment" at the end of bullet 2.

– Insert a new bullet as follows: "3. Promote care coordination between health care providers that transition health care providers away from fee-for-service based reimbursement and toward salary-based payments."

To Accept Conrad Amendment #D1:

On page 92 of the Mark:

– Add a new bullet as follows: "14. Promote improved quality and reduced cost by developing a collaborative of high-quality, low-cost health care institutions charged with: (1) developing, documenting and disseminating best practices and proven care methods; (2) implementing these techniques within their own institutions to demonstrate further improvements in quality and efficiency; and (3) providing assistance to other institutions on how best to employ these techniques to improve health care quality and lower costs."

To Accept Carper Amendment #D2:

On page 93 of the Mark:

– Strike "5. Maintain a close relationship between care coordinators and primary care practitioners;" and replace with "5. Maintain a close relationship between care coordinators, primary care practitioners, specialist physicians, and other health care providers;"

To Accept Kerry Amendment #D5:

On page 93 of the Mark:

Add a provision to include the Medicaid and CHIP programs in the Innovation Center, with the same requirements for testing and evaluation of patient-centered delivery and payment models that have shown evidence of success in the Medicaid and CHIP population as proposed for Medicare.

To correct an error in Title III, Subtitle A: Redistribution of Unused GME slots to Increase Access to Primary Care and Generalist Physicians

On page 103 of the Mark:

– Strike the final sentence in the provision
– Replace with "The indirect medical education adjustment for these resident positions distributed under this provision would be reimbursed at the full IME adjustment factor."

To accept Bingaman Amendment #D2:

In **Title III, Subtitle A,** Redistribution of Unused GME Slots to Increase Access to Primary Care and Generalist Physicians to amend the redistribution criteria for unused graduate medical education slots to reserve 50 percent of such slots provided in the redistribution for states meeting the second and third criteria, with the following modification:

Criteria number two shall read: (2) to hospitals located in a state that is among the top 10 states in terms of the ratio of the total population living in a health professional shortage area (HPSA) determined by the U.S. Department of Health and Human Services as of the date of enactment compared to total population of the state based on the most recent state population projections by the U.S. Census Bureau.

Slots not re-assigned within one year after the Secretary allows for application under the modified criteria may be assigned according to the other criteria established within the Mark.

To accept with Modification Bingaman Amendment #D8:

To add a new section in **Title III, Subtitle A** to establish "Teaching Health Centers" to increase training and improve access to primary care services. Qualified teaching health centers would be

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

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

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

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

To accept with Modification Stabenow Amendment #D4:

To amend **Title III, Subtitle A** to include a provision that would appropriate $50 million per year for FY2012 through FY2015 to establish a graduate nurse education demonstration program in Medicare. Eligible hospitals would receive Medicare reimbursement for the educational costs, clinical instruction costs, and other direct and indirect costs of an eligible hospital attributable to the training of advanced practice nurses with the skills necessary to provide primary and preventive care, transitional care, chronic care management, and other nursing services appropriate for the Medicare-eligible population.

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

practice registered nurses, such as certified registered nurse anesthetists and certified nurse-midwives, in rural and medically underserved areas.

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

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

To accept with Modification Stabenow Amendment #D9:

To amend **Title III, Subtitle A**, regarding National Strategy to Improve Health Care Quality, to fulfill the requirements set forth in such section, the Secretary may contract with a non-profit organization or organizations that have at least five years of experience in developing and implementing quality improvement strategies; have operated such programs on a statewide or multi-state basis to improve patient safety and the quality of health care delivered in hospitals, including at a minimum such programs in hospital intensive care units, hospital-associated infections, hospital perioperative patient safety, and hospital emergency rooms; and working with a variety of institutional health care providers, physicians and other health care practitioners.

To accept with Modification Nelson Amendment #D6:

To amend **Title III, Subtitle A**, Redistribution of Unused GME Slots to Increase Access to Primary Care and Generalist Physicians, by allocating an additional number of new residency training slots for redistribution by adjusting the percent of unused slots that would be included in the pool for redistribution to 65 percent. Slots allocated under this amendment will be available to hospitals located in the ten states with the lowest resident-to-population ratios. The indirect medical education adjustment for resident positions distributed under this provision would be reimbursed at the full IME adjustment factor.

To correct drafting errors in Title III, Subtitle B: Temporary Improvements to the Medicare Hospital Payment Adjustment for Low-Volume Hospitals

On page 120 of the Mark:

– Strike "2,000" on line two
– Replace with "1,500"
– Insert "continuous" between "a" and "linear" on line five
– Strike "below a certain threshold" on line six
– Replace with "with 200 or fewer discharges of individuals with Medicare Part A benefits"
– Strike "2,000" on the final line

– Replace with “1,500”

To clarify in Title III, Subtitle B: Rural Protections

On page 121 of the Mark:

Insert new section entitled, “Technical Correction related to Critical Access Hospitals (CAHs)”, which clarifies that CAHs are eligible to receive 101 percent of reasonable costs for providing outpatient services regardless of billing method and for providing qualifying ambulance services.

To Accept with Modification Rockefeller Amendment #D7:

Amend **Title III, Subtitle B, Part III**, to include provisions from S. 1634 that would require the Secretary to develop and maintain a complaint tracking system capable of tracking complaints through resolution and of producing reports. Also, Sec. 213 of S. 1634 would be included in the Mark to develop a uniform exceptions and appeals process for sponsors of prescription drug plans and Medicare Advantage prescription drug plans by 2012. Further, Sec. 215 would be added to the Mark to require the Office of the Inspector General to report annually on the inclusion of drugs commonly used by dual eligibles on Part D plan formularies. Finally, Sec. 216 would be added to require the Secretary to monitor and track how many full benefit dual eligibles enroll in a plan under Part D and receive retroactive drug coverage, the number of months of retroactive coverage provided, and the amount of reimbursements paid to individuals during the retroactive period. The Secretary would also report annually on total annual expenditures for dual eligibles made under titles XVIII and XIX as well as an analysis of health outcomes and the extent to which these beneficiaries are able to access their benefits under both titles.

To Accept with Modification Bingaman Amendment #D4, Rockefeller Amendment #D6 and Nelson Amendment #D5:

Amend **Title III, Subtitle B, Part III**, to include a provision that eliminates cost sharing under Part D for full-benefit, dual eligible beneficiaries receiving care under a home and community based services under sections 1915, 1932 or 1115 waivers who would otherwise require institutional care. This amendment would be effective no sooner than 2012.

To Accept with Modification Stabenow Amendment #D11:

Amend **Title III, Subtitle B, Part III**, to exempt sponsors of prescription drug plans and Medicare Advantage prescription drug plans from Section 1128A(a)(5) of the Social Security Act in order to allow these plans to waive copayments for first fills of generic drugs as an incentive for beneficiaries to try a generic formulation of a drug. This amendment would be effective no sooner than 2011.

To Add a Provision to Reduce Wasteful Dispensing of Outpatient Prescription Drugs in Long-term Care Settings

The Mark would require Medicare Part D prescription drug and Medicare Advantage prescription drug plans to employ utilization management techniques, such as blister packs, when dispensing medications to beneficiaries who reside in long-term care facilities in order to reduce waste associated with 30-day fills.

To correct a drafting error in Title III, Subtitle C: Medicare Advantage

On page 136, change "two percent" to "three percent" in front of "of the USPCC if they achieve between four and five stars on a five-star ranking system."

To Accept with Modifications Nelson Amendment #D10:

Amend **Title III, Subtitle C**, to allow MA plans to grandfather the extra benefits for their current enrollees in certain areas of the country where average plan bids are at or below 85 percent of local fee-for-service costs. Plans would be able to grandfather enrollees beginning in 2012. The amount of extra benefits would be fixed at levels for 2011 and not indexed. Plans that retain or "grandfather" their current enrollees would also be required to submit bids under competitive bidding in those areas. Bids for covered Medicare benefits under competitive bidding and for grandfathered enrollees would be the same. The difference would be the extra benefits. Bonus payments would not be available to enrollees in grandfathered plans. Bids and extra benefits for grandfathered enrollees would be risk adjusted, as under competitive bidding, except extra benefits for grandfathered plans would also be adjusted for differences in utilization that could result from differences in extra benefits. This provision would also remove the efficiency bonus from the competitive bidding program.

To Accept Lincoln Amendment #D4:

Amend **Title III, Subtitle C**, to create a 45-day period (January 1 – February 15) beginning in 2011 in which beneficiaries who enroll in Medicare Advantage or prescription drug plans during the annual enrollment period can disenroll and return to traditional fee-for-service.

To Accept with Modification Rockefeller Amendment #D8:

Amend **Title III, Subtitle C**, to require special needs plans (SNPs) to be certified by the National Committee for Quality Assurance (NCQA) beginning in 2012 in order to serve targeted populations. The Secretary would have discretion to design the certification requirements in conjunction with NCQA.

To correct drafting error in Title III, Subtitle D: Power Wheelchairs

On page 153 of the Mark:

– Strike "2010" and replace with "2011".

To Accept Schumer Amendment #D2:

Add a new section to **Title III, Subtitle D**

The Secretary of Health and Human Services is directed to convene a public meeting on payment systems for new clinical laboratory diagnostic tests and to submit a report to Congress, summarizing the meeting and providing recommendations for legislative and administrative actions to reform the reimbursement mechanisms for new clinical laboratory diagnostics.

To accept with Modification Lincoln Amendment #D6:

Amend **Title III, Subtitle D** to restore the ratios used in determining geographic hospital wage index reclassification to pre-October 1, 2008 levels until the first fiscal year one year after the Secretary submits the Plan to Reform the Medicare Hospital Wage Index to Congress as required in the Mark. It also would ensure that any applications for reclassification for fiscal year 2011 and subsequent years denied on the basis of the changed ratios would be reconsidered using the pre-existing ratios, and approved, if the applicant meets the pre-existing ratios. This amendment would be implemented in a budget neutral manner.

To accept Wyden Amendment #D1:

To amend **Title III, Subtitle D** to create a Medicare Hospice Concurrent Care (HCC) three-year demonstration program that would allow patients who are eligible for hospice care to also receive all other Medicare covered services during the same period of time. The Secretary would establish 26 sites across the country in both urban and rural areas to examine improvement in patient care, quality of life, and cost-effectiveness that results from the demonstration project. An independent evaluation of this delivery model would be conducted with reports submitted to the Secretary and Congress. This demonstration would be required to be budget neutral.

To accept with Modification Menendez Amendment #D1:

To add a new section to **Title III, Subtitle D**, that would require application of budget neutrality on a national basis in the calculation of the Medicare hospital wage index floor for each all-urban and rural state. In the case of discharges occurring on or after fiscal year 2011, for purposes of applying section 4410 of the Balanced Budget Act of 1997 (42 U.S.C. 1395ww note) and paragraph (h)(4) of section 412.64 of title 42, Code of Federal Regulations, the Secretary of Health and Human Services shall administer subsection (b) of such section 4410 and paragraph (e) of such section 412.64 in the same manner as the Secretary administered such subsection (b) and paragraph (e) for discharges occurring during fiscal year 2008 (through a uniform, national adjustment to the area wage index).

To clarify policy in Title III, Subtitle E: Productivity

On page 155 of the Mark:

– Strike "All other productivity adjustments for other Part B providers would begin in 2011."
– Replace with "For providers paid through the clinical laboratory test fee schedule, the Chairman's Mark replaces the scheduled 0.5 percent payment reduction for years 2011 through 2013 with a full productivity adjustment for 2011 and subsequent years. The clinical laboratory productivity adjustment could not reduce the fee schedule update below zero. In addition to the productivity adjustment, for the years 2011 through 2015, the clinical laboratory test fee schedule would be further reduced by 1.75 percentage points. All other productivity adjustments for other Part B providers would begin in 2011."

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

On page 156 of the Mark:

Add after "margins;" in "(5)": "or payment updates;"

To correct drafting errors in Title III, Subtitle E: Medicare Commission

On page 156 of the Mark:

--Strike "benefit" in "(4)" and replace with "provider payment"
--Add "beneficiary" between "Medicare" and "cost-sharing"

To Accept Conrad Amendment #D6:

Eliminate the sunset on the Medicare Commission and sets the growth target beyond 2019 at GDP per capita plus one percent. Congress would still be required to hold a vote in 2019 under fast-track procedures on the Commission's future, but the Commission would continue unless Congress affirmatively votes to terminate it.

To Accept with Modification Lincoln Amendment #D2:

Add a new section to **Title III, Subtitle B, Part I**

The provision reinstates reimbursement for dual energy x-ray absorptiometry (DXA) services to 70 percent of the 2006 payment rates for 2010 and 2011. It would also authorize the Institute of Medicine to study the effect of Medicare reimbursement reductions for DXA on beneficiary access to bone density tests.

To Accept Conrad Amendment #D5:

Adds a new section to **Title III, Subtitle B, Part I**

The provision extends until January 1, 2012 the bonus payments under Medicare to ambulance service providers which serve the most rural quartile of counties ("super rural" areas as originally defined in Section 414(c) of the Medicare Modernization Act (MMA)).

To correct a drafting error in Title III, Subtitle F: Patient-Centered Outcomes Research

On page 159 of the Mark:
– First sentence of first full paragraph, after "Patient-Centered Outcomes Research Institute", add "which will be tax exempt for Federal tax purposes."

Modifications to the Chairman's Mark, Title IV—Transparency and Program Integrity

To correct an error in Title IV

On page 179, in the Nursing Home Transparency section:

– Strike "(3) lend funds or provide financial guarantees which is equal to or exceeds $50,000;" and renumber (4) as (3) in the paragraph beginning "Additional disclosable parties."

Modifications to the Chairman's Mark, Title V—Fraud, Waste, and Abuse

To clarify the policy in Title V

On page 185, in the Provider Screening section:

– After the sentence that ends "12 months of enactment," insert "A hardship exception to the fee would be permitted, as would waiver of the fee for Medicaid providers for whom the state can demonstrate the fee would impede beneficiary access to care."

Modifications to the Chairman's Mark, Title VI—Revenue Items

To correct drafting error in Title VI

On page 199 of the Mark:

– After the last sentence in the last paragraph, add the sentence "In determining the coverage value for retirees, employers would be able to elect to treat pre-65 retirees together with post-65 retirees."

To correct drafting error in Title VI

On page 201 of the Mark:

– In the first sentence in the second full paragraph, for clarification, the transition relief for the 17 highest cost states applies on an individual basis depending on the state in which the individual resides. The Secretary shall determine the 17 highest cost states based on data available for 2012. The transition rule applies with respect to coverage of a specific individual based on the individual's residence on the first day of a coverage period beginning during the transition period.

To Modify Title VI

On page 205 of the Mark:

– Strike "2009" in the sixth full paragraph and replace with "2010".

To Modify Title VI

On page 215 of the Mark:

– After the last sentence in the fourth full paragraph, add the following: "The term would also not include sales of Class II products that are sold at retail for up to $100 per unit from the definition of covered domestic sales."

To Modify Title VI

On page 217 of the Mark:

– Strike "6" in the first sentence of the fourth full paragraph and replace with "6.7."

To Modify Title VI

On page 218 of the Mark:

– Strike "Annual Fee on Clinical Laboratories"

To Modify Title VI - Modify the Itemized Deduction for Medical Expenses

Current Law

Regular Income Tax. For regular income tax purposes, individuals are allowed an itemized deduction for unreimbursed medical expenses, but only to the extent that such expenses exceed 7.5 percent of adjusted gross income ("AGI").[1]

This deduction is available both to insured and uninsured individuals; thus, for example, an individual with employer-provided health insurance (or certain other forms of tax-subsidized health benefits) may also claim the itemized deduction for the individual's medical expenses not covered by that insurance if the 7.5 percent AGI threshold is met. The medical deduction encompasses health insurance premiums to the extent they have not been excluded from taxable income through the employer exclusion or self-insured deduction.

Alternative Minimum Tax. For purposes of the alternative minimum tax ("AMT"), medical expenses are deductible only to the extent that they exceed 10 percent of AGI.

Description of Proposal

This proposal increases the threshold for the deduction from 7.5 percent of AGI to 10 percent of AGI for regular income tax purposes. The proposal does not change the AMT treatment of the itemized deduction for medical expenses.

The proposal is effective for taxable years beginning after December 31, 2012.

To Accept with Modification Kerry/Snowe/Schumer/Lincoln/Cantwell Amendment # C2:

The provision extends the small business tax credit to organizations exempt from tax under section 501(a) by reason of being described in section 501(c)(3) (i.e., charitable organizations) that would otherwise qualify for the small business tax credit. However, for tax exempt organizations, the applicable percentage for the credit during Phase I is limited to 25 and the applicable percentage for the credit during Phase II is limited to 35. The small business tax credit is otherwise calculated in the same manner for tax exempt organizations that are qualified small employers as the tax credit is calculated for all other qualified small employers. Charitable organizations will be eligible to apply the tax credit against the organization's liability as an employer for payroll taxes for the taxable year to the extent of the amount of income tax withheld from its employees under section 3401(a), the amount of hospital insurance tax withheld from its employees under section 3101(b), and the amount of the hospital tax imposed on the organization under section 3111(b). However, the charitable organization will not be eligible for a credit in excess of the amount of these payroll taxes.

[1] Sec. 213.

To Accept Conrad Amendment #F1:

Add a provision to provide an exclusion from gross income for the value of specified Indian tribe health benefits. The exclusion applies to the value of: (1) health services or benefits provided or purchased by the Indian Health Service ("IHS"), either directly or indirectly, through a grant to or a contract or compact with an Indian tribe or tribal organization or through programs of third parties funded by the IHS;[2] (2) medical care services (in the form of provided or purchased medical care services, accident or health insurance or an arrangement having the same effect, or amounts paid directly or indirectly, to reimburse the member for expenses incurred for medical care) provided by an Indian tribe or tribal organization to a member of an Indian tribe, including the member's spouse or dependents;[3] (3) accident or health plan coverage (or an arrangement having the same effect) provided by an Indian tribe or tribal organization for medical care to a member of an Indian tribe and the member's spouse or dependents; and (4) any other medical care provided by an Indian tribe that supplements, replaces, or substitutes for the programs and services provided by the Federal government to Indian tribes or Indians.

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

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

To Accept with Modification Kerry/Rockefeller/Schumer/Stabenow/Cantwell/Menendez Amendment # F1:

The provision increases the excise tax on insurers to 40 percent of the aggregate value of employer-sponsored health coverage that exceeds a threshold amount.

The provision provides that the threshold amount ($8,000 for individual coverage and $21,000 for family coverage for 2013) is indexed to the Consumer Price Index for Urban Consumers ("CPI-U"), as determined by the Department of Labor beginning in 2014, plus one percent.

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

[3] The terms "accident or health insurance" and "accident or health plan" have the same meaning as when used in sections 104 and 106. The term "medical care" is the same as the definition under section 213. For purposes of the provision, dependents are determined under section 152, but without regard to subsections (b)(1), (b)(2), and (d)(1)(B). Section 152(b)(1) generally provides that if an individual is a dependent of another taxpayer during a taxable year such individual is treated as having no dependents for such taxable year. Section 152(b)(2) provides that a married individual filing a joint return with his or her spouse is not treated as a dependent of a taxpayer. Section 152(d)(1)(B) provides that a "qualifying relative" (i.e., a relative that qualifies as a dependent) does not include a person whose gross income for the calendar year in which the taxable year begins equals or exceeds the exempt amount (as defined under section 151).

The provision increases the threshold amount for retired individuals over the age of 55 by $750 for individual coverage and $2,000 for family coverage. The additional amounts are indexed to the CPI-U, as determined by the Department of Labor beginning in 2014, plus one percent.

The provision increases the threshold amount for plans that cover employees engaged in high risk professions by $750 for individual coverage and $2,000 for family coverage. The additional amounts are indexed to the CPI-U, as determined by the Department of Labor beginning in 2014, plus one percent. For purposes of the modification, employees considered to be engaged in a high risk profession are law enforcement officers, firefighters, members of a rescue squad or ambulance crew, and individuals engaged in the construction, mining, agriculture (but not food processing), forestry or fishing industries.

Under the provision, an individual's threshold cannot be increased by more than $750 for individual coverage or $2,000 for family coverage (indexed as described above, plus any amount under the transition rule for high-cost states), even if the individual would qualify for an increased threshold both on account of his or her status as a retiree over age 55 and as a participant in a plan that covers employees in a high risk profession.

To Accept With Modification Schumer Amendment # F1, Snowe Amendment # F3, Roberts Amendment # F3, and Enzi Amendment # F1:

The provision increases to $2,500 the limit on salary reductions by an employee for a taxable year for purposes of coverage under a health FSA under a cafeteria plan, and changes the effective date to taxable years beginning after December 31, 2010.