

Insurance Reforms	
<i>Annual Limits</i>	-small and large group market plans may only establish "restricted" annual limits, effective six months from enactment -small and large group market plans are prohibited from establishing annual limits, effective 2014
<i>Antitrust Exemption for Insurers</i>	-no provision
<i>Benefit Package</i>	-plans in the individual or small group market must provide the essential health benefits package, effective 2014
<i>Dependent Coverage</i>	-requires insurers that offer dependent coverage to allow uninsured children to remain on their parents' health insurance up until age 26, effective six months from enactment -catastrophic coverage plans available for individuals under age 30
<i>Guaranteed Issue</i>	-guaranteed issue, effective 2014
<i>Guaranteed Renewal</i>	-guaranteed renewal, effective 2014
<i>Insurance Rating</i>	-permits variation based only on tobacco use (1.5:1 limit), age (3:1 limit), family composition, and geographic area, effective 2014 -no rating based on health or gender, effective 2014
<i>Lifetime Limits</i>	-small and large group market plans, including grandfathered health plans, may not impose lifetime limits on coverage, effective six months from enactment
<i>Marketing Practices</i>	-qualified health plans must not use marketing practices that discourage the enrollment of individuals with significant health needs
<i>Medical Loss Ratio (MLR)</i>	-health plans would be required to report the proportion of premium dollars that are spent on items other than medical care -group plans must have an MLR of 85%, effective 2011 -individual plans must have an MLR of 80%, effective 2011 -minimum MLR requirements effective 2011 through December 31, 2013 -rebates would be provided to enrollees if plans failed to have an acceptable MLR, effective 2011

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Insurance Reforms	
<i>National High Risk Pool</i>	-HHS will establish a temporary insurance program for uninsured people denied coverage due to pre-existing conditions, effective 90 days from enactment -effective until the creation of the insurance exchanges in 2014
<i>Non-Discrimination</i>	-no discrimination permitted based on the wages of employees, effective six months from enactment -insurers prohibited from discriminating based on health status, medical condition or history, claims experience, genetic information, disability, evidence of insurability, or any factor determined appropriate by HHS, effective 2014
<i>Pre-Existing Conditions</i>	-prohibits all health insurance plans from excluding children on the basis of a pre-existing condition, effective six months from enactment -prohibits group health plans from excluding patients on the basis of pre-existing conditions, effective 2014
<i>Preventive Services</i>	-plans must provide coverage, without cost-sharing, for preventive services and immunizations, effective six months from enactment
<i>Quality Reporting</i>	-insurance companies must report to HHS and their enrollees regarding a plans' implementation of the following activities: improving health outcomes through quality reporting; preventing hospital readmissions; improved patient safety and reduced medical errors; and wellness and health promotion activities -reporting required within two years of enactment -HHS may impose penalties on insurance companies who fail to report the above information
<i>Rate Review</i>	-establishes an annual review process that requires insurers to submit justifications for premium increases, effective 2011 -plans with excessive rate increases prohibited from participating in the exchanges, effective 2014
<i>Reinsurance for Retiree Health Benefits</i>	-creates access to reinsurance for employer health plans providing coverage for early retirees, effective 90 days from enactment
<i>Rescission</i>	-insurance companies prohibited from rescinding coverage, except in cases of fraud or intentional misrepresentation of material fact, effective six months from enactment
<i>Waiting Periods</i>	-small or large group market plans, including grandfathered health plans, may not impose waiting periods that exceed 90 days, effective 2014

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Health Insurance Exchange	
<i>Establishment, Purpose, and Duties of Exchange</i>	<ul style="list-style-type: none"> -states required to establish an American Health Benefit Exchange by January 1, 2014 -the exchanges will facilitate the purchase of qualified health plans and establish a Small Business Health Options Program (SHOP) to assist small employers in obtaining coverage for employees -states may combine the individual and SHOP exchanges -an exchange may only be a governmental agency or non-profit entity established by a state -states may form regional exchanges with other states, subject to the approval of each state legislature -states may establish subsidiary exchanges within the state -HHS will establish an exchange in a state if that state fails to do so by 2014 -states may form interstate compacts to facilitate the purchase of health insurance, effective July 1, 2013
<i>Benefit Packages</i>	<ul style="list-style-type: none"> -all plans must provide basic services -four benefit categories would be available: bronze, silver, gold, and platinum - based on the actuarial value of the plans -actuarial value of bronze plan is 60%, silver is 70%, gold is 80%, and platinum is 90% -states may require additional benefits to be covered -catastrophic coverage available for individuals under age 30
<i>Eligibility</i>	<ul style="list-style-type: none"> -qualified employers and qualified individuals are eligible to obtain coverage through an exchange -small employers with 100 or less employees may enroll in the exchange -employers with over 100 employees may obtain coverage through an exchange, at the discretion of each state, effective 2017
<i>Funding</i>	<ul style="list-style-type: none"> -HHS will award grants to states to establish an exchange -each exchange must be self-sustaining beginning January 1, 2015 (assessments and user fees on insurance issuers permitted)
<i>Public Health Insurance Option</i>	<ul style="list-style-type: none"> -no public health insurance option -the Office of Personnel Management will contract with private insurers to offer at least two national or multi-state plans to be offered in the Exchanges of each state -the Consumer Operated and Oriented Plan (CO-OP) program permits the creation of non-profit, member-run health insurance companies; HHS would award grants and loans to CO-OPs

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Individual & Employer Responsibility	
<i>Individual Responsibility</i>	<ul style="list-style-type: none"> -individuals must obtain minimum essential coverage for them and their dependents, effective 2014 -hardship and religious exemptions permitted
<i>Individual Penalty</i>	<ul style="list-style-type: none"> -failure to obtain minimum essential coverage will result in a tax as follows: \$325 in 2015; \$695 in 2016 and beyond (indexed by a cost-of-living adjustment) -the penalty amount will also be applied for any dependents that do not have minimum essential coverage (except dependents who are offered employer-sponsored coverage) -no penalty applied to individuals who qualify for hardship or religious exemptions
<i>Employer Responsibility</i>	<ul style="list-style-type: none"> -employers with greater than 200 employees must automatically enroll all new employees in health care coverage -employers with more than 50 employees must offer qualified coverage to their employees
<i>Employer Penalty</i>	<ul style="list-style-type: none"> -for employers with more than 50 employees that do not offer qualified coverage and have at least one employee receiving the premium assistance tax credit, they will be fined \$2,000 multiplied by the number of employees -the first 30 employees will not be counted for the penalty calculation -employers may not have a waiting period for employee enrollment in health coverage that exceeds 90 days, effective 2014
<i>Qualified Coverage</i>	<ul style="list-style-type: none"> -minimum essential coverage includes government-sponsored coverage, employer-sponsored care, grandfathered health plans, and plans offered in the individual market -grandfathered coverage includes coverage in which an individual was enrolled as of the date of enactment -a qualified health plan provides the essential health benefits package, limits annual cost-sharing to the high-deductible health plan limit, limits the annual deductible for small group market plans to \$2,000 (individual) and \$4,000 (families), and does not require cost-sharing for preventive services or immunizations -catastrophic coverage available for individuals under age 30 (does not provide health care benefits until the individual has incurred annual cost-sharing equal to the high-deductible health plan limit, provides at least three primary care visits, and no cost-sharing is permitted for preventive services)

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Tax Provisions (Credits & Revenue Raisers)	
<i>Excise Tax on High-Cost Health Insurance ("Cadillac" tax)</i>	-40% excise tax on health coverage that exceeds \$10,200 for an individual and \$27,500 for families, effective 2018 (annually indexed to CPI-U) -adjusted for age, gender, and high-risk professions (increased threshold of \$1,650/\$3,450) -stand-alone dental and vision plans excluded from the tax
<i>Flexible Spending Accounts (FSAs)</i>	-contributions to FSAs are capped at \$2,500 annually, effective 2013 (indexed to CPI-U)
<i>Health Insurance Provider Industry User Fee</i>	-annual fee on health insurance provider industry, effective 2014 as follows: \$8 billion in 2014, \$11.3 billion in 2015-2016, \$13.9 billion in 2017, \$14.3 billion in 2018, and \$14.3 billion + rate of premium growth in 2019 and beyond
<i>Health Savings Accounts (HSAs)</i>	-the tax on distributions from an HSA or Archer MSA that are not used for qualified medical expenses is raised to 20%, effective 2011
<i>Individual Income Taxes</i>	-increases the hospital insurance payroll tax by 0.9% on individuals earning over \$200,000 and joint filers earning over \$250,000, effective 2013 (income amount not indexed to inflation) -applies a 3.8% Medicare tax on investment income from interest, dividends, royalties, rents, gross income from a trade or business, and net gain from disposition of property for individuals earning over \$200,000 and joint filers earning \$250,000 (income amount not indexed to inflation), effective 2013
<i>Individual Tax Credits</i>	-premium credits and cost-sharing reductions available for individuals and families below 400% of FPL
<i>Medical Device Industry Excise Tax</i>	-2.3% excise tax on medical devices sold in the U.S., effective 2013
<i>Medical Expense Deduction</i>	-increases the threshold for claiming the itemized deduction for medical expenses from 7.5% to 10%, effective 2013
<i>Prescription Drug Industry User Fee</i>	-annual fee on brand name prescription drug manufacturers, effective 2011 as follows: \$2.5 billion in 2011, \$2.8 billion in 2012-2013, \$3 billion in 2014-2016, \$4.0 billion in 2017, \$4.1 billion in 2018, and \$2.8 billion in 2019 and beyond
<i>Tax-Exempt Hospitals</i>	-501(c)(3) hospitals would be required to: conduct a community health needs assessment every three years; implement a financial assistance policy; limit charges to certain patients to amounts generally billed to insured patients; and follow certain debt collection practices

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Tax Provisions (Credits & Revenue Raisers)	
<i>Qualified Medical Expenses</i>	-the cost of over-the-counter medicines may not be reimbursed through a health FSA or HRA, a health savings account, or an Archer MSA, effective 2011
<i>Small Business Credits</i>	-tax credits equal to 50% of the amount paid by a small employer (10 or fewer employees and average annual wages below \$25,000) for employee health coverage -limited to firms with 25 or fewer full-time employees and with average annual wages below \$50,000 -full credit phases out for employers with more than 10 full-time employees or average annual wages between \$25,000 and \$50,000 -tax credits available beginning in 2010
<i>Tax Deduction for Part D Expenses</i>	-eliminates the deduction for the employer subsidy for employers who provide prescription drug coverage to employees eligible for Medicare Part D, effective 2013

Medicare - Provider Payments	
<i>Ambulatory Surgical Centers</i>	-full productivity adjustment incorporated into annual update, effective FY 2011 -HHS to submit a value-based purchasing program plan to Congress by January 1, 2011
<i>Clinical Laboratory</i>	-1.75% reduction, from 2011-2015 -productivity adjustment incorporated into annual update, effective 2011
<i>Durable Medical Equipment (DME)</i>	-productivity adjustment incorporated into annual update, effective 2011 -certain pharmacists are eligible for an exemption from the accreditation requirements
<i>ESRD (Dialysis)</i>	-productivity adjustment incorporated into annual update, effective 2012 -GAO to study the impact of including specified oral drugs in the bundled PPS on Medicare beneficiary access to high-quality dialysis services
<i>Graduate Medical Education (GME)</i>	-would increase the number of GME positions in states with the lowest resident physician-to-patient ratios -would make payments to qualified teaching health centers for GME for primary care services

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Medicare - Provider Payments	
<i>Home Infusion</i>	-no provision
<i>Home Health Agencies</i>	<ul style="list-style-type: none"> -2011-2013 market basket update reduced by 1.0% -productivity adjustment incorporated into annual update, effective 2015 -HHS directed to rebase payments, with a four-year transition, beginning 2014 (payment reductions limited to 3.5% annually) -HHS would establish a provider-specific cap of 10% of revenues that may be reimbursed from outlier payments -3% add-on payment for rural agencies, from April 1, 2010 to January 1, 2016 -HHS would submit a value-based purchasing implementation program to Congress by October 1, 2011
<i>Hospice</i>	<ul style="list-style-type: none"> -FY 2013-2019 market basket update reduced by 0.3% -productivity adjustment incorporated into annual update, effective FY 2013 -HHS, in consulting with MedPAC, will revise the payment system for FY 2013 -quality reporting program established effective FY 2014 (with a 2.0% penalty for failing to report) -pilot testing for value-based purchasing to occur no later than January 1, 2016
<i>Hospitals (Inpatient & Outpatient)</i>	<ul style="list-style-type: none"> -FY 2010-2011 market basket update reduced by 0.25% -FY 2012-2013 market basket update reduced by 0.1% -FY 2014 market basket update reduced by 0.3% -FY 2015-2016 market basket update reduced by 0.2% -FY 2017-2019 market basket update reduced by 0.75% -increased payments to hospitals located in counties in the lowest quartile of per capita Medicare spending, effective 2011-2012 -full productivity reduction to annual update, effective FY 2012 -the inpatient hospital VBP program would transition from pay-for-reporting to pay-for-performance, effective FY 2013 -reduced payments to hospitals with high readmission rates, effective FY 2013 -reduced payments for hospitals that rank in the top quartile of hospital acquired conditions, effective FY 2015
<i>Imaging</i>	<ul style="list-style-type: none"> -increases utilization rate assumption for calculating the payment for advanced imaging equipment from 50% to 75%, effective 2011 -reduction for imaging procedures conducted on contiguous body parts increased from 25% to 50% -physicians must disclose ownership interest in imaging equipment to their patients, effective 2010

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Medicare - Provider Payments	
<i>Independent Payment Advisory Board</i>	<ul style="list-style-type: none"> -establishes the Independent Payment Advisory Board to develop and submit proposals to Congress aimed at extending the solvency of Medicare, slowing cost-growth, improving quality of care, and reducing national health expenditures -Commission proposals will be automatically implemented unless Congress acts in opposition -proposals to modify payments will be effective for payment years 2015 and beyond (2020 for hospitals)
<i>Inpatient Rehabilitation Facilities (IRFs)</i>	<ul style="list-style-type: none"> -FY 2010-2011 market basket update reduced by 0.25% -FY 2012-2013 market basket updated reduced by 0.1% -FY 2014 market basket update reduced by 0.3% -FY 2015-2016 market basket update reduced by 0.2% -FY 2017-2019 market basket update reduced by 0.75% -productivity adjustment incorporated into annual update, effective FY 2012 -quality reporting program established effective FY 2014 (with a 2.0% penalty for failing to report) -pilot testing for value-based purchasing to occur no later than January 1, 2016
<i>Long-Term Care Hospitals (LTCHs)</i>	<ul style="list-style-type: none"> -rate year 2010 market basket update reduced by 0.25% -rate year 2011 market basket update reduced by 0.5% -rate years 2012-2013 market basket update reduced by 0.1% -rate year 2014 market basket update reduced by 0.3% -rate years 2015-2016 market basket update reduced by 0.2% -rate years 2017-2019 market basket update reduced by 0.75% -productivity adjustment incorporated into annual update, effective rate year 2012 -quality reporting program established effective rate year 2014 (with a 2.0% penalty for failing to report) -MMSEA section 114(c) and (d) extended for one year -pilot testing for value-based purchasing to occur no later than January 1, 2016
<i>Medicare Advantage (MA)</i>	<ul style="list-style-type: none"> -reduces MA benchmarks relative to 2011 levels, beginning in 2012 (with a transition period) -MA benchmarks will vary from 95% of Medicare spending (high-cost areas) to 115% of Medicare spending (low-cost areas) -high-quality plans eligible for incentive payments -requires 85% MLR for MA plans, effective 2014 (failure to achieve 85% will result in a rebate paid to HHS) -failure to achieve 85% MLR can result in suspended beneficiary enrollment or contract termination -special needs plans program extended through 2013

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Medicare - Provider Payments	
<i>Medicare DSH Payments</i>	-Medicare DSH payments would be reduced as the number of uninsured patients is reduced, effective FY 2014
<i>Medicare Improvement Fund</i>	-eliminates the Medicare Improvement Fund
<i>Medicare Part D (Prescription Drug Benefit)</i>	-provides a \$250 rebate for Part D enrollees who hit the doughnut hole in 2010 -brand name drugs provided to Part D enrollees will be discounted by 50% off the negotiated price for drugs prescribed during the doughnut hole, effective 2011 -the doughnut hole is gradually closed by requiring brand and generic drugs to be offered at 75% discounts by 2020
<i>Outpatient Therapy</i>	-extends the outpatient therapy caps exceptions process through December 31, 2010
<i>Physicians</i>	-no change to the Medicare Physician Fee Schedule (SGR formula) -HHS would make appropriate adjustments to misvalued RVUs -increases PQRI incentive payment by 0.5% for 2011-2014 -increased Medicare payments to physicians with low practice costs in 2010 -extends the PQRI program through 2014 and provides a penalty for physicians who do not participate in 2015 (1.5% reduction) and beyond (2% reduction) -HHS to develop a Physician Compare website by January 1, 2011 -requires HHS to apply a budget-neutral payment modifier to the physician fee schedule to pay physicians differentially based upon the relative quality of care they achieve for beneficiaries, implemented in 2015
<i>Physician Self-Referral (Specialty Hospitals)</i>	-prohibits new/expanded physician ownership in hospitals -grandfathers physician-owned hospitals in operation as of December 31, 2010
<i>Post-Acute Care</i>	-quality measures for post-acute care will be developed -the Center for Medicare and Medicaid Innovation will examine PAC payment reforms
<i>Skilled Nursing Facilities (SNFs)</i>	-productivity adjustment incorporated into annual update, effective FY 2012 -HHS to develop and submit a value-based purchasing implementation program to Congress by October 1, 2011 -implementation of the RUG-IV classification system may not occur prior to October 1, 2011

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Medicare - Primary Care, Coordinated Care, Delivery System Reform	
<i>Accountable Care Organizations (ACOs)</i>	<ul style="list-style-type: none"> -HHS to establish the Medicare Shared Savings Program to promote accountability and coordination of Medicare Parts A and B services -would allow groups of providers who meet certain statutory criteria to be recognized as ACOs and be eligible to share in the cost-savings achieved by the Medicare program -eligible ACOs would be groups of providers and suppliers who have an established mechanism for joint decision making, including: practitioners in group practices; networks of practices; partnerships or joint ventures between hospitals and practitioners; hospitals employing practitioners; and such other groups are determined eligible by HHS -HHS may give priority to ACOs currently operating within other payer arrangements -program must be established by January 1, 2012
<i>Annual Wellness Visit</i>	-beneficiaries will have access to a comprehensive health risk assessment, effective 2011
<i>Bundled Payments</i>	<ul style="list-style-type: none"> -HHS required to develop a national, voluntary bundled payment pilot program to provide incentives for providers to coordinate care, effective 2013 -program may be expanded after January 1, 2016
<i>Center for Medicare and Medicaid Innovation Center</i>	<ul style="list-style-type: none"> -creates the Center for Medicare and Medicaid Innovation to test, evaluate, and expand different payment structures and methodologies -established by 2011
<i>Medical Home</i>	<ul style="list-style-type: none"> -HHS to award grants to fund medical home models -the Independent Medicare Advisory Board would test medical home models
<i>Preventive Services Cost-Sharing</i>	-waives cost-sharing for preventive services, effective 2011
<i>Reimbursement for Primary Care Services</i>	-provides a 10% bonus payment on select primary care services and general surgeons providing care in health professional shortage areas, effective 2011-2016

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Medicare - Quality & Transparency Initiatives	
<i>Nursing Home Transparency</i>	-requires public disclosure of nursing home ownership information -nursing homes must develop compliance programs and implement staff training programs -enhanced civil monetary penalties (CMPs)
<i>Physician Payments Sunshine</i>	-requires annual public reporting of any payments made by drug or device manufacturers to physicians, effective March 31, 2013
<i>Quality Measures</i>	-provides additional resources to HHS to strengthen and improve the quality measure development process, including the development of new measures, including post-acute care measures -HHS shall develop, and update annually, national priorities for quality performance improvement and develop new quality measures -HHS/AHRO to fund studies examining how to improve quality outcomes
<i>Quality Reporting</i>	-quality reporting programs established for LTCHs, IRFs, hospice, and PPS-exempt cancer hospitals
<i>Value-Based Purchasing (VBP)</i>	-VBP program enhanced for inpatient hospitals -directs studying VBP for ASCs, home health agencies, LTCHs, SNFs, and hospice

Medicare - Fraud & Abuse	
<i>Compliance Programs</i>	-requires all providers and suppliers to implement compliance programs -HHS would develop core elements for inclusion in a compliance program
<i>Enhanced Penalties</i>	-would increase penalties and extend the use of CMPs -CMS would have additional flexibility to impose intermediate sanctions
<i>Health Care Fraud & Abuse Control Fund</i>	-increases funding for the Health Care Fraud and Abuse Control Fund by \$250 million over ten years
<i>Screening of Providers & Suppliers</i>	-HHS required to screen all providers and suppliers, including advanced screening procedures for certain types of at-risk providers and suppliers

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Medicaid Program	
<i>Accountable Care Organizations (ACOs)</i>	-establishes a demonstration project to allow pediatric medical providers to be recognized as ACOs and share in the federal and state savings
<i>Bundled Payments</i>	-establishes a demonstration project to study the use of bundled payments for hospital and physician services -demonstration project will run from January 1, 2012 through December 31, 2016 in up to eight states
<i>Compliance Programs</i>	-requires providers to establish compliance programs
<i>Coverage</i>	-requires states to cover individuals and families at or below 133% of FPL, effective 2014 -federal government to pay 100% of the cost of Medicaid expansion in 2014-2016, 95% of the cost in 2017, 94% of the cost in 2018, 93% of the cost in 2019, and 90% of the cost in 2020 and beyond
<i>DSH Payments</i>	-Medicaid DSH payments would be reduced to reflect higher levels of insured, effective 2014 -total DSH reduction is \$14.1 billion from 2014-2020
<i>Managed Care Medical Loss Ratio (MLR)</i>	-no provision
<i>Medicaid Improvement Fund</i>	-eliminates the Medicaid Improvement Fund
<i>Medicaid Prescription Drug Coverage</i>	-increases the Medicaid drug rebate from 15.1% to 23.1% of AMP, effective 2010 -increases the rebate for generic drugs from 11% to 13% of AMP, effective 2010 -extends drug rebate to Medicaid managed care organizations, effective 2010 -applies the drug rebate to new formularies of brand name drugs, effective 2010
<i>Medical Home</i>	-creates a new state plan option to establish a health home to deliver integrated care to enrollees with at least two chronic conditions, effective 2011
<i>Preventive Services</i>	-encourages states to offer coverage of preventive services and immunizations
<i>Primary Care Services</i>	-payment rates to physicians providing primary care services must equal at least 100% of the Medicare payment rate in 2013 and 2014 -federal government to fund the cost of this requirement

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Public Health & Workforce

Health Care Workforce

- establishes the National Health Care Workforce Commission, which would report to Congress and the Administration on the state of the existing health care workforce and identify future needs and goals
- the goal of the Commission would be to set a path toward recruiting, training, and retaining a health workforce that meet's current and future health care needs
- requires small business representation on the Commission
- competitive grants would be created to enable State partnerships to complete comprehensive planning and strategies with regard to increasing the number of skilled health care workers
- establishes several regional centers for health workforce analysis to report data related to the development of primary care workforce programs
- provides new educational scholarships and loan repayment programs to recruit medical students to address workforce shortages, with a focus on underserved, uninsured, rural, and minority populations
- offers loan repayment programs for public health students that agree to work at least three years at a public health agency
- offers loan repayment program to allied health professionals employed at certain public health agencies
- extends authorization for the National Health Service Corps scholarship and loan repayment program and increases funding
- authorizes funding for programs aimed at increasing diversity within the existing health care workforce
- provides grants to develop and operate training programs relating to family medicine, general internal medicine, general pediatrics, and physician assistantships
- establishes training programs for direct care workers proving long-term care
- reinstates dental funding in Title VII of the Public Health Service Act
- authorizes funding to geriatric education centers to support training in geriatrics and chronic care management
- awards grants to increase training in the field of mental and behavioral health
- directs the Surgeon General to establish a U.S. Public Health Sciences Track to train health care professionals such as physicians, dentists, nurses, physician assistants, mental and behavioral specialists, and other public health professionals
- eliminates the cap on Commissioned Corps members and establishes a Ready Reserve Corps to respond in times of national emergencies
- increases funding to strengthen nurse education and training programs
- creates a state grant program that awards funds to providers who treat high populations of the medically underserved

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Public Health & Workforce	
	-requires HHS to establish a grant program to assist eligible entities in recruiting students most likely to practice in underserved rural communities
<i>Health Quality and Delivery System Reform</i>	-requires HHS to establish a national strategy to improve health care service quality, delivery of health care services, health outcomes, and the health of the overall population -HHS will implement these priorities at a local, state, and federal level to ensure that providers utilize best practices that focus on efficiency and quality, reduced medical errors, improved medication management, improved emergency care, reduced hospital readmissions, and increased patient education with regard to treatment options -establishes the Interagency Working Group on Health Care Quality to improve quality measures and increase collaboration between Federal departments -authorizes \$75 million over five years to develop quality measures consistent with the national strategy for use in federal programs
<i>Focus on Community Health</i>	-establishes the Community Health Center Fund -provides \$11 billion for community health centers -allows HHS to award grants to community programs that promote healthy lifestyles and decreases the incidence of chronic disease -authorizes funding to promote community health centers ins medically underserved areas -expands on demonstration programs that provide patient navigator services to assist patients overcome barriers to health care services

Prevention & Wellness	
<i>Prevention and Wellness Trust Fund</i>	-establishes the Prevention and Public Health Fund to increase investment in prevention and public health programs to improve health and reduce the growth of health care costs in the public and private sector -invests approximately \$15 billion into this fund
<i>Focus on Prevention</i>	-creates the National Prevention, Health Promotion and Public Health Council to establish and implement a national prevention and health promotion strategy -invests in programs at the federal, state, and local level to increase access to clinical preventive services, improve preventive training, reduce chronic disease rates, increase patient education and outreach, pursue

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Prevention & Wellness	
	<ul style="list-style-type: none"> innovative approaches, and reduce overall health care disparities -establishes a grant program to provide training to graduate medical residents in preventive medicine specialties -establishes the Community Preventive Services Task Force to review the effectiveness of population-based services and develops recommendations -directs HHS to develop a promotional and educational campaign emphasizing national prevention (to be developed through a public/private effort) -HHS will also develop a website to provide information on health promotion and disease prevention -authorizes a grant program to school-based health clinics that provide services to medically underserved children -establishes an oral health care prevention campaign developed by the CDC -creates a program to focus on and improve the health status of pre-Medicare beneficiaries between 55 and 64 -the CDC will provide funds and assistance to help states increase the immunization coverage -instructs any ongoing or new federal health program to assess and analyze health disparities
<i>Focus on Wellness</i>	<ul style="list-style-type: none"> -creates a 10 state pilot project that tests the impact of providing wellness programs to at-risk communities (e.g., nutritional counseling, physical activity plans, smoking cessation) -specific focus on wellness programs for individuals with disabilities and the pre-Medicare population to prevent incidents of chronic disease
<i>Employer Wellness Programs</i>	<ul style="list-style-type: none"> -HHS to develop criteria for comprehensive workplace wellness programs; grants will be available for such programs -requires HHS to award grants to small employers for the purpose of providing their employees with access to workplace wellness programs (this grant program will be in place for five years) -increases the level of financial incentives available to employees who participate in employer-provided wellness programs from 20% of health insurance premiums to 30%, effective 2014 -requires the CDC to evaluate best employer-based wellness programs -provides educational campaigns and assistance to promote the benefits of worksite health promotion
<i>Wellness Program Demonstration</i>	<ul style="list-style-type: none"> -HHS, Treasury, and Labor will establish a ten-state demonstration project to test wellness program components, effective not later than July 1, 2014 -program may be expanded, effective July 1, 2017

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Miscellaneous Provisions	
<i>340B Program</i>	<ul style="list-style-type: none"> -expands participation in the 340B program to children's hospitals, free standing cancer hospitals, critical access hospitals, rural referral centers, and sole community hospitals -the 340B expansion does not apply to inpatient drugs -adopts certain compliance requirements for manufacturers to prevent overcharges and other violations
<i>Comparative Effectiveness Research</i>	<ul style="list-style-type: none"> -establishes the Patient-Centered Outcomes Research Institute to identify national priorities for comparative clinical effectiveness research -prohibits the Institute or HHS from mandating coverage or reimbursement policies based on the Institute's research -funded by appropriations and an annual fee imposed on all health insurance policies
<i>Congressional Budget Office (CBO) Analysis</i>	<ul style="list-style-type: none"> -\$938 billion cost over 2010-2019 -\$143 billion reduction in federal deficit over 2010-2019 -\$1.2 trillion reduction in federal deficit over 2020-2029 -32 million reduction in the number of uninsured by 2019 (94% insured rate)
<i>Generic Biologics (Follow-On Biologics)</i>	<ul style="list-style-type: none"> -establishes a pathway for licensure of a biological product based on its similarity to a previously licensed biological product (reference product) -prohibits the approval of an application as either biosimilar or interchangeable until 12 years from the date on which the reference product is first approved -allows a Medicare Part B biosimilar to be assigned a separate billing code to be reimbursed under the Part B "ASP + 6%" methodology
<i>Generic Drug Settlements</i>	<ul style="list-style-type: none"> -no provision
<i>Pharmacy Benefit Manager (PBM) Disclosure</i>	<ul style="list-style-type: none"> -PBMs participating in Part D or the exchanges must report to HHS information regarding rebates, discounts, or price concessions, along with generic drug utilization.

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