

Insurance Reforms		
Provision	H.R. 3590 - Patient Protection and Affordable Care Act (Senate bill)	H.R. 3962 - Affordable Health Care for America Act (*passed the House November 7)
<i>Antitrust Exemption for Insurers</i>	-no provision	-removes antitrust exemption for health insurers and medical malpractice insurers
<i>Benefit Package</i>	-plans in the individual or small group market must provide the essential health benefits package, effective 2014	-plans must meet the requirements of qualified health benefits plans, effective 2013 (five-year grace period provided for employer-sponsored plans)
<i>Dependent Coverage</i>	-requires insurers that offer dependent coverage to allow uninsured children to remain on their parents' health insurance up until the 26 th birthday, effective 2011	-requires health insurers to allow uninsured children to remain on their parents' health insurance up until the 27 th birthday
<i>Guaranteed Issue and Renewal</i>	-guaranteed issue and renewal required, effective 2014	-guaranteed issue and renewal required
<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	-permits variation based only on geographic area, family size, and age (2:1 limit), effective 2013
<i>Lifetime/Annual Limits</i>	-small and large group market plans may not impose unreasonable lifetime or annual limits on coverage, effective 2011 -plans in the group market may not impose annual cost-sharing that exceeds the high-deductible health plan out-of-pocket limits, effective 2014	-no lifetime limits on health care benefits permitted
<i>Marketing Practices</i>	-qualified health plans must not use marketing practices that discourage the enrollment of individuals with significant health needs	-Health Choices Commissioner has the authority to define marketing standards for health plans
<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 80% -individual plans must have an MLR of 75%	-plans must have a minimum MLR of 85%, effective 2010 -applies to individual, small, and large group markets -HHS to establish a uniform MLR definition

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	-effective 2011 through December 31, 2013	
<i>National High Risk Pool</i>	-HHS will establish a temporary insurance program for uninsured people denied coverage due to pre-existing conditions within 90 days of enactment -effective until the creation of the insurance exchange	-temporary insurance program for uninsured people or those denied coverage due to pre-existing conditions, effective 2010 through the creation of the insurance exchange
<i>Non-Discrimination</i>	-no discrimination permitted based on the wages of employees, effective 2011 -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	-authority provided to Health Choices Commissioner to set non-discrimination rules -requires mental health parity and substance abuse disorder benefits parity
<i>Pre-Existing Conditions</i>	-prohibits excluding patients on the basis of pre-existing conditions, effective 2014	-prohibits excluding patients on the basis of pre-existing conditions, effective 2013 -prior to 2013, the period by which plans can look back for pre-existing conditions is reduced from six months to 30 days
<i>Preventive Services</i>	-plans must provide coverage, without cost-sharing, for preventive services and immunizations, effective 2011	-no cost-sharing for preventive services, as defined by HHS
<i>Quality Reporting</i>	-insurance companies must report to HHS and the 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	-no provision

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	-HHS may impose penalties for failure to report -effective 2011	
<i>Rescission</i>	-insurance companies prohibited from rescinding coverage, except in cases of fraud or intentional misrepresentation of material fact, effective 2011	-insurance companies may not rescind coverage except in instances of clear and convincing fraud, effective July 1, 2010
<i>Sunshine on Premium Increases</i>	-establishes an annual review process that requires insurers to submit justifications for premium increases, effective 2010	-establishes an annual review process that requires insurers to submit justifications for premium increases, effective 2010

Health Insurance Exchange		
Provision	H.R. 3590 - Patient Protection and Affordable Care Act (Senate bill)	H.R. 3962 - Affordable Health Care for America Act (*passed the House November 7)
<i>Establishment, Purpose, and Duties of Exchange</i>	-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 approval of each state legislature -states may establish subsidiary exchanges within the state -HHS will establish an exchange in a state if that	-national Health Insurance Exchange established within the new Health Choices Administration -Health Choices Commissioner will establish standards, accept bids, negotiate and enter into contracts with qualified plans, and conduct outreach and enrollment of eligible individuals and employers -states may operate a state-based exchange in lieu of the national Health Insurance Exchange (subject to the approval of the Health Choices Commissioner) -states may form interstate compacts to facilitate the purchase of health insurance, effective 2015

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	<ul style="list-style-type: none"> state fails to do so by 2014 -states may form interstate compacts to facilitate the purchase of health insurance, effective July 1, 2013 	
<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 	<ul style="list-style-type: none"> -non-Medicare/Medicaid eligible individuals without health insurance may obtain coverage in the exchange -small employers with 25 or fewer employees may obtain coverage in 2013, 50 or fewer employees in 2014, and 100 or fewer employees in 2015 -employers with more than 100 employees may be eligible in 2015 or beyond, subject to the Health Choices Commissioner
<i>Benefit Packages</i>	<ul style="list-style-type: none"> -four benefit categories would be available: bronze, silver, gold, and platinum - based on the actuarial value of the plans -all plans must provide basic services -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 	<ul style="list-style-type: none"> -basic plan must be offered by any entity participating in the Exchange (i.e., essential benefits package and 70% actuarial value) -an entity also may offer enhanced, premium, and premium-plus plans
<i>Public Health Insurance Option</i>	<ul style="list-style-type: none"> -a community health insurance option will be included in the exchanges as an insurance option (states may pass legislation opting out) -initial start-up funding must be repaid within nine years -HHS may contract with qualified non-profit entities to perform administrative functions of the community health insurance option -HHS will negotiate the reimbursement rates paid to providers 	<ul style="list-style-type: none"> -HHS to establish a public health insurance option to be offered solely within the Health Insurance Exchange, starting in 2013 -must be self-sustaining after initial \$2 billion funding -payment rates will be negotiated by HHS -HHS may utilize innovative payment initiatives and delivery system reforms -Medicare providers presumed to participate unless they opt-out

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	-no mandatory provider participation -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	-Health Choices Commissioner to establish a CO-OP program within 6 months of enactment and provide loans and grants to eligible non-profit entities
<i>Funding</i>	-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)	-Health Insurance Exchange Trust Fund created to operate the Exchange -funded by appropriations and enforcement of individual and employer mandate
<i>Assistance for Certain Individuals</i>	-premium credits and cost-sharing reductions available for individuals and families below 400% of FPL	-premium and cost-sharing affordability credits available for individuals and families below 400% of FPL

Individual & Employer Responsibility		
Provision	H.R. 3590 - Patient Protection and Affordable Care Act (Senate bill)	H.R. 3962 - Affordable Health Care for America Act (*passed the House November 7)
<i>Individual Responsibility</i>	-individuals must obtain minimum essential coverage for them and their dependents, effective 2014 -hardship and religious exemptions permitted	-individuals must obtain acceptable health insurance coverage for themselves and their dependents, effective 2013 -acceptable coverage includes grandfathered or employer-sponsored insurance, government insurance (e.g., Medicare, VA), and "qualified coverage" offered in the exchange -hardship and religious exemptions permitted
<i>Qualified Coverage</i>	-minimum essential coverage includes government-	-grandfathered coverage includes: individual health

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	<p>sponsored coverage, employer-sponsored care, grandfathered health plans, and plans offered in the individual market</p> <ul style="list-style-type: none"> -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), no cost-sharing for preventive services or immunizations -“Young Invincibles” catastrophic coverage available as follows: only individuals under age 30 are eligible; 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 for preventive services 	<p>insurance coverage as of 2013, (subject to limits on new enrollment and premium increases); and employer-sponsored health insurance until 2018</p> <ul style="list-style-type: none"> -qualified health benefits plans must follow the following requirements: no pre-existing conditions denial; guaranteed issue and renewal; no rescissions; age rating limited to 2:1; variation limited to family composition and geographic area; dependent coverage until age 27; 90 notice required for cost increases or coverage decreases; covers the essential health benefits package; annual \$5,000 (individual) or \$10,000 (family) limit on cost-sharing; no cost-sharing for preventive services; no annual or lifetime limits; minimum actuarial value of 70%; uniform marketing standards; and timely grievance and appeals mechanisms
<i>Individual Penalty</i>	<ul style="list-style-type: none"> -failure to obtain minimum essential coverage will result in a tax as follows: \$95 in 2014; \$350 in 2015; \$750 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 -no penalty applied to individuals who qualify for hardship or religious exemptions 	<ul style="list-style-type: none"> -failure to obtain acceptable health care coverage will result in a 2.5% tax on the modified adjusted gross income of the individual -no penalty applied to individuals who qualify for hardship or religious exemptions -penalty effective 2013 -sliding-scale limits on annual out-of-pocket expenditures
<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 	<ul style="list-style-type: none"> -employers must offer a qualified health benefits plan or current employer-sponsored insurance

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	<p>coverage</p> <ul style="list-style-type: none"> -employers with more than 50 employees must offer coverage to their employees 	<p>employers must contribute at least 72.5% of the premium for full-time employees (for individual coverage) and at least 65% of the premium for full-time employees (for family coverage)</p> <ul style="list-style-type: none"> -a salary reduction to pay for coverage is not treated as an acceptable employer contribution -for part-time employees, the employer contribution will be a proportional amount -employers must contribute 8% of an employer's average wages to the Health Insurance Exchange Trust Fund for each employee who obtains coverage through the Exchange -employers must meet essential health benefits standards for employer-sponsored coverage, effective 2018
<i>Employer Penalty</i>	<ul style="list-style-type: none"> -for employers with more than 50 employees that do not offer coverage and have at least one employee receiving the premium assistance tax credit, they will be fined the lesser of \$750 multiplied by the number of employees or \$3,000 for each employee receiving the tax credit -employers with more than 50 employees will pay a fine for implementing waiting periods for employees who wish to enroll in coverage, as follows: \$400 per employee during a 30-60 day waiting period; \$600 for any employee during a waiting period exceeding 60 days 	<ul style="list-style-type: none"> -for employers not offering health insurance to employees, the following tax penalty will be assessed, effective 2013 -8% tax on wages for employers with annual payrolls exceeding \$750,000 -6% tax on wages for employers with annual payrolls between \$670,000 and \$750,000 -4% tax on wages for employers with annual payrolls between \$585,000 and \$670,000 -2% tax on wages for employers with annual payrolls between \$500,000 and \$585,000 -no penalty for employers with annual payrolls that do not exceed \$500,000

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Tax Provisions (Credits & Revenue Raisers)		
Provision	H.R. 3590 - Patient Protection and Affordable Care Act (Senate bill)	H.R. 3962 - Affordable Health Care for America Act (*passed the House November 7)
<i>Individual Tax Credits</i>	-premium credits and cost-sharing reductions available for individuals and families below 400% of FPL	-affordability credits available to individuals and families up to 400% of FPL who are not enrolled in employer-sponsored coverage -affordability credits available if employer-sponsored coverage costs greater than 12% of income -premium and cost-sharing affordability credits may only be used for basic plans in 2013 and 2014; premium credits may be used after 2014 for enhanced or premium plans -premium affordability credits (capped at 12% of income), actuarial value enhancements (up to 97%), and cost-sharing affordability credits (from \$500 to \$5,000) are available on a sliding scale up to 400% of FPL
<i>Small Business Credits</i>	-tax credits equal to 50% of the amount paid by a small employer for employee health coverage -limited to firms with 25 or fewer full-time employees and with average annual wages below \$40,000 -full credit phases out for employers with more than 10 full-time employees or average annual wages between \$20,000 and \$40,000 -tax credits available beginning in 2011, however, full credit amount is not available until 2014	-tax credit equal to 50% of the amount paid by a small employer for employee health coverage -phased out for employers with 10-25 employees -phased out for employers with average annual wages between \$20,000 and \$40,000 -credits available beginning in 2013 (capped at two years per firm)
<i>Income Taxes</i>	-increases the hospital insurance payroll tax by 0.5% on individuals earning over \$200,000 and couples earning \$250,000, effective 2013	-5.4% tax on modified adjusted gross income that exceeds \$1,000,000 (joint filers) and \$500,000 (single filers)
<i>Insurance Fees</i>	-40% excise tax on employer-sponsored health coverage that exceeds \$8,500 for an individual and \$23,000 for families, effective 2013	-fees assessed on sponsors of private insurance to be transferred to the Comparative Effectiveness Research Trust Fund

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<i>Flexible Spending Accounts (FSAs)</i>	-contributions to FSAs are capped at \$2,500 annually, effective 2011	-contributions to FSAs are capped at \$2,500 annually, effective 2013
<i>Qualified Medical Expenses</i>	-cost of over-the-counter medicines may not be reimbursed through a health FSA or HRA -cost of over-the-counter medicines may not be reimbursed on a tax-free basis through an HSA or Archer MSA, effective 2011	-cost of over-the-counter medicines may not be reimbursed through a health FSA or HRA -cost of over-the-counter medicines may not be reimbursed on a tax-free basis through an HSA or Archer MSA, effective 2011
<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	-the tax on distributions from an HSA that are not used for qualified medical expenses is raised to 20%, effective 2011
<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 no more than the amount billed to insured patients; and follow certain debt collection practices	-no provision
<i>Prescription Drug Industry User Fee</i>	-\$2.3 billion annual fee on prescription drug manufacturer industry, effective 2010	-no provision
<i>Medical Device Industry User Fee</i>	-\$2 billion annual fee on medical device manufacturer industry, effective 2010	-2.5% excise tax on the sale of every medical device for use in the U.S.
<i>Health Insurance Provider Industry User Fee</i>	-\$6.7 billion annual fee on health insurance provider industry, effective 2010	-no provision
<i>Medical Expense Deduction</i>	-increases the threshold for claiming the itemized deduction for medical expenses from 7.5% to 10%, effective 2013	-no provision

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Medicare - Provider Payments		
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<i>Ambulatory Surgical Centers (ASCs)</i>	-full productivity adjustment incorporated into annual update, effective FY 2011	-productivity adjustment incorporated into annual update, effective FY 2010 -quality data must be reported to HHS, effective 2012 -cost data must be submitted to HHS
<i>Clinical Laboratory</i>	-1.75% reduction, from 2011-2015 -productivity adjustment incorporated into annual update, effective 2011	-productivity adjustment incorporated into annual update, effective FY 2010
<i>CMS Innovation Center</i>	-creates the Center for Medicare and Medicaid Innovation to test, evaluate, and expand different payment structures and methodologies -established by 2011	-creates the Center for Medicare and Medicaid Payment Innovation Center within CMS by 2011 -will test and expand new payment models that encourage higher quality care and reduced costs
<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	-waives surety bond requirement for pharmacies enrolled as DME suppliers for at least 5 years -ensures continued beneficiary access to oxygen equipment -productivity adjustment incorporated into annual update for non-competitively bid DME, effective FY 2010
<i>ESRD (Dialysis)</i>	-productivity adjustment incorporated into annual update, effective 2012	-no provision
<i>Geographic Variation</i>	-no provision	-IOM will examine geographic variation in Medicare -HHS will submit an implementation plan to revise Medicare payment systems to reflect geographic variation -payment changes automatically implemented unless Congress affirmatively disapproves
<i>Graduate Medical</i>	-would increase the number of GME positions in	-provides incentives for the training of primary care

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<i>Education (GME)</i>	states with the lowest resident physician-to-patient ratios -would make payments to qualified teaching health centers for GME for primary care services	physicians and encourages medical residency training in non-hospital settings
<i>Home Infusion</i>	-no provision	-MedPAC would submit a report to Congress regarding recommendations for adding Medicare coverage for home infusion (by July 1, 2011)
<i>Home Health Agencies</i>	-2011 and 2012 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 2013 (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	-2010 update of 0% -productivity adjustment incorporated into annual update, effective FY 2010 -accelerates the case mix adjustment so that it occurs in 2010, instead of 2011 -directs HHS to rebase the home health PPS for 2011 -market basket update cannot be below 0% -directs MedPAC study the variation in Medicare home health agency margins
<i>Hospice</i>	-FY 2013-2019 market basket update reduced by 0.5% -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)	-productivity adjustment incorporated into annual update, effective FY 2010 -extends moratorium on hospice wage-index phase-out for FY 2010

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<i>Hospitals (Inpatient & Outpatient)</i>	<ul style="list-style-type: none"> -FY 2010-2011 market basket update reduced by 0.25% -FY 2012-2019 market basket update reduced by 0.2% -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 	<ul style="list-style-type: none"> -productivity adjustment incorporated into annual update for inpatient and outpatient hospital services, effective FY 2010 -market basket update cannot be below 0% -reduced payments for hospitals that have preventable readmissions, effective FY 2012
<i>Imaging</i>	<ul style="list-style-type: none"> -increases utilization rate assumption for calculating the payment for advanced imaging equipment from 50% to 65%, effective 2010-2012, 70% in 2013, and 75% in 2014 and beyond -reduction for imaging conducted on contiguous body parts increased from 25% to 50% -physicians must disclose ownership interest in imaging equipment to their patients, effective 2010 	<ul style="list-style-type: none"> -increases utilization rate assumption for advanced diagnostic imaging services from 50% to 75%, effective 2011 -reduction for imaging conducted on contiguous body parts increased from 25% to 50%, effective 2011
<i>Inpatient Rehabilitation Facilities (IRFs)</i>	<ul style="list-style-type: none"> -FY 2010-2011 market basket update reduced by 0.25% -productivity adjustment incorporated into annual update, effective FY 2012 -FY 2012-2019 market basket update reduced by 0.2% -quality reporting program established effective FY 2014 (with a 2.0% penalty for failing to report) 	<ul style="list-style-type: none"> -FY 2010 market basket update of 0% for 2nd-4th quarters -productivity adjustment incorporated into annual update, effective FY 2011

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<i>Long-Term Care Hospitals (LTCHs)</i>	<ul style="list-style-type: none"> -rate years 2010-2011 market basket update reduced by 0.25% -rate years 2012-2019 market basket update reduced by 0.2% -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 	<ul style="list-style-type: none"> -productivity adjustment incorporated into annual update, effective FY 2010
<i>Medicare Advantage (MA)</i>	<ul style="list-style-type: none"> -MA benchmarks calculated through competitive bidding, with a four-year transition effective 2012 -plans could grandfather in extra benefits for current enrollees where average plan bids are at or below 75% of local FFS costs -bonus payment available for care coordination and management activities, effective 2014 -bonus payment available for quality achievement or improvement in plan performance, effective 2014 -prohibits higher cost-sharing than under fee-for-service for certain services, effective 2011 -special needs plans program extended through 2013 	<ul style="list-style-type: none"> -reduces MA payment rates to fee-for-service levels by 2013 -quality incentive payments phased-in from 2011-2013 -prohibits higher cost-sharing amounts under MA than would be required under traditional fee-for-service or Medicaid (for dual-eligibles), effective 2011 -requires a medical loss ratio of at least 85%, effective 2014 -special needs plans program extended through 2012
<i>Medicare Advisory Board</i>	<ul style="list-style-type: none"> -establishes the Independent Medicare Advisory Board to develop and submit proposals to Congress aimed at extending the solvency of Medicare, slowing cost-growth, and improving quality of care -Commission proposals will be automatically implemented unless Congress acts in opposition -proposals to modify payments will be effective for 	<ul style="list-style-type: none"> -no provision

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	payment years 2015 and beyond	
<i>Medicare DSH Payments</i>	-Medicare DSH payments would equal 25% of the payments that would otherwise be made, with additional reductions for reduced numbers of uninsured, effective FY 2015	-reduces Medicare DSH payments beginning in 2017 if the uninsured rate drops significantly between 2012-2014
<i>Medicare Improvement Fund</i>	-eliminates the Medicare Improvement Fund	-appropriates \$8 billion to the Medicare Improvement Fund
<i>Medicare Part D (Prescription Drug Benefit)</i>	-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 July 1, 2010 -eliminates cost-sharing for dual-eligibles receiving care under a home and community-based waiver program, effective no earlier than January 1, 2012 -closes the doughnut hole for 2010 only by \$500	-closes 2010 doughnut hole by \$500 and phases it out completely by 2019 -requires drug manufacturers to provide Medicaid rebates to drugs used by dual eligibles, effective 2010 -HHS will negotiate part D drug prices -brand name drugs provided to Part D enrollees will be discounted by 50% for drugs prescribed during the doughnut hole, effective 2010
<i>Outpatient Therapy</i>	-extends the outpatient therapy caps exceptions process through December 31, 2010	-extends the outpatient therapy caps exceptions process through December 31, 2011
<i>Physicians</i>	-2010 update to the physician fee schedule would be 0.5% -HHS would make appropriate adjustments to misvalued RVUs -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) -requires HHS to apply a budget-neutral payment modifier to the physician fee schedule to pay physicians differentially based upon the relative	-does not address the SGR -establishes incentive payments in 2011 and 2012 for providers in efficient areas, as identified by HHS -the PQRI is extended through 2012 -HHS will study how a readmissions policy could be applied to physicians

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	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 February 1, 2010	-prohibits physician ownership in hospitals -grandfathers physician-owned hospitals in operation as of January 1, 2009
<i>Post-Acute Care (PAC)</i>	-quality measures for PAC will be developed -the Center for Medicare and Medicaid Innovation will examine PAC payment reforms	-reduces payments to SNFs, IRFs, LTCHs, and home health agencies for avoidable readmissions, between FY 2012-2014, -HHS will develop a hospital readmissions policy specific to PAC for FY 2015 and beyond -HHS to study the creation of a bundled payment system for PAC
<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	-FY 2010 market basket update of 0% for 2 nd -4 th quarters -productivity adjustment incorporated into annual update, effective FY 2011

Medicare - Primary Care & Coordinated Care		
Provision	H.R. 3590 - Patient Protection and Affordable Care Act (Senate bill)	H.R. 3962 - Affordable Health Care for America Act (<i>*passed the House November 7</i>)
<i>Accountable Care Organizations (ACOs)</i>	-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 (under the "Shared Savings	-creates an ACO pilot program within Medicare to test alternative payment methodologies, to begin no later than 2012 -a qualifying ACO would be a group of physicians

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Medicare - Primary Care & Coordinated Care		
Provision	H.R. 3590 - Patient Protection and Affordable Care Act (Senate bill)	H.R. 3962 - Affordable Health Care for America Act (*passed the House November 7)
	<p>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 -incentive payments available beginning in 2012</p>	<p>and could include a hospital or any other provider affiliated with the ACO under an arrangement that ensures the provider participates and shares incentive payments -an ACO qualifies to receive an incentive payment if expenditures for items and services are less than a target spending level or growth rate -HHS could issue regulations to implement on a permanent basis, and on a larger geographic scale, one or more models of the ACO program</p>
<i>Medical Home</i>	<p>-HHS to award grants to fund medical home models -the Independent Medicare Advisory Board would test medical home models</p>	<p>-establishes a medical home pilot program to test independent patient-centered medical homes and community-based medical home models -HHS will establish the payment methodology to be used and may expand successful models to larger geographic areas</p>
<i>Bundled Payments</i>	<p>-HHS required to develop a national, voluntary bundled payment pilot program to provide incentives for providers to coordinate care, effective 2013</p>	<p>-increases opportunity for Medicare providers to coordinate care and payment across different settings</p>
<i>Reimbursement for Primary Care Services</i>	<p>-provides a 10% bonus payment on select primary care services and general surgeons providing care in health professional shortage areas, effective 2011-2016</p>	<p>-provides a 5% bonus payment for primary care services, effective 2011 -provides a 10% bonus payment for primary care services provided in health professional shortage areas, effective 2011</p>
<i>Preventive Services Cost-Sharing</i>	<p>-waives cost-sharing for preventive services, effective 2011</p>	<p>-eliminates cost-sharing for all covered preventive services, effective 2011</p>
<i>Annual Wellness Visit</i>	<p>-beneficiaries will have access to a comprehensive health risk assessment beginning in 2011</p>	<p>-no provision</p>

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Medicare - Quality & Transparency Initiatives		
Provision	H.R. 3590 - Patient Protection and Affordable Care Act (Senate bill)	H.R. 3962 - Affordable Health Care for America Act (*passed the House November 7)
<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 	<ul style="list-style-type: none"> -establishes the Center for Comparative Effectiveness Research within the HHS AHRO -GAO will appoint members to the Comparative Effectiveness Research Commission to oversee the newly-created Center -the Center and Commission are prohibited from mandating coverage or reimbursement policies for private or public payers
<i>Nursing Home Transparency</i>	<ul style="list-style-type: none"> -requires public disclosure of nursing home ownership information -nursing homes must develop compliance programs -enhanced CMPs 	<ul style="list-style-type: none"> -requires public disclosure of nursing home ownership information -nursing homes must develop compliance programs within 36 months of enactment -enhanced CMPs
<i>Physician Payments Sunshine</i>	<ul style="list-style-type: none"> -requires annual public reporting of any payments made by drug or device manufacturers to physicians, effective March 31, 2013 	<ul style="list-style-type: none"> -requires annual public reporting of any payments made by drug or device manufacturers to physicians, effective March 31, 2011
<i>Quality Measures</i>	<ul style="list-style-type: none"> -provides additional resources to HHS to strengthen and improve the quality measure development process, including the development of new 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 	<ul style="list-style-type: none"> -HHS to develop national priorities for quality performance improvement and develop new quality measures -quality measures used for payment purposes must be endorsed by a consensus-based entity

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Medicare - Fraud & Abuse		
Provision	H.R. 3590 - Patient Protection and Affordable Care Act (Senate bill)	H.R. 3962 - Affordable Health Care for America Act (*passed the House November 7)
<i>Compliance Programs</i>	-requires all providers and suppliers to implement compliance programs -HHS would develop core elements for inclusion in a compliance program	-requires all providers (except physicians) and suppliers to adopt compliance programs -HHS may disenroll a supplier or impose CMPs for failure to adopt compliance programs
<i>Enhanced Penalties</i>	-would increase penalties and extend the use of CMPs -CMS would have additional flexibility to impose intermediate sanctions	-\$50,000 penalty for false statements: (1) on provider or supplier enrollment applications (includes MA and Part D); (2) on submitted claims for payment; and (3) ordering or prescribing any item or service while excluded from participation -\$15,000 per day penalty for delaying or refusing HHS OIG audit inspections -enhanced penalties effective 2010
<i>Health Care Fraud & Abuse Control Fund</i>	-provides \$10 million in additional funding annually for ten years	-provides an additional \$100 million in annual funding, effective FY 2011
<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	-HHS required to screen all providers and suppliers, including advanced screening procedures for certain types of at-risk providers and suppliers

Medicaid Program		
Provision	H.R. 3590 - Patient Protection and Affordable Care Act (Senate bill)	H.R. 3962 - Affordable Health Care for America Act (*passed the House November 7)
<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	-would allow states to test one or more of the Medicare ACO pilot programs established under this bill under a five-year Medicaid pilot program -enhanced federal matching payments available for

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Medicaid Program		
Provision	H.R. 3590 - Patient Protection and Affordable Care Act (Senate bill)	H.R. 3962 - Affordable Health Care for America Act (<i>*passed the House November 7</i>)
		states' administrative costs (90% for first two years and 75% for final three years)
<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	-no provision
<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 -FMAP will be increased by a statutory formula (but not equal to 100%) for 2017 and beyond	-requires states to cover individuals and families at or below 150% of the federal poverty level -federal government to pay 100% of the cost of Medicaid expansion in 2013-2014 and 91% of the cost in 2015 and beyond
<i>DSH Payments</i>	-Medicaid DSH payments would be reduced by 50% once a state's level of uninsurance decreases by 45% (low DSH states would see a 25% reduction)	-HHS will reduce Medicaid DSH payments by \$10 billion total between FY 2017-2019
<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	-HHS will establish a Medicaid medical home five-year pilot program
<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	-increases the Medicaid drug rebate from 15.1% of AMP to 23.1% of AMP, effective 2010 -extends drug discount to Medicaid managed care organizations (effective July 1, 2010) -applies the drug rebate to new formularies of brand name drugs, effective 2010
<i>Compliance</i>	-requires providers to establish compliance	-requires providers (except physicians and nursing

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Medicaid Program		
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<i>Programs</i>	programs	homes) and suppliers to establish compliance programs
<i>Managed Care Medical Loss Ratio (MLR)</i>	-no provision	-MLR for Medicaid managed care organization must not be less than 85%
<i>Preventive Services</i>	-encourages states to offer coverage of preventive services and immunizations	-requires Medicaid coverage of preventive services, effective July 1, 2010
<i>Primary Care Services</i>	-no provision	-increases Medicaid payment rates for primary care services to Medicare levels (80% in 2010, 90% in 2011 and 100% by 2012) -100% federal matching rate for cost of increase through 2014 -90% federal matching rate for 2015 and beyond
<i>Nursing Facilities</i>	-no provision	-directs HHS to make supplemental payments to nursing facilities with high Medicare and Medicaid populations and high quality care -\$6 billion available for supplemental payments from 2010-2013

Public Health & Workforce		
Provision	H.R. 3590 - Patient Protection and Affordable Care Act (Senate bill)	H.R. 3962 - Affordable Health Care for America Act (*passed the House November 7)
<i>Health Care Workforce</i>	-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	-establishes a Public Health Investment Fund (\$34 billion appropriated for FY 2011-2015) -provides increased educational and training programs through scholarships, loan repayment

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Public Health & Workforce		
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	<ul style="list-style-type: none"> -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 -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 -authorizes funding for programs aimed at increasing diversity within the existing health care workforce -provides new and increased support to the existing health care workforce -provides grants to develop and operate training 	<ul style="list-style-type: none"> programs, and other programs to emphasize the need for increased workforce in primary care and dentistry -increases benefits to participants of the National Health Service Corps -seeks to improve training in family medicine, general pediatrics, physical assistantships, dentistry, nursing, public health workforce, and other primary care practitioners -establishes an advisory committee on Health Workforce Evaluation and Assessment -establishes a public health workforce corps to address public health workforce shortages by providing scholarship and loan repayment programs for public health professionals in medically underserved areas -creates new programs that focus on workforce diversity, cultural competency, and innovations in interdisciplinary settings -requires HHS to collect data on the supply, diversity, and geographic distribution of the nation's health workforce

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Public Health & Workforce		
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	<p>programs relating to family medicine, general internal medicine, general pediatrics, and physician assistantships</p> <ul style="list-style-type: none"> -establishes training programs for direct care workers providing 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 -authorizes funding to promote community health centers in medically underserved areas -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 -increases funding for the National Health Corps scholarship program for FY 2010-2015 -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 	
<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	-creates the Center for Quality Improvement to prioritize quality improvements and implement best practices in the delivery of health care -awards grants to implement these priorities

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Public Health & Workforce		
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	<ul style="list-style-type: none"> -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 	<ul style="list-style-type: none"> -establishes the Assistant Secretary for Health Information to provide key information, develop standards for data collection, and to facilitate better data sharing
<i>Focus on Community Health</i>	<ul style="list-style-type: none"> -allows HHS to award grants to community programs that promote healthy lifestyles and decreases the incidence of chronic disease -expands funding for federally qualified health centers -expands on demonstration programs that provide patient navigator services to assist patients overcome barriers to health care services 	<ul style="list-style-type: none"> -authorizes \$12 billion in funding from FY 2011-2015 to increase the number of community health centers (these funds to be appropriated from the \$34 billion Public Health Investment Fund)

Prevention & Wellness		
Provision	H.R. 3590 - Patient Protection and Affordable Care Act (Senate bill)	H.R. 3962 - Affordable Health Care for America Act (*passed the House November 7)
<i>Prevention and Wellness Trust</i>	<ul style="list-style-type: none"> -establishes the Prevention and Public Health Fund to increase investment in prevention and public 	<ul style="list-style-type: none"> -authorizes up to \$15.4 billion from FY 2011-2015 for the Prevention and Wellness Trust Fund (these

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Prevention & Wellness		
Provision	H.R. 3590 - Patient Protection and Affordable Care Act (Senate bill)	H.R. 3962 - Affordable Health Care for America Act (*passed the House November 7)
<i>Fund</i>	health programs to improve health and reduce the growth of health care costs in the public and private sector -invests approximately \$12.9 billion into this fund	funds to be appropriated from the \$34 billion Public Health Investment Fund)
<i>Focus on Prevention</i>	<ul style="list-style-type: none"> -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 innovative approaches, and reduce overall health care disparities -establishes the Preventive Services Task Force to review evidence and effectiveness of clinical preventive services and develops recommendations -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 	<ul style="list-style-type: none"> -creates a national prevention and wellness strategy to improve the nation's health through evidence-based clinical and community-based prevention -establishes the Task Force on Clinical Preventive Services to further identify and improve preventive services -enhances existing Task Force on Community Preventive services -establishes grants for community-based prevention to address national goals and health care disparities

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Prevention & Wellness		
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	<ul style="list-style-type: none"> 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 	<ul style="list-style-type: none"> -focus on community prevention and wellness services -awards grants and increased funding to certain wellness programs -builds on national strategy to support increased wellness research
<i>Employer Wellness Programs</i>	<ul style="list-style-type: none"> -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 	<ul style="list-style-type: none"> -establishes a grant program for small employers to promote healthy behaviors and provide non-discriminatory incentives among their employees -HHS and Department of Labor have discretion over programs, effective July 1, 2010
<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		
Provision	H.R. 3590 - Patient Protection and Affordable Care Act (Senate bill)	H.R. 3962 - Affordable Health Care for America Act (*passed the House November 7)
<i>Generic Biologics (Follow-On Biologics)</i>	-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	-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>340B Program</i>	-expands participation in the program to children's hospitals, free standing cancer hospitals, critical access hospitals, rural referral centers, and sole community hospitals -adopts certain compliance requirements for manufacturers to prevent overcharges and other violations	-extends participation in the program to children's hospitals, critical access hospitals, Medicare-dependent rural hospitals, sole community hospitals, rural referral centers, and entities receiving funds under Title V of the Social Security Act
<i>Congressional Budget Office (CBO) Cost and Coverage Analysis</i>	-\$849 billion cost over 2010-2019 -\$130 billion reduction in federal deficit over 2010-2019 -31 million reduction in the number of uninsured by 2019 (94% insured rate)	-\$1.052 trillion cost over 2010-2019 -\$138 billion reduction in federal deficit over 2010-2019 -36 million reduction in the number of uninsured by 2019 (96% insured rate)

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