

HR 3590

Patient Protection and Affordable Care Act

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Chamber: House

Policy Area: Health

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Sponsor

Name: Rep. Rangel, Charles B. [D-NY-15]

Party: Democratic • **State:** NY • **Chamber:** House

Cosponsors (40 total)

Cosponsor	Party / State	Role	Date Joined
Rep. Becerra, Xavier [D-CA-31]	D · CA		Sep 17, 2009
Rep. Berkley, Shelley [D-NV-1]	D · NV		Sep 17, 2009
Rep. Blumenauer, Earl [D-OR-3]	D · OR		Sep 17, 2009
Rep. Brown-Waite, Ginny [R-FL-5]	R · FL		Sep 17, 2009
Rep. Crowley, Joseph [D-NY-7]	D · NY		Sep 17, 2009
Rep. Davis, Artur [D-AL-7]	D · AL		Sep 17, 2009
Rep. Davis, Danny K. [D-IL-7]	D · IL		Sep 17, 2009
Rep. Doggett, Lloyd [D-TX-25]	D · TX		Sep 17, 2009
Rep. Etheridge, Bob [D-NC-2]	D · NC		Sep 17, 2009
Rep. Higgins, Brian [D-NY-27]	D · NY		Sep 17, 2009
Rep. Jones, Walter B., Jr. [R-NC-3]	R · NC		Sep 17, 2009
Rep. Kagen, Steve [D-WI-8]	D · WI		Sep 17, 2009
Rep. Kind, Ron [D-WI-3]	D · WI		Sep 17, 2009
Rep. Larson, John B. [D-CT-1]	D · CT		Sep 17, 2009
Rep. Levin, Sander M. [D-MI-12]	D · MI		Sep 17, 2009
Rep. Lewis, John [D-GA-5]	D · GA		Sep 17, 2009
Rep. McDermott, Jim [D-WA-7]	D · WA		Sep 17, 2009
Rep. Meek, Kendrick B. [D-FL-17]	D · FL		Sep 17, 2009
Rep. Neal, Richard E. [D-MA-2]	D · MA		Sep 17, 2009
Rep. Pascrell, Bill, Jr. [D-NJ-8]	D · NJ		Sep 17, 2009
Rep. Pomeroy, Earl [D-ND-At Large]	D · ND		Sep 17, 2009
Rep. Sánchez, Linda T. [D-CA-39]	D · CA		Sep 17, 2009
Rep. Schwartz, Allyson Y. [D-PA-13]	D · PA		Sep 17, 2009
Rep. Skelton, Ike [D-MO-4]	D · MO		Sep 17, 2009
Rep. Stark, Fortney Pete [D-CA-13]	D · CA		Sep 17, 2009
Rep. Tanner, John S. [D-TN-8]	D · TN		Sep 17, 2009
Rep. Thompson, Mike [D-CA-1]	D · CA		Sep 17, 2009
Rep. Van Hollen, Chris [D-MD-8]	D · MD		Sep 17, 2009
Rep. Yarmuth, John A. [D-KY-3]	D · KY		Sep 17, 2009
Rep. Courtney, Joe [D-CT-2]	D · CT		Oct 6, 2009
Rep. Filner, Bob [D-CA-51]	D · CA		Oct 6, 2009
Rep. Green, Al [D-TX-9]	D · TX		Oct 6, 2009
Rep. Gutierrez, Luis V. [D-IL-4]	D · IL		Oct 6, 2009
Rep. Johnson, Henry C. "Hank," Jr. [D-GA-4]	D · GA		Oct 6, 2009
Rep. McGovern, James P. [D-MA-3]	D · MA		Oct 6, 2009
Rep. Moore, Dennis [D-KS-3]	D · KS		Oct 6, 2009
Rep. Peters, Gary C. [D-MI-9]	D · MI		Oct 6, 2009
Rep. Platts, Todd Russell [R-PA-19]	R · PA		Oct 6, 2009
Rep. Titus, Dina [D-NV-3]	D · NV		Oct 6, 2009
Rep. Minnick, Walter [D-ID-1]	D · ID		Oct 7, 2009

Committee Activity

Committee	Chamber	Activity	Date
Ways and Means Committee	House	Referred To	Sep 17, 2009

Subjects & Policy Tags

Policy Area:

Health

Related Bills

Bill	Relationship	Last Action
111 HR 4872	Related bill	Mar 30, 2010: Became Public Law No: 111-152.
111 HRES 1203	Related bill	Mar 21, 2010: Motion to reconsider laid on the table Agreed to without objection.
111 HCONRES 254	Related bill	Mar 19, 2010: Referred to House Administration
111 S 2964	Related bill	Jan 28, 2010: Read twice and referred to the Committee on Finance.
111 S 1790	Related bill	Dec 16, 2009: Placed on Senate Legislative Calendar under General Orders. Calendar No. 233.
111 HR 4204	Related bill	Dec 7, 2009: Referred to the Subcommittee on Health.
111 HR 3688	Related bill	Nov 16, 2009: Referred to the Subcommittee on Health, Employment, Labor, and Pensions.
111 S 1959	Related bill	Oct 28, 2009: Read twice and referred to the Committee on the Judiciary.
111 S 1857	Related bill	Oct 22, 2009: Read twice and referred to the Committee on Health, Education, Labor, and Pensions.
111 HR 3780	Related bill	Oct 8, 2009: Referred to the House Committee on Ways and Means.
111 S 1728	Related bill	Sep 30, 2009: Read twice and referred to the Committee on Finance.
111 S 1423	Related bill	Jul 9, 2009: Read twice and referred to the Committee on Finance.
111 S 1239	Related bill	Jun 11, 2009: Read twice and referred to the Committee on Health, Education, Labor, and Pensions. (text of measure as introduced: CR S6546-6548)
111 HR 2358	Related bill	May 13, 2009: Referred to the Subcommittee on Health.
111 HR 362	Related bill	Jan 14, 2009: Referred to the Subcommittee on Health.

(This measure has not been amended since it was passed by the Senate on December 24, 2009. The summary of that version is repeated here.)

Patient Protection and Affordable Care Act - **Title I: Quality, Affordable Health Care for All Americans - Subtitle A: Immediate Improvements in Health Care Coverage for All Americans** - (Sec. 1001, as modified by Sec. 10101) Amends the Public Health Service Act to prohibit a health plan ("health plan" under this subtitle) from establishing lifetime limits or annual limits on the dollar value of benefits for any participant or beneficiary after January 1, 2014. Permits a restricted annual limit for plan years beginning prior to January 1, 2014. Declares that a health plan shall not be prevented from placing annual or lifetime per-beneficiary limits on covered benefits that are not essential health benefits to the extent that such limits are otherwise permitted.

Prohibits a health plan from rescinding coverage of an enrollee except in the case of fraud or intentional misrepresentation of material fact.

Requires health plans to provide coverage for, and to not impose any cost sharing requirements for: (1) specified preventive items or services; (2) recommended immunizations; and (3) recommended preventive care and screenings for women and children.

Requires a health plan that provides dependent coverage of children to make such coverage available for an unmarried, adult child until the child turns 26 years of age.

Requires the Secretary of Health and Human Services (HHS) to develop standards for health plans (including grandfathered health plans) to provide an accurate summary of benefits and coverage explanation. Directs each such health plan, prior to any enrollment restriction, to provide such a summary of benefits and coverage explanation to: (1) the applicant at the time of application; (2) an enrollee prior to the time of enrollment or re-enrollment; and (3) a policy or certificate holder at the time of issuance of the policy or delivery of the certificate.

Requires group health plans to comply with requirements relating to the prohibition against discrimination in favor of highly compensated individuals.

Requires the Secretary to develop reporting requirements for health plans on benefits or reimbursement structures that: (1) improve health outcomes; (2) prevent hospital readmissions; (3) improve patient safety and reduce medical errors; and (4) promote wellness and health.

Prohibits: (1) a wellness and health promotion activity implemented by a health plan or any data collection activity authorized under this Act from requiring the disclosure or collection of any information relating to the lawful use, possession, or storage of a firearm or ammunition by an individual; (2) any authority provided to the Secretary under this Act from being construed to authorize the collection of such information or the maintenance of records of individual ownership or possession of a firearm or ammunition; or (3) any health insurance premium increase, denial of coverage, or reduction of any reward for participation in a wellness program on the basis of the lawful use, possession, or storage of a firearm or ammunition.

Requires a health plan (including a grandfathered health plan) to: (1) submit to the Secretary a report concerning the ratio of the incurred loss (or incurred claims) plus the loss adjustment expense (or change in contract reserves) to earned

premiums; and (2) provide an annual rebate to each enrollee if the ratio of the amount of premium revenue expended by the issuer on reimbursement for clinical services provided to enrollees and activities that improve health care quality to the total amount of premium revenue for the plan year is less than a 85% for large group markets or 80% for small group or individual markets.

Requires each U.S. hospital to establish and make public a list of its standard charges for items and services.

Requires a health plan to implement an effective process for appeals of coverage determinations and claims.

Sets forth requirements for health plans related to: (1) designation of a primary care provider; (2) coverage of emergency services; and (3) elimination of referral requirements for obstetrical or gynecological care.

(Sec. 1002) Requires the Secretary to award grants to states for offices of health insurance consumer assistance or health insurance ombudsman programs.

(Sec. 1003, as modified by Sec. 10101) Requires the Secretary to establish a process for the annual review of unreasonable increases in premiums for health insurance coverage.

(Sec. 1004) Makes this subtitle effective for plan years beginning six months after enactment of this Act, with certain exceptions.

Subtitle B: Immediate Actions to Preserve and Expand Coverage - (Sec. 1101) Requires the Secretary to establish a temporary high risk health insurance pool program to provide health insurance coverage to eligible individuals with a preexisting condition. Terminates such coverage on January 1, 2014, and provides for a transition to an American Health Benefit Exchange (Exchange).

(Sec. 1102, as modified by Sec. 10102) Requires the Secretary to establish a temporary reinsurance program to provide reimbursement to participating employment-based plans for a portion of the cost of providing health insurance coverage to early retirees before January 1, 2014.

(Sec. 1103, as modified by Sec. 10102) Requires the Secretary to establish a mechanism, including an Internet website, through which a resident of, or small business in, any state may identify affordable health insurance coverage options in that state.

(Sec. 1104) Sets forth provisions governing electronic health care transactions. Establishes penalties for health plans failing to comply with requirements.

(Sec. 1105) Makes this subtitle effective on the date of enactment of this Act.

Subtitle C: Quality Health Insurance Coverage for All Americans - Part I: Health Insurance Market Reforms -

(Sec. 1201, as modified by Sec. 10103) Prohibits a health plan ("health plan" under this subtitle) from excluding any "grandfathered health plan" as defined in section 1251) from: (1) imposing any preexisting condition exclusion; or (2) discriminating on the basis of any health status-related factor. Allows premium rates to vary only by individual or family coverage, rating area, age, or tobacco use.

Requires health plans in a state to: (1) accept every employer and individual in the state that applies for coverage; and (2) renew or continue coverage at the option of the plan sponsor or the individual, as applicable.

Prohibits a health plan from establishing individual eligibility rules based on health status-related factors, including

medical condition, claims experience, receipt of health care, medical history, genetic information, and evidence of insurability.

Sets forth provisions governing wellness programs under the health plan, including allowing cost variances for coverage for participation in such a program.

Prohibits a health plan from discriminating with respect to participation under the plan or coverage against any health care provider who is acting within the scope of that provider's license or certification under applicable state law.

Requires health plans that offer health insurance coverage in the individual or small group market to ensure that such coverage includes the essential health benefits package. Requires a group health plan to ensure that any annual cost-sharing imposed under the plan does not exceed specified limitations.

Prohibits a health plan from: (1) applying any waiting period for coverage that exceeds 90 days; or (2) discriminating against individual participation in clinical trials with respect to treatment of cancer or any other life-threatening disease or condition.

Part II: Other Provisions - (Sec. 1251, as modified by Sec. 10103) Provides that nothing in this Act shall be construed to require that an individual terminate coverage under a group health plan or health insurance coverage in which such individual was enrolled on the date of enactment of this Act. Allows family members of individuals currently enrolled in a plan to enroll in such plan or coverage if such enrollment was permitted under the terms of the plan. Allows new employees and their families to enroll in a group health plan that provides coverage on the date of enactment of this Act.

Defines a "grandfathered health plan" as a group health plan or health insurance coverage in which an individual was enrolled on the date of enactment of this Act.

States that this subtitle and subtitle A shall not apply to: (1) a group health plan or health insurance coverage in which an individual was enrolled on the date of enactment of this Act, regardless of whether the individual renews such coverage after such date of enactment; (2) an existing group health plan that enrolls new employees under this section; and (3) health insurance coverage maintained pursuant to one or more collective bargaining agreements between employee representatives and one or more employers that was ratified before the date of enactment of this Act until the date on which the last of the collective bargaining agreements relating to the coverage terminates.

Applies provisions related to uniform coverage documents and medical loss ratios to grandfathered health plans for plan years beginning after enactment of this Act.

(Sec. 1252) Requires uniform application of standards or requirements adopted by states to all health plans in each applicable insurance market.

(Sec. 1253, as added by Sec. 10103) Directs the Secretary of Labor to prepare an annual report on self-insured group health plans and self-insured employers.

(Sec. 1254, as added by Sec. 10103) Requires the HHS Secretary to conduct a study of the fully-insured and self-insured group health plan markets related to financial solvency and the effect of insurance market reforms.

(Sec. 1255, as modified by Sec. 10103) Sets forth effective dates for specified provisions of this subtitle.

Subtitle D: Available Coverage Choices for All Americans - Part I: Establishment of Qualified Health Plans - (Sec.

1301, as modified by Sec. 10104) Defines "qualified health plan" to require that such a plan provides essential health benefits and offers at least one plan in the silver level at one plan in the gold level in each Exchange through which such plan is offered.

(Sec. 1302, as modified by Sec. 10104) Requires the essential health benefits package to provide essential health benefits and limit cost-sharing. Directs the Secretary to: (1) define essential health benefits and include emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, prescription drugs, preventive and wellness services and chronic disease management, and pediatric services, including oral and vision care; (2) ensure that the scope of the essential health benefits is equal to the scope of benefits provided under a typical employer plan; and (3) provide notice and an opportunity for public comment in defining the essential health benefits. Establishes: (1) an annual limit on cost-sharing beginning in 2014; and (2) a limitation on the deductible under a small group market health plan.

Sets forth levels of coverage for health plans defined by a certain percentage of the costs paid by the plan. Allows health plans in the individual market to offer catastrophic coverage for individuals under age 30, with certain limitations.

(Sec. 1303, as modified by Sec. 10104) Sets forth special rules for abortion coverage, including: (1) permitting states to elect to prohibit abortion coverage in qualified health plans offered through an Exchange in the state; (2) prohibiting federal funds from being used for abortion services; and (3) requiring separate accounts for payments for such services. Prohibits any qualified health plan offered through an Exchange from discriminating against any individual health care provider or health care facility because of its unwillingness to provide, pay for, provide coverage of, or refer for abortions.

(Sec. 1304, as modified by Sec. 10104) Sets forth definitions for terms used in this title.

Part II: Consumer Choices and Insurance Competition Through Health Benefit Exchanges - (Sec. 1311, as modified by Sec. 10104) Requires states to establish an American Health Benefit Exchange that: (1) facilitates the purchase of qualified health plans; and (2) provides for the establishment of a Small Business Health Options Program (SHOP Exchange) that is designed to assist qualified small employers in facilitating the enrollment of their employees in qualified health plans offered in the small group market in the state.

Requires the Secretary to establish criteria for the certification of health plans as qualified health plans, including requirements for: (1) meeting market requirements; and (2) ensuring a sufficient choice of providers.

Sets forth the requirements for an Exchange, including that an Exchange: (1) must be a governmental agency or nonprofit entity that is established by a state; (2) may not make available any health plan that is not a qualified health plan; (3) must implement procedures for certification of health plans as qualified health plans; and (4) must require health plans seeking certification to submit a justification of any premium increase prior to implementation of such increase.

Permits states to require qualified health plans to offer additional benefits. Requires states to pay for the cost of such additional benefits.

Allows a state to establish one or more subsidiary Exchanges for geographically distinct areas of a certain size.

Applies mental health parity provisions to qualified health plans.

(Sec. 1312, as modified by Sec. 10104) Allows an employer to select a level of coverage to be made available to employees through an Exchange. Allows employees to choose to enroll in any qualified health plan that offers that level of coverage.

Restricts the health plans that the federal government may make available to Members of Congress and congressional staff after the effective date of this subtitle to only those health plans that are created under this Act or offered through an Exchange.

Permits states to allow large employers to join an Exchange after 2017.

(Sec. 1313, as modified by Sec. 10104) Requires an Exchange to keep an accurate accounting of all activities, receipts, and expenditures and to submit to the Secretary, annually, a report concerning such accountings. Requires the Secretary to take certain action to reduce fraud and abuse in the administration of this title. Requires the Comptroller General to conduct an ongoing study of Exchange activities and the enrollees in qualified health plans offered through Exchanges.

Part III: State Flexibility Relating to Exchanges - (Sec. 1321) Requires the Secretary to issue regulations setting standards related to: (1) the establishment and operation of Exchanges; (2) the offering of qualified health plans through Exchanges; and (3) the establishment of the reinsurance and risk adjustment programs under part V.

Requires the Secretary to: (1) establish and operate an Exchange within a state if the state does not have one operational by January 1, 2014; and (2) presume that an Exchange operating in a state before January 1, 2010, that insures a specified percentage of its population meets the standards under this section.

(Sec. 1322, as modified by Sec. 10104) Requires the Secretary to establish the Consumer Operated and Oriented Plan (CO-OP) program to foster the creation of qualified nonprofit health insurance issuers to offer qualified health plans in the individual and small group markets. Requires the Secretary to provide for loans and grants to persons applying to become qualified nonprofit health insurance issuers. Sets forth provisions governing the establishment and operation of CO-OP program plans.

(Sec. 1323, deleted by Sec. 10104)

(Sec. 1324, as modified by Sec. 10104) Declares that health insurance coverage offered by a private health insurance issuer shall not be subject to federal or state laws if a qualified health plan offered under the CO-OP program is not subject to such law.

Part IV: State Flexibility to Establish Alternative Programs - (Sec. 1331, as modified by Sec. 10104) Requires the Secretary to establish a basic health program under which a state may enter into contracts to offer one or more standard health plans providing at least the essential health benefits to eligible individuals in lieu of offering such individuals coverage through an Exchange. Sets forth requirements for such a plan. Transfers funds that would have gone to the Exchange for such individuals to the state.

(Sec. 1332) Authorizes a state to apply to the Secretary for the waiver of specified requirements under this Act with respect to health insurance coverage within that state for plan years beginning on or after January 1, 2017. Directs the Secretary to provide for an alternative means by which the aggregate amounts of credits or reductions that would have been paid on behalf of participants in the Exchange will be paid to the state for purposes of implementing the state plan.

(Sec. 1333, as modified by Sec. 10104) Requires the Secretary to issue regulations for the creation of health care choice compacts under which two or more states may enter into an agreement that: (1) qualified health plans could be offered in the individual markets in all such states only subject to the laws and regulations of the state in which the plan was written or issued; and (2) the issuer of any qualified health plan to which the compact applies would continue to be subject to certain laws of the state in which the purchaser resides, would be required to be licensed in each state, and must clearly

notify consumers that the policy may not be subject to all the laws and regulations of the state in which the purchaser resides. Sets forth provisions regarding the Secretary's approval of such compacts.

(Sec. 1334, as added by Sec. 10104) Requires the Director of the Office of Personnel Management (OPM) to: (1) enter into contracts with health insurance issuers to offer at least two multistate qualified health plans through each Exchange in each state to provide individual or group coverage; and (2) implement this subsection in a manner similar to the manner in which the Director implements the Federal Employees Health Benefits Program. Sets forth requirements for a multistate qualified health plan.

Part V: Reinsurance and Risk Adjustment - (Sec. 1341, as modified by Sec. 10104) Directs each state, not later than January 1, 2014, to establish one or more reinsurance entities to carry out the reinsurance program under this section. Requires the Secretary to establish standards to enable states to establish and maintain a reinsurance program under which: (1) health insurance issuers and third party administrators on behalf of group health plans are required to make payments to an applicable reinsurance entity for specified plan years; and (2) the applicable reinsurance entity uses amounts collected to make reinsurance payments to health insurance issuers that cover high risk individuals in the individual market. Directs the state to eliminate or modify any state high-risk pool to the extent necessary to carry out the reinsurance program established under this section.

(Sec. 1342) Requires the Secretary to establish and administer a program of risk corridors for calendar years 2014 through 2016 under which a qualified health plan offered in the individual or small group market shall participate in a payment adjusted system based on the ratio of the allowable costs of the plan to the plan's aggregate premiums. Directs the Secretary to make payments when a plan's allowable costs exceed the target amount by a certain percentage and directs a plan to make payments to the Secretary when its allowable costs are less than target amount by a certain percentage.

(Sec. 1343) Requires each state to assess a charge on health plans and health insurance issuers if the actuarial risk of the enrollees of such plans or coverage for a year is less than the average actuarial risk of all enrollees in all plans or coverage in the state for the year. Requires each state to provide a payment to health plans and health insurance issuers if the actuarial risk of the enrollees of such plan or coverage for a year is greater than the average actuarial risk of all enrollees in all plans and coverage in the state for the year. Excludes self-insured group health plans from this section.

Subtitle E: Affordable Coverage Choices for All Americans - Part I: Premium Tax Credits and Cost-sharing Reductions - Subpart A: Premium Tax Credits and Cost-sharing Reductions - (Sec. 1401, as modified by section 10105) Amends the Internal Revenue Code to allow individual taxpayers whose household income equals or exceeds 100%, but does not exceed 400%, of the federal poverty line (as determined in the Social Security Act [SSA]) a refundable tax credit for a percentage of the cost of premiums for coverage under a qualified health plan. Sets forth formulae and rules for the calculation of credit amounts based upon taxpayer household income as a percentage of the poverty line.

Directs the Comptroller General, not later than five years after enactment of this Act, to conduct a study and report to specified congressional committees on the affordability of health insurance coverage.

(Sec. 1402) Requires reductions in the maximum limits for out-of-pocket expenses for individuals enrolled in qualified health plans whose incomes are between 100% and 400% of the poverty line.

Subpart B: Eligibility Determinations - (Sec. 1411) - Requires the Secretary to establish a program for verifying the eligibility of applicants for participation in a qualified health plan offered through an Exchange or for a tax credit for

premium assistance based upon their income or their citizenship or immigration status. Requires an Exchange to submit information received from an applicant to the Secretary for verification of applicant eligibility. Provides for confidentiality of applicant information and for an appeals and redetermination process for denials of eligibility. Imposes civil penalties on applicants for providing false or fraudulent information relating to eligibility.

Requires the Secretary to study and report to Congress by January 1, 2013, on procedures necessary to ensure the protection of privacy and due process rights in making eligibility and other determinations under this Act.

(Sec. 1412) Requires the Secretary to establish a program for advance payments of the tax credit for premium assistance and for reductions of cost-sharing. Prohibits any federal payments, tax credit, or cost-sharing reductions for individuals who are not lawfully present in the United States.

(Sec. 1413) Requires the Secretary to establish a system to enroll state residents who apply to an Exchange in state health subsidy programs, including Medicaid or the Children's Health Insurance Program (CHIP, formerly known as SCHIP), if such residents are found to be eligible for such programs after screening.

(Sec. 1414) Requires the Secretary of the Treasury to disclose to HHS personnel certain taxpayer information to determine eligibility for programs under this Act or certain other social security programs.

(Sec. 1415) Disregards the premium assistance tax credit and cost-sharing reductions in determining eligibility for federal and federally-assisted programs.

(Sec. 1416, as added by section 10105) Directs the HHS Secretary to study and report to Congress by January 1, 2013, on the feasibility and implication of adjusting the application of the federal poverty level under this subtitle for different geographic areas in the United States, including its territories.

Part II: Small Business Tax Credit - (Sec. 1421, as modified by section 10105) Allows qualified small employers to elect, beginning in 2010, a tax credit for 50% of their employee health care coverage expenses. Defines "qualified small employer" as an employer who has no more than 25 employees with average annual compensation levels not exceeding \$50,000. Requires a phase-out of such credit based on employer size and employee compensation.

Subtitle F: Shared Responsibility for Health Care - Part I: Individual Responsibility - (Sec. 1501, as modified by section 10106) Requires individuals to maintain minimal essential health care coverage beginning in 2014. Imposes a penalty for failure to maintain such coverage beginning in 2014, except for certain low-income individuals who cannot afford coverage, members of Indian tribes, and individuals who suffer hardship. Exempts from the coverage requirement individuals who object to health care coverage on religious grounds, individuals not lawfully present in the United States, and individuals who are incarcerated.

(Sec. 1502) Requires providers of minimum essential coverage to file informational returns providing identifying information of covered individuals and the dates of coverage. Requires the IRS to send a notice to taxpayers who are not enrolled in minimum essential coverage about services available through the Exchange operating in their state.

Part II: Employer Responsibilities - (Sec. 1511) Amends the Fair Labor Standards Act of 1938 to: (1) require employers with more than 200 full-time employees to automatically enroll new employees in a health care plan and provide notice of the opportunity to opt-out of such coverage; and (2) provide notice to employees about an Exchange, the availability of a tax credit for premium assistance, and the loss of an employer's contribution to an employer-provided health benefit plan if the employee purchases a plan through an Exchange.

(Sec. 1513, as modified by section 10106) Imposes fines on large employers (employers with more than 50 full-time employees) who fail to offer their full-time employees the opportunity to enroll in minimum essential coverage or who have a waiting period for enrollment of more than 60 days.

Requires the Secretary of Labor to study and report to Congress on whether employees' wages are reduced due to fines imposed on employers.

(Sec. 1514, as modified by section 10106) Requires large employers to file a report with the Secretary of the Treasury on health insurance coverage provided to their full-time employees. Requires such reports to contain: (1) a certification as to whether such employers provide their full-time employees (and their dependents) the opportunity to enroll in minimum essential coverage under an eligible employer-sponsored plan; (2) the length of any waiting period for such coverage; (3) the months during which such coverage was available; (4) the monthly premium for the lowest cost option in each of the enrollment categories under the plan; (5) the employer's share of the total allowed costs of benefits provided under the plan; and (6) identifying information about the employer and full-time employees. Imposes a penalty on employers who fail to provide such report. Authorizes the Secretary of the Treasury to review the accuracy of information provided by large employers.

(Sec. 1515) Allows certain small employers to include as a benefit in a tax-exempt cafeteria plan a qualified health plan offered through an Exchange.

Subtitle G: Miscellaneous Provisions - (Sec. 1551) Applies the definitions under the Public Health Service Act related to health insurance coverage to this title.

(Sec. 1552) Requires the HHS Secretary to publish on the HHS website a list of all of the authorities provided to the Secretary under this Act.

(Sec. 1553) Prohibits the federal government, any state or local government or health care provider that receives federal financial assistance under this Act, or any health plan created under this Act from discriminating against an individual or institutional health care entity on the basis that such individual or entity does not provide a health care item or service furnished for the purpose of causing, or assisting in causing, the death of any individual, such as by assisted suicide, euthanasia, or mercy killing.

(Sec. 1554) Prohibits the Secretary from promulgating any regulation that: (1) creates an unreasonable barrier to the ability of individuals to obtain appropriate medical care; (2) impedes timely access to health care services; (3) interferes with communications regarding a full range of treatment options between the patient and the health care provider; (4) restricts the ability of health care providers to provide full disclosure of all relevant information to patients making health care decisions; (5) violates the principle of informed consent and the ethical standards of health care professionals; or (6) limits the availability of health care treatment for the full duration of a patient's medical needs.

(Sec. 1555) Declares that no individual, company, business, nonprofit entity, or health insurance issuer offering group or individual health insurance coverage shall be required to participate in any federal health insurance program created by or expanded under this Act. Prohibits any penalty from being imposed upon any such issuer for choosing not to participate in any such program.

(Sec. 1556) Amends the Black Lung Benefits Act, with respect to claims filed on or after the effective date of the Black Lung Benefits Amendments of 1981, to eliminate exceptions to: (1) the applicability of certain provisions regarding rebuttable presumptions; and (2) the prohibition against requiring eligible survivors of a miner determined to be eligible for

black lung benefits to file a new claim or to refile or otherwise revalidate the miner's claim.

(Sec. 1557) Prohibits discrimination by any federal health program or activity on the grounds of race, color, national origin, sex, age, or disability.

(Sec. 1558) Amends the Fair Labor Standards Act of 1938 to prohibit an employer from discharging or discriminating against any employee because the employee: (1) has received a health insurance credit or subsidy; (2) provides information relating to any violation of any provision of such Act; or (3) objects to, or refuses to participate in, any activity, policy, practice, or assigned task that the employee reasonably believed to be in violation of such Act.

(Sec. 1559) Gives the HHS Inspector General oversight authority with respect to the administration and implementation of this title.

(Sec. 1560) Declares that nothing in this title shall be construed to modify, impair, or supersede the operation of any antitrust laws.

(Sec. 1561) Amends the Public Health Service Act to require the Secretary to: (1) develop interoperable and secure standards and protocols that facilitate enrollment of individuals in federal and state health and human services programs; and (2) award grants to develop and adapt technology systems to implement such standards and protocols.

(Sec. 1562, as added by Sec. 10107) Directs the Comptroller General to study denials by health plans of coverage for medical services and of applications to enroll in health insurance.

(Sec. 1563, as added by Sec. 10107) Disallows the waiver of laws or regulations establishing procurement requirements relating to small business concerns with respect to any contract awarded under any program or other authority under this Act.

(Sec. 1563 [sic], as modified by Sec. 10107) Makes technical and conforming amendments.

(Sec. 1563 [sic]) Expresses the sense of the Senate that: (1) the additional surplus in the Social Security trust fund generated by this Act should be reserved for Social Security; and (2) the net savings generated by the CLASS program (established under Title VIII of this Act) should be reserved for such program.

Title II: Role of Public Programs - Subtitle A: Improved Access to Medicaid - (Sec. 2001, as modified by Sec. 10201) Amends title XIX (Medicaid) of the SSA to extend Medicaid coverage, beginning in calendar 2014, to individuals under age 65 who are not entitled to or enrolled in Medicare and have incomes at or below 133% of the federal poverty line. Grants a state the option to expand Medicaid eligibility to such individuals as early as April 1, 2010. Provides that, for between 2014 and 2016, the federal government will pay 100% of the cost of covering newly-eligible individuals.

Increases the federal medical assistance percentage (FMAP): (1) with respect to newly eligible individuals; and (2) between January 1, 2014, and December 31, 2016, for states meeting certain eligibility requirements.

Requires Medicaid benchmark benefits to include coverage of prescription drugs and mental health services.

Grants states the option to extend Medicaid coverage to individuals who have incomes that exceed 133% of the federal poverty line beginning January 1, 2014.

(Sec. 2002) Requires a state to use an individual's or household's modified gross income to determine income eligibility for Medicaid for non-elderly individuals, without applying any income or expense disregards or assets or resources test.

Exempts from this requirement: (1) individuals eligible for Medicaid through another program; (2) the elderly or Social Security Disability Insurance (SSDI) program beneficiaries; (3) the medically needy; (4) enrollees in a Medicare Savings Program; and (5) the disabled.

(Sec. 2003) Revises state authority to offer a premium assistance subsidy for qualified employer-sponsored coverage to children under age 19 to extend such a subsidy to all individuals, regardless of age.

Prohibits a state from requiring, as a condition of Medicaid eligibility, that an individual (or the individual's parent) apply for enrollment in qualified employer-sponsored coverage.

(Sec. 2004, as modified by Sec. 10201) Extends Medicaid coverage to former foster care children who are under 26 years of age.

(Sec. 2005, as modified by Sec. 10201) Revises requirements for Medicaid payments to territories, including an increase in the limits on payments for FY2011 and thereafter.

(Sec. 2006, as modified by Sec. 10201) Prescribes an adjustment to the FMAP determination for certain states recovering from a major disaster.

(Sec. 2007) Rescinds any unobligated amounts available to the Medicaid Improvement Fund for FY2014-FY2018.

Subtitle B: Enhanced Support for the Children's Health Insurance Program - (Sec. 2101, as modified by Sec. 10201) Amends SSA title XXI (State Children's Health Insurance Program) (CHIP, formerly known as SCHIP) to increase the FY2016-FY2019 enhanced FMAP for states, subject to a 100% cap.

Prohibits states from applying, before the end of FY2019, CHIP eligibility standards that are more restrictive than those under this Act.

Deems ineligible for CHIP any targeted low-income children who cannot enroll in CHIP because allotments are capped, but who are therefore eligible for tax credits in the Exchanges.

Requires the Secretary to: (1) review benefits offered for children, and related cost-sharing imposed, by qualified health plans offered through an Exchange; and (2) certify those plans whose benefits and cost-sharing are at least comparable to those provided under the particular state's CHIP plan.

Prohibits enrollment bonus payments for children enrolled in CHIP after FY2013.

Requires a state CHIP plan, beginning January 1, 2014, to use modified gross income and household income to determine CHIP eligibility.

Requires a state to treat as a targeted low-income child eligible for CHIP any child determined ineligible for Medicaid as a result of the elimination of an income disregard based on expense or type of income.

(Sec. 2102) Makes technical corrections to the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA).

Subtitle C: Medicaid and CHIP Enrollment Simplification - (Sec. 2201) Amends SSA title XIX (Medicaid) to require enrollment application simplification and coordination with state health insurance Exchanges and CHIP via state-run websites.

(Sec. 2202) Permits hospitals to provide Medicaid services during a period of presumptive eligibility to members of all Medicaid eligibility categories.

Subtitle D: Improvements to Medicaid Services - (Sec. 2301) Requires Medicaid coverage of: (1) freestanding birth center services; and (2) concurrent care for children receiving hospice care.

(Sec. 2303) Gives states the option of extending Medicaid coverage to family planning services and supplies under a presumptive eligibility period for a categorically needy group of individuals.

Subtitle E: New Options for States to Provide Long-Term Services and Supports - (Sec. 2401) Authorizes states to offer home and community-based attendant services and supports to Medicaid beneficiaries with disabilities who would otherwise require care in a hospital, nursing facility, intermediate care facility for the mentally retarded, or an institution for mental diseases.

(Sec. 2402) Gives states the option of: (1) providing home and community-based services to individuals eligible for services under a waiver; and (2) offering home and community-based services to specific, targeted populations

Creates an optional eligibility category to provide full Medicaid benefits to individuals receiving home and community-based services under a state plan amendment.

(Sec. 2403) Amends the Deficit Reduction Act of 2005 to: (1) extend through FY2016 the Money Follows the Person Rebalancing Demonstration; and (2) reduce to 90 days the institutional residency period.

(Sec. 2404) Applies Medicaid eligibility criteria to recipients of home and community-based services, during calendar 2014 through 2019, in such a way as to protect against spousal impoverishment.

(Sec. 2405) Makes appropriations for FY2010-FY2014 to the Secretary, acting through the Assistant Secretary for Aging, to expand state aging and disability resource centers.

(Sec. 2406) Expresses the sense of the Senate that: (1) during the 111th session of Congress, Congress should address long-term services and supports in a comprehensive way that guarantees elderly and disabled individuals the care they need; and (2) long-term services and supports should be made available in the community in addition to institutions.

Subtitle F: Medicaid Prescription Drug Coverage - (Sec. 2501) Amends SSA title XIX (Medicaid) to: (1) increase the minimum rebate percentage for single source drugs and innovator multiple source drugs; (2) increase the rebate for other drugs; (3) require contracts with Medicaid managed care organizations to extend prescription drug rebates (discounts) to their enrollees; (4) provide an additional rebate for new formulations of existing drugs; and (5) set a maximum rebate amount.

(Sec. 2502) Eliminates the exclusion from Medicaid coverage of, thereby extending coverage to, certain drugs used to promote smoking cessation, as well as barbiturates and benzodiazepines.

(Sec. 2503) Revises requirements with respect to pharmacy reimbursements.

Subtitle G: Medicaid Disproportionate Share Hospital (DSH) Payments - (Sec. 2551, as modified by Sec. 10201) Reduces state disproportionate share hospital (DSH) allotments, except for Hawaii, by 50% or 35% once a state's uninsured rate decreases by 45%, depending on whether they have spent at least or more than 99.9% of their allotments on average during FY2004-FY2008. Requires a reduction of only 25% or 17.5% for low DSH states, depending on

whether they have spent at least or more than 99.9% of their allotments on average during FY2004-FY2008. Prescribes allotment reduction requirements for subsequent fiscal years.

Revises DSH allotments for Hawaii for the last three quarters of FY2012 and for FY2013 and succeeding fiscal years.

Subtitle H: Improved Coordination for Dual Eligible Beneficiaries - (Sec. 2601) Declares that any Medicaid waiver for individuals dually eligible for both Medicaid and Medicare may be conducted for a period of five years, with a five-year extension, upon state request, unless the Secretary determines otherwise for specified reasons.

(Sec. 2602) Directs the Secretary to establish a Federal Coordinated Health Care Office to bring together officers and employees of the Medicare and Medicaid programs at the Centers for Medicare and Medicaid Services (CMS) to: (1) integrate Medicaid and Medicare benefits more effectively; and (2) improve the coordination between the federal government and states for dual eligible individuals to ensure that they get full access to the items and services to which they are entitled.

Subtitle I: Improving the Quality of Medicaid for Patients and Providers - (Sec. 2701) Amends SSA title XI, as modified by CHIPRA, to direct the Secretary to: (1) identify and publish a recommended core set of adult health quality measures for Medicaid eligible adults; and (2) establish a Medicaid Quality Measurement Program.

(Sec. 2702) Requires the Secretary to identify current state practices that prohibit payment for health care-acquired conditions and to incorporate them, or elements of them, which are appropriate for application in regulations to the Medicaid program. Requires such regulations to prohibit payments to states for any amounts expended for providing medical assistance for specified health care-acquired conditions.

(Sec. 2703) Gives states the option to provide coordinated care through a health home for individuals with chronic conditions. Authorizes the Secretary to award planning grants to states to develop a state plan amendment to that effect.

(Sec. 2704) Directs the Secretary to establish a demonstration project to evaluate the use of bundled payments for the provision of integrated care for a Medicaid beneficiary: (1) with respect to an episode of care that includes a hospitalization; and (2) for concurrent physician services provided during a hospitalization.

(Sec. 2705) Requires the Secretary to establish a Medicaid Global Payment System Demonstration Project under which a participating state shall adjust payments made to an eligible safety net hospital or network from a fee-for-service payment structure to a global capitated payment model. Authorizes appropriations.

(Sec. 2706) Directs the Secretary to establish the Pediatric Accountable Care Organization Demonstration Project to authorize a participating state to allow pediatric medical providers meeting specified requirements to be recognized as an accountable care organization for the purpose of receiving specified incentive payments. Authorizes appropriations.

(Sec. 2707) Requires the Secretary to establish a three-year Medicaid emergency psychiatric demonstration project. Makes appropriations for FY2011.

Subtitle J: Improvements to the Medicaid and CHIP Payment and Access Commission (MACPAC) - (Sec. 2801) Revises requirements with respect to the Medicaid and CHIP Payment and Access Commission (MACPAC) and the Medicare Payment Advisory Commission (MEDPAC), including those for MACPAC membership, topics to be reviewed, and MEDPAC review of Medicaid trends in spending, utilization, and financial performance.

Requires MACPAC and MEDPAC to consult with one another on related issues.

Makes appropriations to MACPAC for FY2010.

Subtitle K: Protections for American Indians and Alaska Natives - (Sec. 2901) Sets forth special rules relating to Indians.

Declares that health programs operated by the Indian Health Service (IHS), Indian tribes, tribal organizations, and Urban Indian organizations shall be the payer of last resort for services they provide to eligible individuals.

Makes such organizations Express Lane agencies for determining Medicaid and CHIP eligibility.

(Sec. 2902) Makes permanent the requirement that the Secretary reimburse certain Indian hospitals and clinics for all Medicare part B services.

Subtitle L: Maternal and Child Health Services - (Sec. 2951) Amends SSA title V (Maternal and Child Health Services) to direct the Secretary to make grants to eligible entities for early childhood home visitation programs. Makes appropriations for FY2010-FY2014.

(Sec. 2952) Encourages the Secretary to continue activities on postpartum depression or postpartum psychosis, including research to expand the understanding of their causes and treatment.

Authorizes the Secretary to make grants to eligible entities for projects to establish, operate, and coordinate effective and cost-efficient systems for the delivery of essential services to individuals with or at risk for postpartum conditions and their families. Authorizes appropriations for FY2010-FY2012.

(Sec. 2953, as modified by Sec. 10201) Directs the Secretary to allot funds to states to award grants to local organizations and other specified entities to carry out personal responsibility education programs to educate adolescents on both abstinence and contraception for the prevention of pregnancy and sexually transmitted infections, as well as on certain adulthood preparation subjects. Makes appropriations for FY2010-FY2014.

(Sec. 2954) Makes appropriations for FY2010-FY2014 for abstinence education.

(Sec. 2955) Requires the case review system for children aging out of foster care and independent living programs to include information about the importance of having a health care power of attorney in transition planning.

Title III: Improving the Quality and Efficiency of Health Care - Subtitle A: Transforming the Health Care Delivery System - Part I: Linking Payment to Quality Outcomes under the Medicare Program - (Sec. 3001) Amends SSA title XVIII (Medicare) to direct the Secretary to establish a hospital value-based purchasing program under which value-based incentive payments are made in a fiscal year to hospitals that meet specified performance standards for a certain performance period.

Directs the Secretary to establish value-based purchasing demonstration programs for: (1) inpatient critical access hospital services; and (2) hospitals excluded from the program because of insufficient numbers of measures and cases.

(Sec. 3002) Extends through 2013 the authority for incentive payments under the physician quality reporting system. Prescribes an incentive (penalty) for providers who do not report quality measures satisfactorily, beginning in 2015.

Requires the Secretary to integrate reporting on quality measures with reporting requirements for the meaningful use of electronic health records.

(Sec. 3003) Requires specified new types of reports and data analysis under the physician feedback program.

(Sec. 3004) Requires long-term care hospitals, inpatient rehabilitation hospitals, and hospices, starting in rate year 2014, to submit data on specified quality measures. Requires reduction of the annual update of entities which do not comply.

(Sec. 3005) Directs the Secretary, starting FY2014, to establish quality reporting programs for inpatient cancer hospitals exempt from the prospective payment system.

(Sec. 3006, as modified by Sec. 10301) Directs the Secretary to develop a plan to implement value-based purchasing programs for Medicare payments for skilled nursing facilities (SNFs), home health agencies, and ambulatory surgical centers.

(Sec. 3007) Directs the Secretary to establish a value-based payment modifier, under the physician fee schedule, based upon the quality of care furnished compared to cost.

(Sec. 3008) Subjects hospitals to a penalty adjustment to hospital payments for high rates of hospital acquired conditions.

Part II: National Strategy to Improve Health Care Quality - (Sec. 3011, as modified by Sec. 10302) Amends the Public Health Service Act to direct the Secretary, through a transparent collaborative process, to establish a National Strategy for Quality Improvement in health care services, patient health outcomes, and population health, taking into consideration certain limitations on the use of comparative effectiveness data.

(Sec. 3012) Directs the President to convene an Interagency Working Group on Health Care Quality.

(Sec. 3013, as modified by Sec. 10303) Directs the Secretary, at least triennially, to identify gaps where no quality measures exist as well as existing quality measures that need improvement, updating, or expansion, consistent with the national strategy for use in federal health programs.

Directs the Secretary to award grants, contracts, or intergovernmental agreements to eligible entities for purposes of developing, improving, updating, or expanding such quality measures.

Requires the Secretary to develop and update periodically provider-level outcome measures for hospitals and physicians, as well as other appropriate providers.

(Sec. 3014, as modified by Sec. 10304) Requires the convening of multi-stakeholder groups to provide input into the selection of quality and efficiency measures.

(Sec. 3015, as modified by Sec. 10305) Directs the Secretary to: (1) establish an overall strategic framework to carry out the public reporting of performance information; and (2) collect and aggregate consistent data on quality and resource use measures from information systems used to support health care delivery. Authorizes the Secretary to award grants for such purpose.

Directs the Secretary to make available to the public, through standardized Internet websites, performance information summarizing data on quality measures.

Part III: Encouraging Development of New Patient Care Models - (Sec. 3021, as modified by Sec. 10306) Creates within CMS a Center for Medicare and Medicaid Innovation to test innovative payment and service delivery models to reduce program expenditures while preserving or enhancing the quality of care furnished to individuals. Makes appropriations for FY2010-FY2019.

(Sec. 3022, as modified by Sec. 10307) Directs the Secretary to establish a shared savings program that: (1) promotes accountability for a patient population; (2) coordinates items and services under Medicare parts A and B; and (3) encourages investment in infrastructure and redesigned care processes for high quality and efficient service delivery.

(Sec. 3023, as modified by Sec. 10308) Directs the Secretary to establish a pilot program for integrated care (involving payment bundling) during an episode of care provided to an applicable beneficiary around a hospitalization in order to improve the coordination, quality, and efficiency of health care services.

(Sec. 3024) Directs the Secretary to conduct a demonstration program to test a payment incentive and service delivery model that utilizes physician and nurse practitioner directed home-based primary care teams designed to reduce expenditures and improve health outcomes in the provision of items and services to applicable beneficiaries.

(Sec. 3025, as modified by Sec. 10309) Requires the Secretary to establish a hospital readmissions reduction program involving certain payment adjustments, effective for discharges on or after October 1, 2012, for certain potentially preventable Medicare inpatient hospital readmissions.

Directs the Secretary to make available a program for hospitals with a high severity adjusted readmission rate to improve their readmission rates through the use of patient safety organizations.

(Sec. 3026) Directs the Secretary to establish a Community-Based Care Transitions Program which provides funding to eligible entities that furnish improved care transitions services to high-risk Medicare beneficiaries.

(Sec. 3027) Amends the Deficit Reduction Act of 2005 to extend certain Gainsharing Demonstration Projects through FY2011.

Subtitle B: Improving Medicare for Patients and Providers - Part 1: Ensuring Beneficiary Access to Physician Care and Other Services - (Sec. 3101, deleted by section 10310) (Sec. 3102) Extends through calendar 2010 the floor on geographic indexing adjustments to the work portion of the physician fee schedule. Revises requirements for calculation of the practice expense portion of the geographic adjustment factor applied in a fee schedule area for services furnished in 2010 or 2011. Directs the Secretary to analyze current methods of establishing practice expense geographic adjustments and make appropriate further adjustments (a new methodology) to such adjustments for 2010 and subsequent years.

(Sec. 3103) Extends the process allowing exceptions to limitations on medically necessary therapy caps through December 31, 2010.

(Sec. 3104) Amends the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 to extend until January 1, 2010, an exception to a payment rule that permits laboratories to receive direct Medicare reimbursement when providing the technical component of certain physician pathology services that had been outsourced by certain (rural) hospitals.

(Sec. 3105, as modified by Sec. 10311) Amends SSA title XVIII (Medicare) to extend the bonus and increased payments for ground ambulance services until January 1, 2011.

Amends the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) to extend the payment of certain urban air ambulance services until January 1, 2011.

(Sec. 3106, as modified by Sec. 10312) Amends the Medicare, Medicaid, and SCHIP Extension Act of 2007, as modified

by the American Recovery and Reinvestment Act, to extend for two years: (1) certain payment rules for long-term care hospital services; and (2) a certain moratorium on the establishment of certain hospitals and facilities.

(Sec. 3107) Amends MIPPA to extend the physician fee schedule mental health add-on payment provision through December 31, 2010.

(Sec. 3108) Allows a physician assistant who does not have an employment relationship with a SNF, but who is working in collaboration with a physician, to certify the need for post-hospital extended care services for Medicare payment purposes.

(Sec. 3109) Amends title XVIII, as modified by MIPPA, to exempt certain pharmacies from accreditation requirements until the Secretary develops pharmacy-specific standards.

(Sec. 3110) Creates a special part B enrollment period for military retirees, their spouses (including widows/ widowers), and dependent children, who are otherwise eligible for TRICARE (the health care plan under the Department of Defense [DOD]) and entitled to Medicare part A (Hospital Insurance) based on disability or end stage renal disease, but who have declined Medicare part B (Supplementary Medical Insurance).

(Sec. 3111) Sets payments for dual-energy x-ray absorptiometry services in 2010 and 2011 at 70% of the 2006 reimbursement rates. Directs the Secretary to arrange with the Institute of Medicine of the National Academies to study and report to the Secretary and Congress on the ramifications of Medicare reimbursement reductions for such services on beneficiary access to bone mass measurement benefits.

(Sec. 3112) Eliminates funding in the Medicare Improvement Fund FY2014.

(Sec. 3113) Directs the Secretary to conduct a demonstration project under Medicare part B of separate payments for complex diagnostic laboratory tests provided to individuals.

(Sec. 3114) Increases from 65% to 100% of the fee schedule amount provided for the same service performed by a physician the fee schedule for certified-midwife services provided on or after January 1, 2011.

Part II: Rural Protections - (Sec. 3121) Extends through 2010 hold harmless provisions under the prospective payment system for hospital outpatient department services.

Removes the 100-bed limitation for sole community hospitals so all such hospitals receive an 85% increase in the payment difference in 2010.

(Sec. 3122) Amends the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, as modified by other federal law, to extend from July 1, 2010, until July 1, 2011, the reasonable cost reimbursement for clinical diagnostic laboratory service for qualifying rural hospitals with under 50 beds.

(Sec. 3123, as modified by Sec. 10313) Extends the Rural Community Hospital Demonstration Program for five additional years. Expands the maximum number of participating hospitals to 30, and to 20 the number of demonstration states with low population densities.

(Sec. 3124) Extends the Medicare-dependent Hospital Program through FY2012.

(Sec. 3125, as modified by Sec. 10314) Modifies the Medicare inpatient hospital payment adjustment for low-volume hospitals for FY2011-FY2012.

(Sec. 3126) Revises requirements for the Demonstration Project on Community Health Integration Models in Certain Rural Counties to allow additional counties as well as physicians to participate.

(Sec. 3127) Directs MEDPAC to study and report to Congress on the adequacy of payments for items and services furnished by service providers and suppliers in rural areas under the Medicare program.

(Sec. 3128) Allows a critical access hospital to continue to be eligible to receive 101% of reasonable costs for providing: (1) outpatient care regardless of the eligible billing method such hospital uses; and (2) qualifying ambulance services.

(Sec. 3129) Extends through FY2012 FLEX grants under the Medicare Rural Hospital Flexibility Program. Allows the use of grant funding to assist small rural hospitals to participate in delivery system reforms.

Part III: Improving Payment Accuracy - (Sec. 3131, as modified by Sec. 10315) Requires the Secretary, starting in 2014, to rebase home health payments by an appropriate percentage, among other things, to reflect the number, mix, and level of intensity of home health services in an episode, and the average cost of providing care.

Directs the Secretary to study and report to Congress on home health agency costs involved with providing ongoing access to care to low-income Medicare beneficiaries or beneficiaries in medically underserved areas, and in treating beneficiaries with varying levels of severity of illness. Authorizes a Medicare demonstration project based on the study results.

(Sec. 3132) Requires the Secretary, by January 1, 2011, to begin collecting additional data and information needed to revise payments for hospice care.

Directs the Secretary, not earlier than October 1, 2013, to implement, by regulation, budget neutral revisions to the methodology for determining hospice payments for routine home care and other services, which may include per diem payments reflecting changes in resource intensity in providing such care and services during the course of an entire episode of hospice care.

Requires the Secretary to impose new requirements on hospice providers participating in Medicare, including requirements for: (1) a hospice physician or nurse practitioner to have a face-to-face encounter with the individual regarding eligibility and recertification; and (2) a medical review of any stays exceeding 180 days, where the number of such cases exceeds a specified percentage of them for all hospice programs.

(Sec. 3133, as modified by Sec. 10316) Specifies reductions to Medicare DSH payments for FY2015 and ensuing fiscal years, especially to subsection (d) hospitals, to reflect lower uncompensated care costs relative to increases in the number of insured. (Generally, a subsection [d] hospital is an acute care hospital, particularly one that receives payments under Medicare's inpatient prospective payment system when providing covered inpatient services to eligible beneficiaries.)

(Sec. 3134) Directs the Secretary periodically to identify physician services as being potentially misvalued and make appropriate adjustments to the relative values of such services under the Medicare physician fee schedule.

(Sec. 3135) Increases the presumed utilization rate for calculating the payment for advanced imaging equipment other than low-tech imaging such as ultrasound, x-rays and EKGs.

Increases the technical component payment "discount" for sequential imaging services on contiguous body parts during the same visit.

(Sec. 3136) Restricts the lump-sum payment option for new or replacement chairs to the complex, rehabilitative power-driven wheelchairs only. Eliminates the lump-sum payment option for all other power-driven wheelchairs. Makes the rental payment for power-driven wheelchairs 15% of the purchase price for each of the first three months (instead of 10%), and 6% of the purchase price for each of the remaining 10 months of the rental period (instead of 7.5%).

(Sec. 3137, as modified by Sec. 10317) Amends the Tax Relief and Health Care Act of 2006, as modified by other federal law, to extend "Section 508" hospital reclassifications until September 30, 2010, with a special rule for FY2010. ("Section 508" refers to Section 508 of the Medicare Modernization Act of 2003, which allows the temporary reclassification of a hospital with a low Medicare area wage index, for reimbursement purposes, to a nearby location with a higher Medicare area wage index, so that the "Section 508 hospital" will receive the higher Medicare reimbursement rate.)

Directs the Secretary to report to Congress a plan to reform the hospital wage index system.

(Sec. 3138) Requires the Secretary to determine if the outpatient costs incurred by inpatient prospective payment system-exempt cancer hospitals, including those for drugs and biologicals, with respect to Medicare ambulatory payment classification groups, exceed those costs incurred by other hospitals reimbursed under the outpatient prospective payment system (OPPS). Requires the Secretary, if this is so, to provide for an appropriate OPPS adjustment to reflect such higher costs for services furnished on or after January 1, 2011.

(Sec. 3139) Allows a biosimilar biological product to be reimbursed at 6% of the average sales price of the brand biological product.

(Sec. 3140) Directs the Secretary to establish a Medicare Hospice Concurrent Care demonstration program under which Medicare beneficiaries are furnished, during the same period, hospice care and any other Medicare items or services from Medicare funds otherwise paid to such hospice programs.

(Sec. 3141) Requires application of the budget neutrality requirement associated with the effect of the imputed rural floor on the area wage index under the Balanced Budget Act of 1997 through a uniform national, instead of state-by-state, adjustment to the area hospital wage index floor.

(Sec. 3142) Directs the Secretary to study and report to Congress on the need for an additional payment for urban Medicare-dependent hospitals for inpatient hospital services under Medicare.

(Sec. 3143) Declares that nothing in this Act shall result in the reduction of guaranteed home health benefits under the Medicare program.

Subtitle C: Provisions Relating to Part C - (Sec. 3201, as modified by Sec. 10318) Bases the MedicareAdvantage (MA) benchmark on the average of the bids from MA plans in each market.

Revises the formula for calculating the annual Medicare+Choice capitation rate to reduce the national MA per capita Medicare+Choice growth percentage used to increase benchmarks in 2011.

Increases the monthly MA plan rebates from 75% to 100% of the average per capita savings.

Requires that bid information which MA plans are required to submit to the Secretary be certified by a member of the American Academy of Actuaries and meet actuarial guidelines and rules established by the Secretary.

Directs the Secretary, acting through the CMS Chief Actuary, to establish actuarial guidelines for the submission of bid information and bidding rules that are appropriate to ensure accurate bids and fair competition.

Actions Timeline

- **Mar 23, 2010:** Signed by President.
- **Mar 23, 2010:** Became Public Law No: 111-148.
- **Mar 22, 2010:** Presented to President.
- **Mar 21, 2010:** Mr. Spratt moved that the House agree to the Senate amendments. (consideration: CR H1854-1890, H1891-2153)
- **Mar 21, 2010:** The previous question was ordered pursuant to the rule. (consideration: CR H2153)
- **Mar 21, 2010:** Resolving differences -- House actions: On motion that the House agree to the Senate amendments Agreed to by recorded vote: 219 - 212 (Roll no. 165). (text as House agreed to Senate amendments: CR H1920-2152)
- **Mar 21, 2010:** On motion that the House agree to the Senate amendments Agreed to by recorded vote: 219 - 212 (Roll no. 165). (text as House agreed to Senate amendments: CR H1920-2152)
- **Mar 21, 2010:** Motion to reconsider laid on the table Agreed to without objection.
- **Mar 21, 2010:** Cleared for White House.
- **Dec 29, 2009:** Message on Senate action sent to the House.
- **Dec 24, 2009:** Considered by Senate. (consideration: CR S13890-14132)
- **Dec 24, 2009:** Passed/agreed to in Senate: Passed Senate with an amendment and an amendment to the Title by Yea-Nay Vote. 60 - 39. Record Vote Number: 396. (text: CR S13890-14212)
- **Dec 24, 2009:** Passed Senate with an amendment and an amendment to the Title by Yea-Nay Vote. 60 - 39. Record Vote Number: 396. (text: CR S13890-14212)
- **Dec 24, 2009:** Measure amended in Senate by unanimous consent after passage by Unanimous Consent.
- **Dec 24, 2009:** Senate ordered measure printed as passed.
- **Dec 23, 2009:** Considered by Senate. (consideration: CR S13796-13866)
- **Dec 23, 2009:** Cloture invoked in Senate by Yea-Nay Vote. 60 - 39. Record Vote Number: 395.
- **Dec 22, 2009:** Considered by Senate. (consideration: CR S13714-13744, S13745-13751)
- **Dec 21, 2009:** Considered by Senate. (consideration: CR S13640-13646, S13647-13660, S13661-13695)
- **Dec 21, 2009:** Motion by Senator Reid to commit to Senate Committee on Finance with instructions that the Committee report back with the following amendment (SA 3280) fell when cloture was invoked on amendment SA 3276 in Senate. (consideration: CR S13640)
- **Dec 20, 2009:** Considered by Senate. (consideration: CR S13558-13628)
- **Dec 19, 2009:** Considered by Senate. (consideration: CR S13477-13489)
- **Dec 19, 2009:** Cloture motion on the motion to proceed rendered moot in Senate. (consideration: CR S13477-13478; text: CR S13477-13478)
- **Dec 19, 2009:** Cloture motion the bill presented in Senate. (consideration: CR S13478; text: CR S13478)
- **Dec 19, 2009:** Motion by Senator Reid to commit to Senate Committee on Finance with instructions that the Committee report back with the following amendment (SA 3280) made in Senate. (consideration: CR S13478)
- **Dec 17, 2009:** Motion to proceed to consideration of measure made in Senate. (consideration: CR S13376)
- **Dec 17, 2009:** Cloture motion on the motion to proceed to the measure presented in Senate. (consideration: CR S13376; text: CR S13376)
- **Dec 17, 2009:** Motion to proceed to consideration of measure withdrawn in Senate. (consideration: CR S13376)
- **Dec 16, 2009:** Considered by Senate. (consideration: CR S13280-13295)
- **Dec 16, 2009:** Motion by Senator Hutchison to commit to Senate Committee on Finance tabled in Senate by Yea-Nay Vote. 56 - 41. Record Vote Number: 379. (consideration: CR S13280, S13295)
- **Dec 15, 2009:** Considered by Senate. (consideration: CR S13205-13219, S13219-13242)
- **Dec 15, 2009:** Motion by Senator Crapo to commit to Senate Committee on Finance under the order of 12/14/2009, not having achieved 60 votes in the affirmative, the motion was rejected in Senate by Yea-Nay Vote. 45 - 54. Record Vote Number: 376. (consideration: CR S13205, S13237-13238)
- **Dec 15, 2009:** Motion by Senator Crapo to commit to Senate Committee on Finance under the order of 12/14/2009, not having achieved 60 votes in the affirmative, the motion was withdrawn in Senate.
- **Dec 15, 2009:** Motion by Senator Hutchison to commit to Senate Committee on Finance with instructions made in Senate. (consideration: CR S13239-13242; text: CR S13239)
- **Dec 14, 2009:** Cloture motion on the Crapo motion to commit withdrawn by unanimous consent in Senate.
- **Dec 13, 2009:** Considered by Senate. (consideration: CR S13131-13132)

Dec 13, 2009: Cloture motion on the Crapo motion to commit presented in Senate. (consideration: CR S13131-13132; text: CR S13132)

- **Dec 10, 2009:** Considered by Senate. (consideration: CR S12836-12876)
- **Dec 9, 2009:** Considered by Senate. (consideration: CR S12745-12791, S12791-12799)
- **Dec 8, 2009:** Considered by Senate. (consideration: CR S12648-12664, S12664-12699)
- **Dec 8, 2009:** Motion by Senator McCain to commit to Senate Committee on Finance, under the order of 12/8/2009, not having achieved 60 votes in the affirmative, the motion was rejected in Senate by Yea-Nay Vote. 42 - 57. Record Vote Number: 370. (consideration: CR S12648, S12684)
- **Dec 8, 2009:** Motion by Senator McCain to commit to Senate Committee on Finance, under the order of 12/8/2009, not having achieved 60 votes in the affirmative, the motion was withdrawn in Senate. (consideration: CR S12648, S12684)
- **Dec 8, 2009:** Motion by Senator Crapo to commit to Senate Committee on Finance with instructions made in Senate. (consideration: CR S12685-12686; text: CR S12685)
- **Dec 7, 2009:** Considered by Senate. (consideration: CR S12565-12613)
- **Dec 7, 2009:** Motion by Senator McCain to commit to Senate Committee on Finance with instructions made in Senate. (consideration: CR S12603-12609; text: CR S12603-12604)
- **Dec 6, 2009:** Considered by Senate. (consideration: CR S12524-12552)
- **Dec 5, 2009:** Considered by Senate. By Unanimous Consent. (consideration: CR S12462-12516)
- **Dec 5, 2009:** Motion by Senator Johanns to commit to Senate Committee on Finance under the order of 12/5/2009, not having achieved 60 votes in the affirmative, the motion was rejected in Senate by Yea-Nay Vote. 41 - 53. Record Vote Number: 364. (consideration: CR S12462, S12496)
- **Dec 5, 2009:** Motion by Senator Johanns to commit to Senate Committee on Finance under the order of 12/5/2009, not having achieved 60 votes in the affirmative, the motion was withdrawn in Senate. (consideration: CR S12496)
- **Dec 4, 2009:** Considered by Senate. (consideration: CR S12356-12408)
- **Dec 4, 2009:** Motion by Senator Hatch to commit to Senate Committee on Finance under the order of 12/4/2009, not having achieved 60 votes in the affirmative, the motion was rejected in Senate by Yea-Nay Vote. 41 - 57. Record Vote Number: 362. (consideration: CR S12356, S12396-12397)
- **Dec 4, 2009:** Motion by Senator Hatch to commit to Senate Committee on Finance under the order of 12/4/2009, not having achieved 60 votes in the affirmative, the motion was withdrawn in Senate. (consideration: CR S12397)
- **Dec 4, 2009:** Motion by Senator Johanns to commit to Senate Committee on Finance with instructions made in Senate. (consideration: CR S12397)
- **Dec 3, 2009:** Considered by Senate. (consideration: CR S12265-12300, S12300-12317)
- **Dec 3, 2009:** Motion by Senator McCain to commit to Senate Committee on Finance under the order of 12/2/2009, not having achieved 60 votes in the affirmative, the motion was rejected in Senate by Yea-Nay Vote. 42 - 58. Record Vote Number: 358. (consideration: CR S12265, S12293-12294)
- **Dec 3, 2009:** Motion by Senator McCain to commit to Senate Committee on Finance under the order of 12/2/2009, not having achieved 60 votes in the affirmative, the motion was withdrawn in Senate. (consideration: CR S12294)
- **Dec 3, 2009:** Motion by Senator Hatch to commit to Senate Committee on Finance with instructions made in Senate. (consideration: CR S12306-12317)
- **Dec 2, 2009:** Considered by Senate. (consideration: CR S12094-12106, S12106-12152)
- **Dec 1, 2009:** Considered by Senate. (consideration: CR S12021-12031, S12033-12066)
- **Nov 30, 2009:** Considered by Senate. (consideration: CR S11985-12005)
- **Nov 30, 2009:** Motion by Senator McCain to commit to Senate Committee on Finance with instructions made in Senate. (consideration: CR S11997-12005; text: CR S11997)
- **Nov 21, 2009:** Motion to proceed to consideration of measure considered in Senate. (consideration: CR S11907-11967)
- **Nov 21, 2009:** Cloture on the motion to proceed to the bill invoked in Senate by Yea-Nay Vote. 60 - 39. Record Vote Number: 353. (consideration: CR S11967; text: CR S11967)
- **Nov 21, 2009:** Motion to proceed to consideration of measure agreed to in Senate by Unanimous Consent.
- **Nov 21, 2009:** Measure laid before Senate by motion. (consideration: CR S11967)
- **Nov 20, 2009:** Motion to proceed to consideration of measure considered in Senate. (consideration: CR S11826-11879, S11888-11903)
- **Nov 19, 2009:** Motion to proceed to consideration of measure made in Senate. (consideration: CR S11578)
- **Nov 19, 2009:** Cloture motion on the motion to proceed to the bill presented in Senate. (consideration: CR S11578; text: CR S11578)

Oct 13, 2009: Read the second time. Placed on Senate Legislative Calendar under General Orders. Calendar No. 175.

- **Oct 8, 2009:** Considered as unfinished business. (consideration: CR H11126-11127)
- **Oct 8, 2009:** Passed/agreed to in House: On motion to suspend the rules and pass the bill Agreed to by the Yeas and Nays: (2/3 required): 416 - 0 (Roll no. 768).(text: CR 10/7/2009 H10550)
- **Oct 8, 2009:** On motion to suspend the rules and pass the bill Agreed to by the Yeas and Nays: (2/3 required): 416 - 0 (Roll no. 768). (text: CR 10/7/2009 H10550)
- **Oct 8, 2009:** Motion to reconsider laid on the table Agreed to without objection.
- **Oct 8, 2009:** Received in the Senate. Read the first time. Placed on Senate Legislative Calendar under Read the First Time.
- **Oct 7, 2009:** Mr. Blumenauer moved to suspend the rules and pass the bill.
- **Oct 7, 2009:** Considered under suspension of the rules. (consideration: CR H10550-10554)
- **Oct 7, 2009:** DEBATE - The House proceeded with forty minutes of debate on H.R. 3590.
- **Oct 7, 2009:** At the conclusion of debate, the Yeas and Nays were demanded and ordered. Pursuant to the provisions of clause 8, rule XX, the Chair announced that further proceedings on the motion would be postponed.
- **Sep 17, 2009:** Introduced in House
- **Sep 17, 2009:** Referred to the House Committee on Ways and Means.