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The Affordable Health Care For America Act (H.R.3962)
Section-by-Section Summary – Key Provisions of Interest to CNMs/CMs

The following are key provisions of the health care reform bill passed by the U.S. House of Representatives on Saturday, November 7, 2009, that ACNM believes will be of interest to ACNM members:

TITLE I—IMMEDIATE REFORMS

Sec. 101. National High-Risk Pool Program. Enacts a temporary insurance program with financial assistance for those who have been uninsured for several months or denied a policy because of pre-existing conditions. The funding for this program is capped at $5 million and it terminates when those funds are exhausted or when the Health Insurance Exchange is up and running.

Sec. 103. Ending health insurance rescission abuse. Prohibits health insurance companies from rescinding coverage except in instances of fraud and requires independent review of any rescission determination, effective July 1, 2010.

Sec. 104. Sunshine on price gouging by health insurance issuers. Establishes an annual review process for increases in health insurance premiums by the Secretary of HHS in conjunction with the States that requires insurers to submit a justification for any premium increases prior to implementation. Effective for plan years beginning January 1,2010.

Sec. 105. Requiring the Option of Extension of Dependent Coverage for Uninsured Young Adults. Requires health insurers to allow individuals through age 26, not otherwise covered, to remain on their parents' health insurance at their parents' choice for plan years beginning January 1, 2010.

Sec. 106. Limitations on pre-existing condition exclusions by group health plans in advance of applicability of new prohibition of pre-existing condition exclusions. Prior to the bill's complete prohibition on pre-existing condition exclusions beginning in 2013, this provision shortens the time that plans can look back for pre-existing conditions from 6 months to 30 days and shortens the time plans may exclude coverage of certain benefits generally fro 12 months to 3 months. Effective for plan years beginning January 1, 2010.

Sec. 107. Prohibiting acts of domestic violence from being treated as pre-existing conditions. Prohibits insurers from limiting or denying coverage based on acts stemming from domestic violence for plan years beginning January 1, 2010.

Sec. 108. Ending health insurance denials and delays of unnecessary treatment for children with deformities. Requires plans to pay for reconstructive surgery for children with deformities for plan years beginning January 1, 2010.

Sec. 109. Elimination of lifetime aggregate limits. Prohibits health insurers from utilizing lifetime limits on benefits for plan years beginning January 1, 2010.

Sec 110. Prohibition against post-retirement reductions of retiree health benefits by group health plans. Prohibits employers from reducing retiree health benefits below what was offered to retirees at the time of their retirement unless reductions are also made to active workers' health benefits. Effective as of date of enactment.

Sec. 112. Wellness Program Grants. Establishes a grant program for small employers to assist with the creation of employee wellness programs that promote health behaviors in a non-discriminatory manner.

Sec. 113. Extension of COBRA continuation coverage. Extends COBRA eligibility to permit individuals to remain in their COBRA policy until the Health Insurance Exchange is up and running.

Sec. 114. State Health Access Program Grants. Builds on an existing grant program to enhance incentives for states to move forward with a variety of health reform initiatives that would expand access to affordable health care for the uninsured prior to 2013.

Sec. 115. Administrative simplification. Requires the Secretary of HHS to adopt standards for typical transactions between insurers and providers such as claims, eligibility, enrollment, and prior authorization building on the standards in the Health Insurance Portability and Accountability Act of 1996. It establishes implementation and enforcement mechanisms for such standards.

TITLE II – PROTECTIONS AND STANDARDS FOR QUALIFIED HEALTH BENEFITS PLANS

SUBTITLE A – GENERAL STANDARDS

Sec. 202. Protecting the choice to keep current coverage. Allows the maintenance of current individual health plans as "grandfathered plans" and provides for a five year grace period for current group health plans to meet specified standards (insurance and benefit requirements).

SUBTITLE B – STANDARDS GUARANTEEING ACCESS TO AFFORDABLE COVERAGE

Sec. 211. Prohibiting pre-existing condition exclusions. Prohibits the application of pre-existing condition exclusions.

Sec. 212. Guaranteed issue and renewal for insured plans and prohibiting rescissions. Requires guaranteed issue (no one can be denied health insurance) and renewal of insurance policies and prohibits the use of rescissions except in instances of fraud.

Sec. 214. Nondiscrimination in benefits; **parity in mental health and substance abuse disorder benefits.** Provides authority to the Health Choices Commissioner to set non-discrimination rules and ensures that mental health and substance use disorder parity and genetic nondiscrimination laws apply o qualified health benefits plans.

Sec. 215. Ensuring adequacy of provider networks. Provides authority to the Health Choices Commissioner to set network adequacy standards that qualified plans must meet.

Sec. 216. Requiring the option of extension of dependent coverage for uninsured young adults. Permanently extends the requirement that health plans allow individuals through age 26, not otherwise covered, to remain on their parents' health insurance at their parents' choice.

Sec. 217. Consistency of costs and coverage under qualified health benefits plans during plan year. Requires qualified health benefits plans to provide at least 90 days notice in advance of any increase or decrease in coverage, but includes an exception to protect the health and safety of enrollees.

SUBTITLE C – STANDARDS GUARANTEEING ACCESS TO ESSENTIAL BENEFITS

Sec. 221. Coverage of essential benefits package. Requires qualified plans to meet the benefit standards recommended by the Benefits Advisory Committee and adopted by the Secretary of HHS. Plans outside the Exchange must offer at least the essential benefits and others as they choose. Plans within the Exchange must meet the specified benefit packages, including being able to offer additional benefits in a specified tier. Allows for the continued offering of separate excepted benefits packages, as in current law, outside of the Exchange.

Sec. 222. Essential benefits package defined. Outlines the broad categories of benefits (including maternity services) required to be included in the essential benefits package, prohibits any cost-sharing for preventive benefits (including well child and well baby care), and limits annual out-of-pocket spending in the essential benefits package to $5,000 for an individual and $10,000 (indexed to CPI) for a family. Defines the initial essential benefit package as being actuarially equivalent to 70% of the package if there were no cost-sharing imposed. Requires the Secretary to assess adding counseling for domestic violence as part of the behavioral health or primary care visit. Prohibits abortion services from being made part of essential benefits package. Prohibits federal funds from being used to pay for abortion (except in cases of rape, incest, and to save life of the woman). Only private premium dollars can be used to provide abortion coverage. Where abortion coverage is provided, funds for this purpose must be segregated from other funds, including affordability credits. Includes a report regarding the need and cost of providing oral health care to adults as part of the essential

benefits package. In the developing the essential benefit package, the Secretary shall support the need for assessment and counseling for domestic violence as part of the behavioral health assessment or primary care visit.

Sec. 223. Health Benefits Advisory Committee. Establishes a Health Benefits Advisory Committee, chaired by the Surgeon General, with private members appointed by the President, the Comptroller General, and representatives of relevant federal agencies. The Advisory Committee will make recommendations to the Secretary of HHS regarding the details of covered health benefits as outlined in Sec. 222, including the establishment of the three tiers of coverage: basic, enhanced and premium.

SUBTITLE D – ADDITIONAL CONSUMER PROTECTIONS

Sec. 231. Requiring fair marketing practices by health insurers. Provides the Health Choices Commissioner with the authority to define marketing standards that qualified plans are required t meet.

Sec. 232. Requiring fair grievance and appeals mechanisms. Requires each qualified plan to meet standards defined by the Health Choices Commissioner for timely internal grievance and appeals mechanisms and to establish an external review process that provides for an impartial, independent and de novo review of denied claims. The determination is binding.

Sec. 233. Requiring information transparency and plan disclosure. Requires qualified plans to meet standards established by the Health Choices Commissioner relating to transparency and timely disclosure of plan documents and information, including providing health care providers with information regarding their payments. It also requires the use of plain language in the disclosures (including the issuance of guidance as to what "plain language" means) and advance notice of changes to the plans.

Sec. 234. Application to qualified health benefits plans not offered through the Health Insurance Exchange. Provides flexibility to the Health Choices Commissioner to decide what protections of sections 231-233 should apply to qualified plans outside of the Health Insurance Exchange.

Sec. 235. Timely payment of claims. Applies Medicare's timely payment of claims standards to the plans offering coverage through the Exchange.

Sec. 237. Application of Administrative Simplification. Requires insurers and providers to use common standards for transactions such as claims payment, eligibility and enrollment building on the Health Insurance Portability and Accountability Act of 1996.

Sec. 238. State prohibitions on discrimination against health care providers. Clarifies that this Act does not supersede state laws that prohibit health plans from discriminating against health care providers acting within the scope of their licenses or certifications.

Sec. 239. Protection of physician prescriber information. Requires a study by the Secretary of HHS on the use of physician prescriber information in sales and marketing practices of pharmaceutical manufacturers and make recommendations as to the actions needed by Congress or the Secretary to protect providers from biased marketing and sales practices.

SUBTITLE E – GOVERNANCE

Sec. 241. Health Choices Administration; Health Choices Commissioner. Establishes the Health Choices Administration, an independent executive branch agency. The Health Choices Commissioner is appointed by the President.

Sec. 242. Duties and authority of Commissioner. The Health Choices Commissioner carries out functions including: establishment of qualified plan standards, establishment and operation of the Health Insurance Exchange, administration of affordability credits, and additional functions as laid out within the bill. The Commissioner can collect data necessary to carry out his or her duties and to promote quality and value and address disparities in health care. Such information can also be shared with HHS. The Commissioner also has oversight and enforcement authority including the authority to impose sanctions and suspend enrollment of a plan. This authority requires the Commissioner to coordinate with the Department of HHS, the Department of Labor and State insurance regulators.

Sec. 243. Consultation and coordination. Requires the Health Choices Commissioner to consult with other regulatory bodies and state and federal agencies in carrying out his or her duties and to ensure appropriate oversight and enforcement.

Sec. 244. Health Insurance Ombudsman. Establishes a Qualified Health Benefits Plan Ombudsman to assist individuals in navigating the new health reform system and report to Congress on recommendations for improvements in administration of the program.

Sec. 258. Application of state and federal laws regarding abortion. Makes clear that nothing in this act pre-empts state laws with regard to abortion nor changes existing federal laws regarding conscience protections, willingness or refusal to provide abortion, and discrimination on the basis of such willingness or refusal.

Sec. 259. Nondiscrimination on abortion and respect for rights of conscience. No federal agency, program, or any state or local government that receives financial assistance under this act may discriminate against a provider on the basis of whether they provide coverage or refer for abortion services.

Sec. 261. Construction regarding standard of care. Clarifies that provisions in this Act relating to delivery system reform, reducing hospital acquired infections, and other provisions shall not be used to establish the standard or duty of care in a malpractice suit.

Sec. 262. Restoring application of anti-trust laws to health insurers. Removes the anti-trust exemption for health insurers and medical malpractice insurers.

Sec. 263. Study and report on methods to increase EHR use by small health care providers. Requires the Secretary of Health and Human Services to conduct a study of potential methods to increase the use of qualified electronic health records by small providers including higher reimbursement rates, training, and education.

TITLE III —HEALTH INSURANCE EXCHANGE AND RELATED PROVISIONS

SUBTITLE A – HEALTH INSURANCE EXCHANGE

Sec. 301. Establishment of Health Insurance Exchange; outline of duties; definitions. Establishes a Health Insurance Exchange under the purview of the Health Choices Administration that will facilitate the offering of health insurance choices. The Health Choices Commissioner establishes a process through which to obtain bids, negotiate and enter into contracts with qualified plans, and ensure that the different levels of benefits are offered with appropriate oversight and enforcement. The Commissioner also facilitates outreach and enrollment, creates and operates a risk pooling mechanism, and ensures consumer protections.

Sec. 302. Exchange-eligible individuals and employers. Defines who is eligible for participation in the Health Insurance Exchange including employers and individuals. In year one, individuals not enrolled in other acceptable coverage as well as small employers with 25 or fewer employees are allowed into the Exchange. In year two, employers with 50 and fewer employees are allowed into the Exchange. In year three, the Commissioner is, at a minimum, required to open the Exchange to employers with 100 and fewer employees, but is permitted from this year forward to expand employer participation as appropriate, with the goal of allowing all employers access to the Exchange.

Defines acceptable coverage to include enrollment in other qualified coverage and most other federal health programs.

Medicaid-eligible individuals will be enrolled in Medicaid, not the Exchange.

Once an individual or an employer enrolls in coverage through the Exchange, they remain eligible for Exchange coverage even if circumstances change that would otherwise exclude them.

Requires that employers who offer coverage through the Exchange contribute at least the required contribution toward such coverage and permit their employees the freedom to choose any plan within the Exchange.

Requires the Commissioner to conduct periodic surveys of Exchange-eligible individuals and employers to measure satisfaction.

Requires the Commissioner to conduct a study regarding access to the Exchange to determine if there are significant groups and types of individuals and employers who are not Exchange eligible, but who would have improved benefits and affordability if made eligible. The report is due in year three and year six of the Exchange and continued thereafter. It is to include recommendations as appropriate for changes to the eligibility standards.

Sec. 303. Benefits package levels. The Health Choices Commissioner specifies the benefits that must be made available in each year – including a requirement that each participating plan provide one basic plan in each service area in which they operate. It is then optional for the plan to offer one enhanced and one premium plan. The differences between the three main plans (i.e. basic, enhanced and premium) are the levels of cost-sharing required, not the benefits covered. The Commissioner shall establish a permissible range of cost-sharing variation that is not to exceed plus or minus 10% with regard to each benefit category.

There is a fourth tier called premium-plus. In this package, plans can offer extra benefits like dental or vision coverage for adults, or other non-covered benefits. To ensure consumers know what they are paying extra for, these packages must detail the cost of the extra benefits separately. Plans may offer multiple premium-plus options.

States can require the application of state benefit mandates to all Exchange participating plans, but only if there is an agreement with the Commissioner that the state will reimburse the Commissioner for any additional cost of affordability credits in that state due to the State benefit requirements.

Sec. 308. Optional operation of State-based health insurance exchanges. Permits states to offer their own Exchange or join with a group of states to create their own exchange in lieu of the federal Health Insurance Exchange, provided that the state(s) perform all of the duties of the federal Exchange as approved by the Health Choices Commissioner. The Commissioner has authority to terminate state exchanges if they are not meeting their obligations. Presumes that any State operating an Exchange prior to 2010 is allowed to continue doing so.

Sec. 309. Interstate health insurance compacts. Effective January 1, 2015, would allow 2 or more States to form Health Care Choice Compacts to facilitate the purchase of individual health insurance across State lines. Calls on the National Association of Insurance Commissioners to develop model guidelines for such compacts. Ensures that such compacts require licensure in each state and maintains authority of the State in which a covered individual resides to protect the individual. Allows States to apply for grants from the Secretary of HHS to help implement such compacts.

Sec. 310. Health Insurance Cooperatives. Requires the Health Choices Commissioner to establish a "Consumer Operated and Oriented Plan Program" known as the CO-OP Program, to assist organizations that wish to start up a non-profit health insurance cooperative and provides start up loans for these organizations.

SUBTITLE B – PUBLIC HEALTH INSURANCE OPTION

Sec. 321. Establishment and administration of a public health insurance option as an Exchange-qualified health benefits plan. Requires the Secretary of Health and Human Services to develop a public health insurance option to be offered starting in 201 as a plan choice within the Health Insurance Exchange. It participates on a level playing field with private plan choices. Like private plans, it must offer the same benefits, abide by the same insurance market reforms, follow provider network requirements and other consumer protections.

Sec. 322. Premiums and financing. Premiums for the public option are geographically-adjusted and are required to be set so as to fully cover the cost of coverage as well as administrative costs of the plan. This includes a requirement that the public option, like private plans, include a contingency margin in its premium to cover unexpected cost variations. In order to establish the public option, there is an initial appropriation of $2 billion for administrative costs and in order to provide for initial claims reserves before the collection of premiums such sums as necessary to cover 90 days worth of claims reserves based on projected enrollment. These start up funds are amortized into the premiums for the public option to be recouped over the first 10 years of operation. The plan must be self-sustaining after that initial funding.

Sec. 323. Payment rates for items and services. The Secretary of Health and Human Services negotiates payment for health care providers and items and services, including prescription drugs, for the public health insurance option. Medicare providers are presumed to be participating in the public option unless they opt out. There are no penalties for opting out and providers have at least a one-year period prior to the beginning of the public option to opt out.

Sec. 324. Modernized payment initiatives and delivery system reform. The Secretary shall evaluate the progress of payment and delivery system reforms and apply them to the public option and how t pays for medical services to promote better quality and more efficient use of medical care. Such payment changes must seek to reduce cost for enrollees, improve health outcomes, reduce health disparities, address geographic variation in the provision of medical services, prevent or manage chronic illnesses, or promote integrated patient-centered care.

Sec. 325. Provider participation. Provides the Secretary of HHS with the authority to develop conditions of participation for the public health insurance option. Providers must be licensed or otherwise recognized in the state in which they do business. Physician participation comes in two types: preferred physicians are those physicians who agree to accept the public option's payment rate (without regard to cost-sharing) as payment in full, participating non-preferred physicians are those who agree not to impose charges in excess of the balance billing limitations as set forth by the Secretary. Providers must be excluded from participating in the public option if they are excluded from other federal health programs.

Sec. 329. Enrollment in Public Health Insurance Option is voluntary. Clarifies that no one is required to participate in the public health insurance option – it is a voluntary choice.

Sec. 330. Enrollment in Public Health Insurance Option by Members of Congress. Makes clear that Members of Congress are eligible to join the public health insurance option.

SUBTITLE C – INDIVIDUAL AFFORDABILITY CREDITS

Sec. 341. Availability through Health Insurance Exchange. Creates affordability credits to ensure that people with incomes up to 400% of federal poverty have affordable health coverage. These credits are phased out according to a schedule defined in the act as individual and family incomes up to 400% of poverty and the credits apply only to Exchange-participating plans. Affordability credits reduce the costs of both premium and annual out-of-pocket spending. Individuals apply through the Commissioner or Health Insurance Exchange for the credits, or through other entities approved by the Commissioner. The Commissioner, through an agreement with the Commissioner of Social Security, must conduct a verification process to confirm citizenship or lawful presence in the United States before any individual is eligible for affordability credits. In the first two years, affordability credits can only be used to purchase a basic plan. After that, the Commissioner establishes a process to allow them to be used for enhanced and premium plans in a way that makes clear the individuals who select those options will be responsible for any difference in costs.

Sec. 342. Affordability credit eligible individual. In order to receive affordability credits, individuals must have individual coverage through an Exchange-participating health benefits plan (though not through an employer purchasing coverage through the Exchange). Family and individual incomes must be below 400% of the federal poverty limit to access the affordability credits, and the individual must not be eligible for Medicaid or enrolled in Medicare or other acceptable coverage. In general, employees who are offered employer coverage are ineligible for affordability credits within the Exchange. Beginning in year two, employees who meet an affordability test showing that coverage under their employer-provided plan would cost more than 12% of income, are eligible to obtain income-based affordability credits in the Exchange.

Sec. 343. Affordability premium credit. The affordability premium amount is calculated on a sliding scale starting at 1.5% of income for those at or below 133% of poverty and phasing out at 12% of income for those at 400% of poverty. The way this phase out works is specifically detailed in the act. The reference premium is the average premium for the three lowest cost basic plans in the area in which the individual reside. There is an out-of-pocket maximum set at $500 for an individual and $1000 for a family at the lowest income tier rising to $5,000 for an individual and $10,000 for a family at the highest income tier for individuals receiving affordability credits.

Sec. 344. Affordability cost-sharing credit. The affordability cost-sharing credit reduces cost-sharing for individuals and families at or below 133% of poverty up to 400% of the federal poverty limit as specified in the act.

Sec. 345. Income determinations. To determine income, the Health Choices Commissioner uses income data from the individual's most recent tax return. The federal poverty level applied is the level in effect as of the date of the application. The Commissioner takes such steps as are appropriate to ensure accuracy of determinations and redeterminations to protect program integrity. Processes are established for individuals with significant changes in income to inform the Commissioner of such change. There are penalties for misrepresentation of income. The Secretary of Health and Human Services is required to conduct a study examining the feasibility and implication of adjusting the application of the federal poverty level for different geographic areas so as to reflect the variations in the cost-of-living among various areas in the country.

Sec. 347. No Federal payment for undocumented aliens. Prohibits anyone not lawfully present in the United States from obtaining affordability credits.

TITLE IV—SHARED RESPONSIBILITY

SUBTITLE A – INDIVIDUAL RESPONSIBILITY

Sec. 401. Individual responsibility. Cross-references the shared responsibility provision in the Internal Revenue Code where an individual has the choice of maintaining acceptable coverage or paying a tax.

SUBTITLE B – EMPLOYER RESPONSIBILITY

PART 1—Health Coverage Participation Requirements

Sec. 411. Health coverage participation requirements. Provides the rules that apply to an employer that elects to provide health coverage (an "offering employer") in lieu of the payroll contribution that applies to a non-offering employer. An offering employer generally must offer all of its employees the option of selecting individual or family health coverage.

Sec. 412. Employer responsibility to contribute toward employee and dependent coverage. Provides that the minimum employer contribution in the case of an offering employer is 72.5% of the premium for individual coverage, and 65% of the premium for family coverage or a proportional amount for non-fulltime employees. Family coverage for this purpose includes the employee's spouse and qualifying children. Requires employers to provide for automatic enrollment of their employee into their employment-based health plan with the lowest applicable employee premium.

Sec. 413. Employer contributions in lieu of coverage. Requires an offering employer to contribute to the Exchange for each employee who declines the employer's coverage

offer and enters the Exchange via the affordability test outlined in the act. The contribution is generally 8% of the average salary for the employer. Small employers with annual payrolls at or below $500,000, are exempt from this requirement. The contribution phases up from 0-8% between an annual payroll of $500,000 and $750,00, at which point employers are subject to the full 8% contribution requirement.

Sec. 414. Authority related to improper steering. Authorizes the creation of rules that would prohibit employers from engaging in practices that steer employees away from employer-offered coverage and into coverage offered under the Exchange.

TITLE V—AMENDMENTS TO INTERNAL REVENUE CODE OF 1986

SUBTITLE A – PROVISIONS RELATING TO HEALTH CARE REFORM

PART 1—SHARED RESPONSIBILITY

Subpart A—Individual Responsibility

Sec. 501. Tax on individuals without acceptable health care coverage. Provides for a 2.5% additional tax on the modified adjusted gross income of an individual who does not obtain acceptable health coverage for the individual or dependents claimed on the individual's tax return. Authorizes the Department of Treasury and the Exchange to establish a hardship exemption from the additional tax. Acceptable coverage includes grandfathered individual and employer coverage, certain government coverage (e.g., Medicare, Medicaid, certain coverage provided to veterans, military employees, retirees, and their families, and members of Indian tribes), and coverage obtained pursuant to the Exchange or an employer offer of coverage.

Subpart B—Employer Responsibility

Sec. 511. Election to satisfy health coverage participation requirements. Provides rules under which an employer makes an election to offer health coverage (an "offering employer") in lieu of the payroll tax that applies to a non-offering employer. This section also provides for an excise tax that applies to an offering employer if the employer fails to follow the rules governing an offer of coverage.

Sec. 512. Health care contributions of nonelecting employers. Establishes a payroll tax of 8% of the wages that an employer pays to its employees for employers who choose not to offer coverage. Certain small employers are exempt from this or are subject to a graduated tax rate. An exempt small business is an employer with an annual payroll that does not exceed $500,000. The 8% payroll tax phases in for employers with annual payroll from $500,000 through $750,000.

PART 2—CREDIT FOR SMALL BUSINESS EMPLOYEE HEALTH COVERAGE EXPENSES

Sec. 521. Credit for small business employee health coverage expenses. Provides for a tax credit equal to 50% of the amount paid by a small employer for employee health

coverage. The tax credit is phased out in the case of an employer with 10 to 25 employees, and is also phased out in the case of an employer with average wages of $20,000 to $40,000 per year. An employer may elect to use the credit for a maximum of 2 taxable years.

SUBTITLE B – OTHER REVENUE PROVISIONS

PART 1—GENERAL PROVISIONS

Sec. 551. Surcharge on high income individuals. Establishes a 5.4 percent tax on modified adjusted gross income in excess of $1 million in the case of a joint return ($500,000 in the case of other returns). The tax is estimated to affect only 0.3 percent of all households and only 1.2 percent of sole proprietors, partners, and s-corporation shareholders operating a business.

Sec. 552. Excise tax on medical devices. Establishes a 2.5 percent excise tax on medical devices sold for use in the U.S. The excise tax does not apply to exported devices and does not apply to retail sales of devices.

DIVISION B— MEDICARE AND MEDICAID IMPROVEMENTS

TITLE I—IMPROVING HEALTH CARE VALUE

SUBTITLE B—PROVISIONS RELATED TO PART B

PART 1—Physicians' Services

Sec. 1124. Modifications to the Physician Quality Reporting Initiative (PQRI). Extends through 2012 payments under the PQRI program, which provide incentives to physicians (and other professionals, including CNMs) who report quality data to Medicare. Creates a review process for physicians who choose to have their PQRI submissions reviewed and directs the Secretary to integrate the PQRI program and the "meaningful use" measures used by the health information technology incentive program.

SUBTITLE E – IMPROVEMENTS TO MEDICARE PART D

Sec. 1181. Elimination of coverage gap. Eliminates Part D donut hole, beginning with a $500 reduction in 2010, and completing phase-out by 2019. Pays for the elimination of the gap with funds raised by requiring drug manufacturers to provide Medicaid rebates for drugs used by full dual eligible and low-income subsidy recipients.

Sec. 1182. Discounts for certain Part D drugs in original coverage gap. Incorporates voluntary PhRMA agreement to provide discounts of 50% for brand-name drugs used by Part D enrollees in the Part D donut hole, beginning in 2010.

TITLE II – MEDICARE BENEFICIARY IMPROVEMENTS

SUBTITLE B – REDUCING HEALTH DISPARITIES

Sec. 1221. Ensuring effective communication in Medicare. Requires the Secretary of HHS to conduct a study that examines the extent to which Medicare providers utilize, offer or make available language services for beneficiaries who are limited English proficient and ways that Medicare should develop payment systems for language services.

Sec. 1222. Demonstration to promote access for Medicare beneficiaries with limited English proficiency by providing reimbursement for culturally and linguistically appropriate services. Instructs the Secretary to carry out a demonstration program to reimburse Medicare providers, in multiple provider settings, for the provision of language services. Requires the Secretary to evaluate the demonstration program and make recommendations on the expansion of such services to the entire Medicare program.

Sec. 1223. Institute of Medicine report on impact of language access services. Requires the Secretary to contract with the Institute of Medicine to conduct a study that examines the impact on the quality f care, access to care, the reduction in medical errors and costs or savings associated with the provision of language access services to limited English proficient populations.

SUBTITLE C—MISCELLANEOUS IMPROVEMENTS

TITLE III—PROMOTING PRIMARY CARE, MENTAL HEALTH SERVICES, AND COORDINATED CARE

Sec. 1301. Accountable Care Organization pilot program. Creates an alternative payment model within fee-for-service Medicare to reward physician-led organizations that take responsibility for the costs and quality of care received by their patient panel over time. Accountable Care Organizations (ACOs) can include groups of physicians organized around a common delivery system (including a hospital), an independent practice association, a group practice, or other common practice organizations.

ACOs that reduce the costs of their patients relative to a spending benchmark are rewarded with a share of the programmatic savings, conditional on meeting quality targets as well. CMS may allow ACOs to continue operating so long as they are reducing costs while maintaining quality or improving quality while maintaining costs.

Sec. 1302. Medical home pilot program. An expansion and reorientation of the medical home demo in Medicare. Establishes a medical home pilot program to assess the feasibility of reimbursing for qualified patient-centered medical homes. There are two models in the provision: 1) the *independent patient-centered medical home*, structured around a provider, is targeted at the top half of high-need Medicare beneficiaries with multiple chronic diseases, and 2) the *community based medical home*, which may include any eligible beneficiary, is targeted at a broader population of Medicare

beneficiaries and allows for State-based or non-profit entities to provide care-management supervised by a beneficiary designated primary care provider. Provides approximately $1.8 billion for the pilot programs. The Secretary is authorized to expand the program only if quality measures have been met and budget neutrality is demonstrate.

Sec. 1303. Payment incentive for selected primary care services. Increases the Medicare payment rate by 5% for primary care services of physicians specializing in primary care. Physicians specializing in primary care are defined both by specialty (e.g., family practitioners, internists, and others) and by share of a practice in primary care (at least 50% of allowed charges are for primary care services). Eligible practitioners (including certified nurse-midwives) practicing in health professions shortage areas receive an additional 5%.

Sec. 1304. Increased reimbursement rate for certified nurse-midwives. Increases the payment rate for nurse midwives for covered services from 65% of the rate that would be paid were a physician performing a service to the full rate.

Sec. 1305. Coverage and waiver of cost-sharing for preventive services. Waives all Medicare cost sharing (both co-insurance and deductibles) for preventive services.

Sec. 1310. Expanding access to vaccines. Transfers coverage from Medicare Part D to Medicare Part B for all Medicare-covered vaccines. Vaccines but for influenza will be paid for according to the average sales price methodology.

Sec. 1311. Expansion of Medicare-Covered Preventive Services at Federally Qualified Health Centers. Expands Medicare reimbursements for preventive services furnished by federally qualified health centers.

Sec. 1312. Independence at Home Demonstration Program. Creates a new demonstration program for chronically ill Medicare beneficiaries to test a payment incentive and service deliver system that utilizes physician and nurse practitioner directed home-based primary care teams aimed at reducing expenditures and improving health outcomes.

TITLE IV—QUALITY

SUBTITLE A—COMPARATIVE EFFECTIVENESS RESEARCH

Sec. 1401. Comparative Effectiveness Research (CER). Creates a new Center at the Agency for Healthcare Research and Quality, supported by a combination of public and private funding that will conduct, support and synthesize CER. Establishes an independent stakeholder commission which recommends to the Center research priorities, study methods, and ways to disseminate research. The commission would have its own source of funding and also be responsible for evaluating the processes of the center and authorized to make reports directly to Congress. A majority of the Commission members would be required to be physicians, other health care practitioners, consumers or patients. Contains protections to ensure that subpopulations are appropriately accounted

for in research study design and dissemination protections to prevent the Center and Commission from mandating payment, coverage or reimbursement policies; protections to ensure that research findings are not construed to mandate coverage, reimbursement or other policies to any public or private payer, and clarify that federal officers and employees will not interfere in the practice of medicine.

SUBTITLE C—QUALITY MEASUREMENTS

Sec. 1441. Establishment of national priorities for quality improvement. Directs the Secretary to establish national priorities for performance improvement, incorporating recommendations from outside entities. These priorities should reflect areas that contribute to a large burden of disease, have high potential to decrease morbidity and mortality and improve performance, address health disparities, and have the potential to produce the most rapid change based on current evidence.

Sec. 1442. Development of new quality measures; GAO evaluation of data collection process for quality measurement. Based on the national priorities for performance improvement established in this part, the Secretary shall develop, test and update new patient-centered and population-based quality measures for the assessment of health care services. Provides $25 million for this section. Instructs GAO to periodically evaluate the program to determine the effectiveness of the quality measures and the extent to which these measures can result in quality improvement and cost savings, and report to Congress.

Sec. 1443. Multi-stakeholder pre-rulemaking input into selection of quality measures. Provides for stakeholder input into the use of quality measures for purposes of payment. Each year, the Secretary shall make public a list of measures being considered for usage for payment systems. Under a transparent process, a consensus-based entity shall convene a multi-stakeholder group to provide recommendations for the usage of measures in a timely fashion, and the Secretary shall consider these recommendations.

Sec. 1444. Application of quality measures. Ensures that quality measures selected by the Secretary are endorsed by a consensus-based entity with a contract with the Secretary under section 1890, except in certain circumstances, e.g., the measure has not been evaluated and no comparable endorsed measure exists. If the Secretary chooses to use a measure that the entity considers but does not endorse, the Secretary shall include the rationale for continued use in rulemaking. Applies this standard to inpatient hospitals, physician services, and renal dialysis services.

SUBTITLE D—PHYSICIAN PAYMENTS SUNSHINE PROVISION

Sec. 1451. Reports on financial relationships between manufacturers and distributors of covered drugs, devices, biologicals, or medical supplies under Medicare, Medicaid, or CHIP and physicians and other health care entities and between physicians and other health care entities. Requires manufacturers or distributors to electronically report to the HHS OIG any payments or other transfers of value above a $5 de minimis made to a "covered recipient" and requires hospitals, manufacturers, distributors, and group purchasing organizations to report any ownership share by a physician. Failure to report

is subject to civil monetary penalties from $1000 to $10,000 (max $150,000 per year) per payment, transfer of value, or investment interest not disclosed; penalties for knowing failure to report range from $10,000 to $100,000 per payment, not to exceed $1,000,000 in one year or .1% of revenues for that year.

TITLE VII—MEDICAID AND CHIP

SUBTITLE A—MEDICAID AND HEALTH REFORM

Sec. 1701. Eligibility for individuals with income below 150 percent of the Federal poverty level.

(a) Requires State Medicaid programs to cover non-disabled, childless adults under age 65 not eligible for Medicare with incomes at or below 150% of FPL ($16,200 per year for an individual). The federal government would pay 100% of the costs of Medicaid coverage for this population in 2013 and 2014, then 91% in 2015 and beyond.

(b) Requires State Medicaid programs to cover children, parents, and individuals with disabilities under age 65 with income at or below 150% of FPL ($33,100 per year for a family of 4). For individuals in these categories with incomes between the levels in effect in the state as of June 16, 2009 and 150% of FPL, the federal government would pay 100% of the costs of Medicaid coverage in 2013 and 2014 and 91% in 2015 and beyond.

(c) Requires State Medicaid programs to cover newborns up to the first 60 days of life who do not otherwise have coverage upon birth. The federal government would pay 100% of the costs of Medicaid coverage for these newborns.

SUBTITLE B — PREVENTION

Sec. 1711. Required coverage of preventive services. Requires State Medicaid programs to cover, without cost-sharing, preventive services that are recommended by the U.S. Preventive Services Task Force and appropriate for Medicaid beneficiaries.

Sec. 1712. Tobacco cessation. Prohibits State Medicaid programs from excluding tobacco cessation products from coverage.

Sec. 1713. Optional coverage of nurse home visitation services. Allows State Medicaid programs to cover home visits by trained nurses to families with a first-time pregnant woman or child under 2 eligible for Medicaid.

Sec. 1714. State eligibility option for family planning services. Allows State Medicaid programs to cover low-income women who are not pregnant for family planning services and supplies without obtaining a waiver. Allows State Medicaid programs to cover such services for such women during a presumptive eligibility period.

SUBTITLE C — ACCESS

Sec. 1721. Payments to primary care practitioners. Requires that State Medicaid programs reimburse for primary care services furnished by physicians and other practitioners (including certified nurse-midwives) at no less than 80% of Medicare rates in

2010, 90% in 2011, and 100% in 2012 and after. Maintains the Medicare payment differentials between physicians and other practitioners. The federal government would pay 100% of the incremental costs attributable to this requirement through 2014, then 90% in 2015 and beyond.

Sec. 1722. Medical home pilot program. Establishes a 5-year pilot program to test the medical home concept with Medicaid beneficiaries including medically fragile children and high-risk pregnant women. The federal government would match costs of community care workers at 90% for the first two years and 75% for the next 3 years, up to a total of $1.235 billion.

Sec. 1724. Optional coverage for freestanding birth center services. Allows State Medicaid programs to cover services provided by birth centers that are not hospitals.

Sec. 1728. Assuring adequate payment levels for services. Requires State Medicaid programs to submit annually to the Secretary payment rates to be used to reimburse providers for furnishing covered services and directs the Secretary to review such rates for sufficiency.

Sec. 1730. Quality measures for maternity and adult health services under Medicaid and CHIP. Appropriates $40 million for 2010-2015 for the Secretary to develop a set of measures for the quality of maternity care and other adult care provided under Medicaid and CHIP, and to develop a standardized format for reporting such quality measures for use by the states.

Sec. 1730A. Accountable care organization pilot program. Directs the Secretary to establish a program to allow State Medicaid programs to pilot one or more of the models used in the Medicare ACO pilot program established by section 1301 of the bill. Administrative costs would be matched at 90% in the first two years of a pilot project, 75% in the last three.

Sec. 1907. Establishment of Center for Medicare and Medicaid Innovation within CMS. Establishes within the Centers for Medicare and Medicaid Services a Center for Medicare & Medicaid Innovation. The purpose of the Center will be to research, develop, test, and expand innovative payment and delivery arrangements to improve the quality and reduce the cost of care provided to patient in each program. Dedicated funding is provided to allow for testing of models that require benefits not currently covered by Medicare. Successful models can be expanded within both programs.

DIVISION C – PUBLIC HEALTH AND WORKFORCE DEVELOPMENT

Sec. 2002. Public health investment fund. Establishes the Public Health Investment Fund and deposits a total of $34 billion for use over the next five years (FY 2011 – FY 2015). These funds are authorized to be appropriated by the Committee on Appropriations for activities in this Division (described below) and are over and above the level of appropriations provided for these activities for FY 2008.

TITLE I – COMMUNITY HEALTH CENTERS

Sec. 2101. Increased funding. Authorizes an additional $12 billion over the next five years (FY 2011 – FY 2015) for community health centers to be appropriated from the Public Health Investment Fund (under Sec. 2002). Such funds are over and above the level of appropriations provided for FY 2008.

TITLE II – WORKFORCE

SUBTITLE A – PRIMARY CARE WORKFORCE

PART 1 – National Health Service Corps

Sec. 2201. National Health Service Corps. Increases loan repayment benefits for each Corps member to a maximum of $50,000 per year. Allows fulfillment of Corps service obligation through part-time service as well as through clinical teaching (for up to 20% of the period of obligated service).

Sec. 2202. Authorization of appropriations. Authorizes an additional $1.8 billion over the next five years (FY 2011 – FY 2015) for the National Health Service Corps to be appropriated from the Public Health Investment Fund (under Sec. 2002). Such sums are over and above the level of appropriations provided for FY 2008.

PART 2 – Promotion of Primary Care and Dentistry

Sec. 2211. Frontline Health Providers. Establishes a loan repayment program to address health care needs in geographic areas ("health professional needs areas") not currently recognized as health professional shortage areas. Eligible providers include those who qualify to participate in the National Health Service Corps as well as other categories f physicians and health professionals.

SUBTITLE B – NURSING WORKFORCE

Sec. 2221. Amendments to Public Health Service Act. Makes a number of improvements in nursing programs, including increasing loan repayment benefits for nursing students and faculty; removing the cap on awards for nursing students pursuing a doctoral degree; and clarifying that nurse-managed health centers are eligible for grant awards. Authorizes an additional $638 million over the next five years (FY 2011 – FY 2015) for various nursing programs to be appropriated from the Public Health Investment Fund (under Sec. 2002). Such funds are over and above the level of appropriations provided for FY 2008.

SUBTITLE C – PUBLIC HEALTH WORKFORCE

Sec. 2231. Public Health Workforce Corps. Establishes a Public Health Workforce Corps to address public health workforce shortages. Modeled on the National Health Service Corps, the program provides scholarship and loan repayment support for public health professionals serving in areas of need.

Sec. 2232. Enhancing the public health workforce. Provides funding to support public health training programs.

Sec. 2233. Public health training centers. Revises the goals for the public health training grant programs to comport with the Secretary's new national prevention and wellness strategy (under Sec. 3121).

Sec. 2235. Authorization of appropriations. Authorizes an additional $283 million over the next five years (FY 2011 – FY 2015) for various public health workforce programs to be appropriated from the Public Health Investment Fund (under Sec. 2002). Such funds are over and above the level of appropriations provided for FY 2008.

SUBTITLE D – ADAPTING WORKFORCE TO EVOLVING HEALTH SYSTEM NEEDS

PART 1 – Health Professions Training for Diversity

Sec. 2241. Scholarships for disadvantaged students, loan repayments and fellowships regarding faculty positions, and educational assistance in the health professions regarding individuals from disadvantaged backgrounds. Provides scholarship and loan repayment support for individuals from disadvantaged backgrounds serving in the health professions. Provides funding for the Health Careers Opportunities Program that supports health professions schools that recruit and train individuals from disadvantaged backgrounds.

Sec. 2242. Nursing workforce diversity grants. Clarifies requirements for the Secretary to consult with various nursing associations.

Sec. 2243. Coordination of diversity and cultural competency programs. Requires the Secretary to coordinate workforce diversity and cultural and linguistic competency activities to enhance effectiveness and avoid duplication of effort.

PART 2 – Interdisciplinary Training Programs

Sec. 2251. Cultural and linguistic competence training for health professionals. Establishes a new program to promote cultural and linguistic competence among health care professionals.

Sec. 2252. Innovations in interdisciplinary care training. Establishes a new program to support the development and operation of interdisciplinary training programs for health professionals to improve coordination within and across health care settings, including training in medical home models and models that integrate physical, mental, or oral health services.

PART 3 – Advisory Committee on Health Workforce Evaluation and Assessment

Sec. 2261. Health workforce evaluation and assessment. Creates an Advisory Committee on Health Workforce Evaluation and Assessment to assess the adequacy and

appropriateness of the nation's health workforce, and to make recommendations to the Secretary on federal workforce policies to ensure that such workforce is meeting the nations needs.

PART 4 – Health Workforce Assessment

Sec. 2271. Health workforce assessment. Requires the Secretary to collect data on the supply, diversity, and geographic distribution of the Nation's health workforce, including individuals participating in various federal workforce programs.

PART 5 – Authorization of Appropriations

Sec. 2281. Authorization of appropriations. Authorizes an additional $1.0 billion over the next five years (FY 2011 – FY 2015) for various workforce programs (including Centers of Excellence) to be appropriated from the Public Health Investment Fund (under section 2002). (Such funds are over and above the level of appropriations provided in FY 2008.)

TITLE III – PREVENTION AND WELLNESS

Sec. 2301. Prevention and wellness. Amends the Public Health Service Act (PHSA) to establish a new Title XXXI that includes 11 new PHSA sections – Sec. 3111, 3121, 3131, 3132, 3141, 3142, 3143, 3151, 3161, 3162, and 3171 (described below).

SUBTITLE A – PREVENTION AND WELLNESS TRUST

Sec. 3111. Prevention and wellness trust. Establishes a Prevention and Wellness Trust that authorizes appropriations from the Public Health Investment Fund (under Sec. 2002) of $15.4 billion over the next five years (FY 2011 – FY 2015) to fund activities under Subtitle C (Prevention Task Forces), Subtitle D (Prevention and Wellness Research), Subtitle E (Delivery of Community-Based Prevention and Wellness Services) and Subtitle F (Core Public Health Infrastructure and Activities) of new PHSA Title XXXI.

SUBTITLE B – NATIONAL PREVENTION AND WELLNESS STRATEGY

Sec. 3121. National prevention and wellness strategy. Requires the Secretary to develop and periodically update a national strategy designed to improve the nation's health through evidence-based clinical and community-based prevention and wellness activities.

SUBTITLE C – PREVENTION TASK FORCES

Sec. 3131. Task Force on Clinical Preventive Services. Converts the existing U.S. Preventive Services Task Force into the Task Force on Clinical Preventive Services. The charge to the Task Force is to conduct evidence-based systemic reviews of data and literature to determine which clinical preventive services (*i.e.*, preventive services delivered by traditional health care providers in clinical settings) are scientifically proven to be effective.

Sec. 3132. Task Force on Community Preventive Services. Codifies the existing Task Force on Community Preventive Services. The charge to the Task Force is to conduct evidence-based systematic reviews of data and literature to determine which community preventive services (*i.e.*, preventive services that are delivered outside traditional clinical settings and frequently implemented across targeted groups are scientifically proven to be effective.

SUBTITLE D—PREVENTION AND WELLNESS RESEARCH

Sec. 3141. Prevention and wellness research activity coordination. Directs the CDC and NIH directors to take into consideration the national strategy on prevention (under Sec. 3121), recommendations from the Task Force on Clinical Preventive Services (under Sec. 3131), and recommendations from the Task Force on Community Preventive Services (under Sec. 3132) in conducting or supporting research on prevention and wellness.

Sec. 3142. Community prevention and wellness research grants. Provides support for CDC research on community preventive services.

Sec. 3143. Research on subsidies and rewards to encourage wellness and healthy behaviors. Provides support for research on incentivizing proven healthy behaviors and for the inclusion of effective incentive programs in the essential benefits package or in community prevention and wellness programs.

SUBTITLE E – DELIVERY OF COMMUNITY PREVENTION AND WELLNESS SERVICES

Sec. 3151. Community prevention and wellness services grants. Establishes a grant program to support the delivery of evidence-based, community-based prevention and wellness services across the country. Eligible entities include state and local governments, nonprofits, and consortia such as community partnerships representing Health Empowerment Zones. At least 50% of grant funds must be spent on implementing services whose primary purpose is to reduce health disparities.

SUBTITLE F – CORE PUBLIC HEALTH INFRASTRUCTURE

Sec. 3161. Core public health infrastructure for State, local, and tribal health departments. Establishes a grant program at CDC to improve core public health infrastructure at the state, local, and tribal level. Includes formula grants to state health departments and competitive grants for state, local or tribal health departments. Establishes a public health accreditation program for public health departments and laboratories.

Sec. 3162. Core public health infrastructure and activities for CDC. Provides support for CDC to address unmet and emerging public health needs.

SUBTITLE G—GENERAL PROVISIONS

Sec. 3171. Definitions. Defines various terms for the purposes of PHSA Title XXXI. Provides for transitioning the existing U.S. Preventive Services Task Force into the new Task Force on Clinical Preventive Services and for transitioning the existing Task Force on Community Preventive Services into the new Task Force on Community Preventive Services.

TITLE IV—QUALITY AND SURVEILLANCE

Sec. 2401. Implementation of best practices in the delivery of health care. Creates a Center for Quality Improvement to identify, develop, evaluate and help implement best practices.

Sec. 2403. Authorization of appropriations. Authorizes an additional $1.5 billion over the next five years (FY 2011 – FY 2015) for quality improvement and data-related activities to be appropriated from the Public Health Investment Fund (under Sec. 2002). Such funds are over and above the level of appropriations provided for FY 2008.

TITLE V – OTHER PROVISIONS

SUBTITLE B – PROGRAMS

PART 1 – Grants for Clinics and Centers

Sec. 2511. School-based health clinics. Establishes a new program to support school-based health clinics that provide health services to children and adolescents. Authorizes $50 million for FY 2011 and such sums as may be necessary for each of FY 2012 through FY 2015 to carry out this program.

Sec. 2512. Nurse-managed health centers. Establishes a new program to support nurse-managed health centers (centers operated by advanced practice nurses that provide comprehensive primary care and wellness services to underserved or vulnerable populations). Authorizes such sums as may be necessary for each of FY 2011 through FY 2015 to carry out this program.

PART 2 – Other Grant Programs

Sec. 2521. Comprehensive programs to provide education to nurses and create a pipeline to nursing. Establishes a new program at the Department of Labor to address projected nurse shortages; to increase the capacity for educating nurses; and to support training programs. Authorizes such sums as may be necessary for each of FY 2011 through FY 2015 to carry out this program.

Sec. 2523. Reauthorization of telehealth and telemedicine grant programs. Reauthorizes programs to support telehealth networks and telehealth resource centers and to provide incentives to coordinate telemedicine licensure activities among states. Authorizes $10

million for FY 2011 and such sums as may be necessary for each of FY 2012 through FY 2015 to carry out each of the three programs.

Sec. 2525. Extension of Wisewoman Program. Reauthorizes the NIH Wisewoman ("Well-Integrated Screening and Evaluation for Women Across the Nation") Program and removes the three-state limitation on state participation in the program. Wisewoman consists of demonstration projects to provide preventive health (and appropriate follow-up) services to women. Authorizes $70 million for FY 2011; $73 million for FY 2012; $77 million for FY 2013; $81 million for FY 2014; and $85 million for FY 2015 to carry out this program.

Sec. 2526. Healthy teen initiative to prevent teen pregnancy. Establishes a new program for states to provide evidence-based education to reduce teen pregnancy or sexually transmitted infections. Permits states to work with public or private nonprofit organizations, including schools and community-based and faith-based organizations. Authorizes $50 million for each of FY 2011 through FY 2015 to carry out this program.

Sec. 2529. Postpartum depression. Encourages the Secretary to expand and intensify activities on postpartum conditions, including research, epidemiological studies, the development of improved screening and diagnostic techniques, and information and education programs. Requires the Secretary to conduct a study on the benefits of screening for postpartum conditions. Expresses the sense of Congress that the Director of the National Institute of Mental Health may conduct a nationally representative longitudinal study on the relative mental health consequences for women of resolving a pregnancy (intended and unintended) in various ways. Authorizes such sums as may be necessary for each of FY 2011 through FY 2013 to carry out these activities.

Sec. 2530. Grants to promote positive health behaviors and outcomes. Establishes a new training program for community heath workers to promote positive health behaviors (e.g., improved nutrition, decreased tobacco use) among populations in medically underserved areas. Authorizes $30 million for each of FY 2011 through FY 2015 to carry out this program.

Sec. 2531. Medical liability alternatives. Establishes an incentive program for States to adopt and implement alternatives (certificate of merit or "early offer") as alternatives to traditional medical malpractice litigation. Such alternatives may not include provisions that limit attorneys' fees or impose caps on damages. Authorizes such sums as may be necessary to carry out this program.

Sec. 2532. Infant mortality pilot programs. Establishes a new program to support pilot projects designed to reduce infant mortality. Authorizes $10 million for each of FY 2011 through FY 2015 to carry out this program.

Sec. 2533. Secondary school health sciences training program. Establishes a new program to support health sciences curricula in public secondary schools, including middle schools, to prepare students for careers in health professions. Authorizes such sums as may be necessary for each of FY 2011 through FY 2015 to carry out this program.

Sec. 2534. Community-based collaborative care networks. Establishes a new program to support community-based collaborative care networks, a consortium of health care providers offering coordinated and integrated health care services for low-income patient populations or medically-underserved communities. Authorizes such sums as may be necessary for each of FY 2011 through FY 2015 to carry out this program.

Sec. 2535. Community-based overweight and obesity prevention program. Establishes a new program to prevent overweight and obesity among children through improved nutrition and increased physical activity. Authorizes $10 million for FY 2011 and such sums as may be necessary for each of FY 2012 through FY 2015 to carry out this program.

Sec. 2537. Medical-legal partnerships. Establishes a nationwide demonstration program to evaluate the effectiveness of medical-legal partnerships in assisting patients and their families in navigating health-related programs and activities. Authorizes such sums as may be necessary for each of FY 2011 through FY 2015 to carry out this program.

PART 4 – Pain Care and Management Programs

Sec. 2561. Institute of Medicine Conference on Pain. Requires the Secretary to seek to enter into an agreement with the Institute of Medicine of the National Academies to convene a Conference on Pain. Authorizes $500,000 for each of FY 2011 and FY 2012 to carry out the conference.

Sec. 2562. Pain research at National Institutes of Health. Encourages the NIH Director to continue and expand, through the Pain Consortium, a program of basic and clinical research on pain, including research on the treatment of pain.

Sec. 2563. Public awareness campaign on pain management. Requires the Secretary to establish and implement a national education outreach and awareness campaign on pain management. Authorizes $2 million for FY 2011 and $4 million for each of FY 2012 through FY 2015 to carry out the campaign.

SUBTITLE E – MISCELLANEOUS

Sec. 2586. Health centers under Public Health Service Act; liability protections for volunteer practitioners. Extends medical malpractice liability protection currently available for employees or licensed or certified health professionals under contract with a community health centers to volunteer practitioners providing uncompensated services at such centers.

Sec. 2588. Office of Women's Health. Codifies the HHS Office of Women's Health and within the director's office of each of the following HHS agencies: Agency for Health Research and Quality, Centers for Disease Control and Prevention, Food and Drug Administration, Health Resources and Services Administration, and Substance Abuse and Mental Health Services Administration.

Sec. 2591. Online health workforce training programs. Establishes a new program for the Secretary of Labor to support online training of health care workers. Authorizes $50 million for each of FY 2011 through FY 2020 to carry out this program.

DIVISION D— INDIAN HEALTH

TITLE I—INDIAN HEALTH, HUMAN RESOURCES, AND DEVELOPMENT

Sec. 101. Purpose. States that the purpose of IHCIA Title I is to increase the number of Indian health professionals, to the maximum extent feasible, and to assure an optimum supply of health professionals for IHS, tribal, and urban Indian health care entities.

Sec. 102. Health Professions Recruitment Program for Indians. Authorizes grants to tribes, tribal organizations, urban Indian organizations, and public and nonprofit entities for recruitment of Indians into health professions.

Sec. 103. Health Professions Preparatory Scholarship Program for Indians. Authorizes scholarships to Indians for compensatory pre-professional education as well as pre-graduate education leading to a baccalaureate degree in a preparatory field for a health profession.

Sec. 104. Indian Health Professions Scholarships. Authorizes scholarships to Indians enrolled full- or part-time in accredited schools pursuing courses of study in the health professions, in accordance with Sec. 338A of the Public Health Service Act (42 U.S.C. 254l).

Sec. 106. Scholarship Programs for Indian Tribes. Directs the Secretary to make grants to tribes and tribal organizations for scholarships to educate Indians to serve as health professionals in Indian communities.

Sec. 107. Indian Health Service Extern Programs. Authorizes an extern program for enrollees in health professions recruitment programs under Sec. 102(a), including high school programs.

Sec. 108. Continuing Education Allowances. Authorizes the Secretary to provide programs or allowances for individuals to transition into Indian Health Programs. This section also authorizes programs and allowances for IHS and tribal health professionals to take leave of their duty for professional consultation and for refresher training, professional management, and leadership training courses.

Sec. 109. Community Health Representative Program. Directs the Secretary to establish through IHS, tribes, and tribal organizations a program of health paraprofessionals, called Community Health Representatives (CHRs), to provide health care, health promotion, and disease prevention services in Indian communities.

Sec. 110. Indian Health Service Loan Repayment Program. Directs the Secretary to establish a loan repayment program for health professionals who contract to work for a

specified tie for, or are already employed by, Indian Health Programs or urban Indian health programs.

Sec. 111. Scholarship and Loan Repayment Recovery Fund. Establishes a fund, consisting of such amounts collected from contract breaches under Sections 104, 106, and 110, plus any appropriation to the Fund and interest. The fund will be used to finance scholarships, recruitment efforts and to employ health professionals.

Sec. 113. Indian Recruitment and Retention Program. Requires the Secretary to fund, on a competitive basis, demonstration projects to enable Indian Health Programs and urban Indian organizations to recruit, place, and retain health professionals to meet their staffing needs.

Sec. 114. Advanced Training and Research. Directs the Secretary to establish a program to enable health professionals who have worked for an IHS, tribal, or urban Indian health program for a substantial period of time to pursue advanced training or research in areas of study where the Secretary determines a need exists.

Sec. 115. Quentin N. Burdick American Indians Into Nursing Program. Requires the Secretary to make grants to nursing schools, tribally-controlled, community and vocational colleges, and nurse- midwife and advanced practice nurse programs to increase the number of nurses serving Indians, through scholarships, recruitment, continuing education or other programs encouraging nursing services to American Indians .

Sect.116. Tribal Cultural Orientation. Requires the Secretary to establish a mandatory training program, for appropriate IHS employees serving tribes in each IHS Area, in the history and culture of the tribes they serve and the tribes' relationship to IHS.

Sec. 117. Indians Into Medicine Program. Authorizes the Secretary to provide grants to colleges and universities to maintain and expand the Indians Into Medicine Program (INMED).

Sec. 118. Health Training Programs of Community Colleges. Requires the Secretary to award grants to accredited and accessible community colleges to assist in establishing health profession education programs leading to a degree or diploma for individuals desiring to practice on or near an Indian reservation or in an Indian Health Program.

Sec. 119. Retention Bonus. Authorizes the Secretary to pay retention bonuses to any health professional employed by an IHS or tribal or urban Indian health program who agrees to continue their current employment for not less than one year.

Sec. 120. Nursing Residency Program. Requires the Secretary to establish a program to enable Indians who are licensed practical nurses, licensed vocational nurses, and registered nurses working for an Indian Health Program or urban Indian health program for at least 1 year to pursue advanced training in a residency program.

Sec. 123. Health Professional Chronic Shortage Demonstration Programs. Authorizes the Secretary to fund demonstration programs for Tribal Health Programs to address chronic shortages in health professionals.

Sec.124. National Health Service Corps. Prohibits the Secretary from removing a member of the National Health Service Corps from an IHS or tribal or urban Indian heath program, or withdrawing funding to support such member, unless the Secretary ensures that Indians will experience no reduction in services.

TITLE II—HEALTH SERVICES

Sec. 213. Indian Women's Health Care. Requires the Secretary, acting through IHS, to monitor and improve the quality of Indian women's health care delivered through programs administered by IHS.

Source: U.S. House of Representatives, Committee on Energy & Commerce, Committee on Education & Labor, Committee on Ways and Means.