EMPOWERING PATIENTS FIRST ACT

A Solution from Representative Tom Price (GA-06) for Access to Affordable, Quality Health Care for All Americans

Sec. 2. Repeal of PPACA and Health Care-Related HCERA Provisions

- Provides for a full repeal of ObamaCare and all health care-related provisions included in the Health Care and Education Reconciliation Act

Title I – Tax Incentives for Maintaining Health Insurance Coverage

Sec. 101. Refundable Tax Credit for Health Insurance Costs of Low-Income Individuals

- Refundable credit: amount tied to average insurance on individual market adjusted for inflation ($2,613 for individuals/$5,799 for families[1]).
  - $2,000 for an individual
  - $4,000 in the case of a joint return
  - $500 for each additional dependent
  - $5,000 is the maximum amount receivable
- Individual taxpayers earning up to 200% Federal Poverty Level (FPL) receive a full credit, while those between 200% and 300% FPL receive the credit on a sliding scale starting at 100%, and reduced by one percentage point for each $1,000 by the taxpayer's adjusted gross income.
- Defines qualified health insurance (in order to qualify for a tax credit) as any insurance that constitutes medical care (i.e., major medical, qualified coverage in the state of purchase) but does not include excepted benefits as defined in section 9832(c) of the Internal Revenue Code (IRC) such as wrap around, vision-only or disease specific plans.
- The credit is not available to those receiving federal or other benefits including:
  - Medicare, Medicaid, S-CHIP, TRICARE, VA benefits, FEHBP, individuals in employer subsidized group plans, or individuals receiving a deduction for health insurance under Section 103 of this legislation.
- Prohibits an individual who is not a citizen or lawful permanent resident from receiving a credit.
- Recapture provisions for over-accreditation. This mirrors the TAA and PBGC steelworkers advanced credit.
- Provision to make sure it is only one benefit and there is no extra payout, double benefit rule.

Sec. 102. Advance Payment of Credit as Premium Payment for Qualified Health Insurance

- Provides procedures for the advance payment to be sent to the insurer or issuer for the plan of the individuals choosing.

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[1] Center for Policy and Research, *America's Health Insurance Plans, Individual Health Insurance 2006-2007: A Comprehensive Survey of Premiums, Availability, and Benefits*, Page 4

- Standards of confidentiality are included to protect disclosure of individual's yearly earnings.
- Insurers and issuers are required to report to the Treasury to make sure people are receiving their health care and the dollars are being used effectively and efficiently.

Sec. 103. Election of Tax Credit Instead of Alternative Government or Group Plan Benefits

- Allows individuals to opt out of Medicare, Medicaid, TRICARE, and VA benefits and instead receive the tax credit to buy a private health insurance plan.
- Allows for an individual to opt out of Medicare without losing Social Security benefits (as dictated by current law).
- An individual enrolled in either an FEHBP or an employer subsidized group plan may opt out and instead receive a credit.

Sec. 104. Deduction for Qualified Health Insurance Costs of Individuals

- Allows anyone purchasing health insurance to do so with pre-tax dollars (who is not also taking a credit) through an above the line deduction to level the playing field for individuals purchasing health care in the individual market.
- Cap on the deduction up to the average value of the national health exclusion for employer-sponsored insurance (family/ singles) with an annual adjustment for inflation.

Sec. 105. Limitation on Abortion Funding

- Requires that no federal funds authorized under, or credits or deductions allowed under the Internal Revenue Code of 1986 by reason of, this bill may be used to pay for abortion (exceptions if the pregnancy endangers a women's life or was the result of rape or incest) or cover any part of the costs of any health plan that includes coverage of abortion.

Sec. 106. No Government Discrimination Against Certain Health Care Entities

- Prohibits the discrimination of any individual or health care entity that does not provide, cover, or pay for abortions, and allows for accommodations of the conscientious objection of a purchaser or health care provider when a procedure is contrary to the religious beliefs or moral convictions of such purchaser or provider.
- Provides for a private right of action where there is an actual or threatened violation of this section.

Sec. 107. Equal Employer Contribution Rule to Promote Choice

- Instead of an employer choosing health care coverage for its employees, the employer could elect to grant all employees the same pre-tax benefit through a monetary contribution. In turn, the employee could select their own plan whether it is staying with the current employer-sponsored plan or choosing an option from the individual market.
  - If the employer offers more than one plan/policy option, the "defined contribution" is the average amount of the plan options.
  - Applies to all employers and FEHBP.
- Under the "defined contribution" option, if an employee changes jobs, he could still

keep the same coverage.
- The individual moving to the individual market will not experience limitations on pre-existing conditions.
- Conforming amendment to exempt ERISA, IRC, and PHSA from HIPAA requirements for benefits provided under a defined contribution.

Sec. 108. Limitations on State Restrictions on Employer Auto-Enrollment
- States are prohibited from establishing laws that prevent employers from instituting auto-enrollment for health insurance, provided that the employee can opt out of coverage.

Sec. 109. Credit for Small Employers Adopting Auto-Enrollment and Defined Contribution Options
- Small businesses (50 employees and under) may receive grants up to $1,500 per qualified business for offsetting administrative burdens related to instituting an autoenrollment mechanism or a defined contribution.
  - The credit is available on a one time basis.
  - The ability to claim a credit will expire two years after date of enactment.

Sec. 110. HSA Modification and Clarification
- Clarification of treatment of capitated primary care payments as amounts paid for medical care:
  - HSA can be used for pre-paid physician fees, which could include payments for "concierge" or "direct practice" medicine.

Title II--Health Insurance Pooling Mechanisms for Individuals

Subtitle A--Safety Net for Individuals with Pre-Existing Conditions

Sec. 201. Requiring Operation of High-Risk Pools or Other Mechanisms as Condition for Availability of Tax Credit
- Assessments levied by a state for the purposes of funding high risk pools must only be used for funding and administering the high risk or reinsurance mechanism.
  - A state will only receive tax credits for individuals' purchase of qualified insurance if the state implements a high risk mechanism.
  - States who opt to have high risk/reinsurance pools must incorporate the credits into the pools.

Subtitle B—Federal Block Grants for State Insurance Expenditures

Sec. 211. Federal Block Grants for State Insurance Expenditures
- Each State shall receive block grants for the State providing for the use, in connection with providing health benefits coverage, of a high-risk pool, a reinsurance pool, or other risk-adjustment mechanism used for the purpose of subsidizing the purchase of private health insurance.
- Extends funding currently available under the PHSA (established in 2002 under the

TAA) to implement and run high-risk or reinsurance pools that guarantee coverage to those who are rejected by individual market insurers or who receive offers of coverage with premiums above a certain level.
  - Levels are set by the states, and usually, receiving a quote above the premium charged by the high risk pool would make an individual eligible.
  - States may use current funding to transition from a high-risk to reinsurance pool.
- Provides $300 million annually for new and on-going qualified pools to be divided among the states as determined by the Secretary of HHS.
- New annual funding may only go toward the following:
  - Current qualified high-risk and reinsurance pools that only cover "high-risk" populations as defined in this section. Individuals under the Health Care Tax Credit (TAA) for a limited time may be exempted as determined by the Secretary of HHS.
  - Pools created after date of enactment that offer:
    - High-Risk Pools
      - Cover only high-risk individuals (with same exemption)
      - Offer at least one option of a high deductable HSA plan
      - Offer multiple competing plan options
    - Reinsurance Pools
      - Cover only high-risk populations (with the aforementioned exemption)
      - Structures pool on a prospective basis (in order to encourage cost containment measures) under which a health insurance issuer cedes covered lives to the pool in exchange for payment of a reinsurance premium
- Bonus grants are awarded to states that provide:
  - Guaranteed issue to individuals with prior group coverage
  - A reduction in premium trends, actual premiums, or other cost-sharing requirements
  - An expansion or broadening of the pool of high-risk individuals eligible for coverage
  - Adoption of the NAIC Model Health Plan for Uninsurable Individuals Act
- Secretary may request the NAIC to review and update the NAIC Model Health Plan for Uninsurable Individuals Act (defined in the PSHA) as needed by 2011.

Subtitle C—Health Care Access and Availability

Sec. 221. Expansion of Access and Choice Through Individual Membership Associations (IMAs)

- Amends the Public Health Service Act to allow individuals to pool together to provide for health benefits coverage through Individual Membership Associations (IMAs), which are organizations (including churches, alumni associations, trade associations, and other civic groups) operated under the direction of an association that:
  - Has been in existence for at least five years
  - Was formed for purposes other than obtaining insurance
  - Does not condition membership on any health status-related factor

- Places limitations on health plan issuers including:
  - Nondiscrimination in coverage
  - Health benefits coverage requirements must comply with consumer protection requirements and be underwritten by a state licensed health issuer
- Allows IMAs to be exempted from state benefit mandates.
- Provides that the IMA shall provide health benefits coverage only through contracts with health insurance issuers and shall not assume insurance risk with respect to such coverage. Allows an IMA to provide administrative services for members, including accounting, billings, and enrollment information.

Subtitle D—Small Business Health Fairness

Sec. 231-236. Small Business Health Fairness Act (AHPs)

- AHPs allow small business owners to band together across state lines through their membership in a bona fide trade or professional association to purchase health coverage for their families and employees at a lower cost. Increases small businesses' bargaining power, volume discounts and administrative efficiencies while giving them freedom from state-mandated benefit packages.
- Requires solvency standards to protect patients' rights and ensure benefits are paid.
  - Requires AHPs to have an indemnified back-up plan in order to prevent unpaid claims in the event of plan termination.
  - Requires AHPs to undergo independent actuarial certification for financial soundness on a quarterly basis.
  - Requires AHPs to maintain surplus reserves of $2 million in addition to normal claims reserves.

Title III--Interstate Market for Health Insurance

Sec. 301. Cooperative Governing of Individual Health Insurance Coverage

- Increases access to individual health coverage by allowing insurers licensed to sell policies in one state to offer them to residents of any other state.
- Allows consumers to shop for health insurance across state lines just like they do for other insurance products – online, by mail, over the phone, or in consultation with an insurance agent in their hometown.
- Exempts issuers from any secondary state laws that would prohibit or regulate the operation of the issuer in such state, except that any such state may require such an issuer to regulate items such as consumer protections, applicable taxes, etc.
- Requires an issuer to comply with the guaranteed availability requirements under the Public Health Service Act if:
  - The issuer is offering coverage in a primary state that does not accommodate, or provide a working mechanism for, residents of a secondary state; and
  - The secondary state has not adopted a qualified high risk pool as its acceptable alternative mechanism.
- Prohibits an issuer from offering, selling, or issuing individual health insurance coverage in a secondary state:
  - If the state insurance commissioner does not use a risk-based capital formula for

the determination of capital and surplus requirements for all issuers.
    - Unless both the secondary and primary states have legislation or regulations in place establishing an independent review process for individuals who have individual health insurance coverage; or
    - The issuer provides an acceptable mechanism under which the review is conducted by an independent medical reviewer or panel.
- Sets forth criteria for qualification as an independent medical reviewer.
- Gives sole jurisdiction to the primary state to enforce the primary state's covered laws in the primary state and any secondary state.
- Allows the secondary state to notify the primary state if the coverage offered in a secondary state fails to comply with the covered laws of the primary state.
- Effective beginning two years after the date of enactment, individuals in a State may not buy individual health insurance coverage in a secondary State unless the premium for individual health insurance in the primary State (with respect to the individual) exceeds the national average premium by 10 percent or more.

Title IV --Safety Net Reforms

Sec. 401. Requiring Outreach and Coverage Before Expansion of Eligibility

- State Plans shall demonstrates how their eligibility criteria and benefits package will allow the state's annual funding allotment to cover at least 90% of the SCHIP eligible children and pregnant women in the State.
- Prohibits states from providing coverage to newly enrolled children and pregnant women with family incomes above 200% FPL if a state is unable to demonstrate enrollment of 90% or more eligible children in SCHIP.
- Individuals currently enrolled in the program are to be considered grandfathered in SCHIP.

Sec. 402. Easing Administrative Barriers to State Cooperation with Employer-Sponsored Insurance Coverage

- Requires states to now include pathways for premium assistance for employer-sponsored insurance as part of the state plan.
- States are required to offer some form of employer-sponsored coverage for SCHIP and Medicaid beneficiaries, but cannot require enrollment in the program.
- The amount of the federal share of all payments and any additional benefit wraparound provided by the State is capped at the national per capita expenditure for the previous fiscal year (as determined by the Secretary using the best available data) multiplied by the Enhanced FMAP rate for the state. Any additional costs are to be the responsibility of the state.
- States are required to collect proof from the entity receiving the payment that the child is indeed enrolled in credible health care coverage.
- The State is not prohibited from:
    - Offering wrap-around benefits in order for the employer-sponsored plan to meet any state-established minimum benefit requirements
    - Establishing a cost-effectiveness test
    - Establishing limits on beneficiary cost-sharing

- Paying all or part of a beneficiary's cost-sharing requirements
- Paying less than the full cost of the employee's share of the insurance premium, including prorating the cost of the premium to pay for only what the State determines is the portion of the premium that covers children
- Using State funds to pay for benefits above the Federal upper limit on reimbursement
- Allowing beneficiaries enrolled in employer-sponsored plans to change plans and rejoin the standard State SCHIP or Medicaid plan at any time
- Providing any guidance or information it deems appropriate in order to help beneficiaries make an informed decision regarding the option to enroll in the premium assistance coverage option

Sec. 403. Improving Beneficiary Choices in SCHIP and Medicaid

- States must offer vouchers for the purchase of private insurance as an option to their Medicaid and SCHIP populations, but cannot require enrollment.
  - Exception: If the state child health plan or Medicaid program provides, as of the date of the enactment, for a cash out or health savings account type option for those enrolled under the plan.
- States will establish a uniform monthly payment rate for these alternative coverage option plans that must be at least 90% of the per capita monthly cost of the state's standard SCHIP or Medicaid plan.
- A state must allow any willing health insurance plan that is licensed in the state and meets the federal benefit requirements to participate as an alternative SCHIP or Medicaid coverage option in the State.
- Provides beneficiaries with options for higher-quality health care coverage as states may allow plans that are more expensive than the uniform monthly payment rate to participate as a coverage option by allowing the beneficiary to pay the additional premium costs for this higher-quality plan.
- The amount of the Federal share of all payments provided by the state is capped at the national per capita expenditure for the previous fiscal year (as determined by the Secretary using the best available data) multiplied by the Enhanced FMAP rate for the state. Any additional costs are to be the responsibility of the State and/or the beneficiary.
- If the premium for qualified alternative coverage for an enrollee is less than the uniform dollar limitation established by the state then the amount shall be refunded to the federal and state government in proportion otherwise applicable to recovered funds under this title.
  - Exception: If the individual chooses an HSA plan the additional funds can be deposited into that individual's account.

Title V--Insurance Market Reforms: Medical Liability Reform

Sec. 501. Short Title (HEALTH Act) (H.R. 5 – Rep. Gingrey)

Sec. 502. Findings and purpose

Sec. 503. Encouraging Speedy Resolution of Claims

- Sets a statute of limitations of three years after the date of manifestation of injury or one year after the claimant discovers the injury, or should have discovered the injury, whichever comes first, with certain exceptions.
- Lawsuits on behalf of minors under the age of six years must be commenced within three years of the manifestation of the injury or prior to their eighth birthday, whichever provides the longer period, with certain exceptions.

Sec. 504. Compensating Patient Injury

- Limits noneconomic damages to $250,000
- Prohibits the jury from being informed of such limit
- Makes each party liable only for the amount of damages directly proportional to such party's percentage of responsibility.

Sec. 505. Maximizing Patient Recovery

- Requires court supervision over payment arrangements to protect against conflicts of interest that may reduce the amount of damages awarded that are actually paid to claimants.
- Allows the court to restrict the payment of attorney contingency fees.
- Limits the fees to a percentage based on the amount awarded on a sliding scale starting at 40% of the first $50,000 to 15% of any amount in excess of $600,000.

Sec. 506. Additional Health Benefits

- Allows any party to a lawsuit involving injury or wrongful death to introduce evidence of collateral source benefits.
- Allows any opposing party to then introduce evidence of any amount paid or contributed to secure the right to such benefits.
- Prevents providers of such benefits from recovering any amount from the claimant's recovery or from being subrogated to the right of the claimant.

Sec. 507. Punitive Damages

- Allows an award of punitive damages only if:
  - The claimant proves by clear and convincing evidence that the person acted with malicious intent to injure the claimant or that person deliberately failed to avoid unnecessary injury that they knew the claimant was substantially certain to suffer; and
  - Compensatory damages are awarded.
- No claim for punitive damages may be included in the initial lawsuit.
  - A claimant may file an amended pleading for punitive damages if the court finds after filing of a motion by the claimant that there is a substantial probability the claimant will prevail on the claim for punitive damages.
  - At the request of any party, a separate proceeding on the claim for punitive damages will be held. If a separate proceeding is requested, evidence relevant only to punitive damages will not be admissible in the proceeding to determine economic damages.

- Limits punitive damages to the greater of $250,000 or two times the amount of economic damages awarded, whichever is greater.
- Prohibits a punitive damage award in a product liability suit against a manufacturer, distributor, or supplier of a medical product that has been approved by the Food and Drug Administration (FDA) or that is generally recognized among qualified experts as safe and effective pursuant to conditions established by the FDA. Provides exceptions if:
  - The trier of fact finds by clear and convincing evidence that the product is substantially out of compliance with applicable labeling or packaging regulations.
  - A person knowingly misrepresented or withheld from the FDA required information that is material and causally related to the harm suffered by the claimant.
  - An illegal payment is made to an FDA official to secure approval of the medical product. Prohibits a product liability suit against a medical care provider who prescribes or dispenses such a medical product approved by the FDA.
- A health care provider who prescribes, or dispenses pursuant to a prescription, a medical product approved, licensed, or cleared by the FDA cannot be named as a party to a product liability lawsuit involving such product.

Sec. 508. Limitation on Recovery in a Health Care Lawsuit Based on Compliance with Best Practice Guidelines (H.R. 2363)

- The Secretary of Health and Human Services shall enter into a contract with a qualified physician consensus-building organization, such as the Physician Consortium for Performance Improvement (PCPI), in concert and agreement with medical specialty societies, to develop best practices guidelines for treatment of medical conditions.
  - The PCPI (convened by the AMA and comprised of over 100 medical specialty societies, state medical societies, AHRQ, CMS, and others) works on quality of care and patient safety through the development, testing, and maintenance of evidence-based clinical performance measures and measurement resources for physicians.
- Secretarial review and approval: The Secretary shall issue, by regulation, after notice and opportunity for public comment, endorsed best practice measures.
  - Limitation: the Secretary may not make a rule that includes guidelines other than those approved and submitted by physician specialty organizations
- There can be no non-economic damages awarded with respect to treatment that is consistent with a best practice guideline
- No punitive damages may be awarded against a health care practitioner based on such treatment where:
  - Such treatment was subject to the quality review by the consensus entity and was found to be safe, effective, and appropriate;
  - Such treatment was approved in guidelines that underwent full review by the consensus entity, public comment, approval by the Secretary and dissemination, or;
  - Such medical treatment is generally recognized among qualified experts (medical providers and relevant specialty societies) as safe, effective, and appropriate

- The safe harbors will apply in federal courts and in any state action, if such claim concerns items or services with respect to which payment is made under Medicare, Medicaid, SCHIP, or for which the claimant receives a federal tax benefit.
- Timeline:
  - The consensus entity shall submit best practice measures within 18 months of enactment.
  - Safe harbor best practices must be established within 24 months after date of enactment.
  - States may build upon or add more "safe harbors."

Sec. 509. State Grants to Create Administrative Health Care Tribunals

- Secretary may award grants to States for the development and implementation of administrative health care tribunals.
- Each case must first be reviewed by a panel of experts made up of no less than 3 or more than 7 members (at least half physicians or health care professionals), selected by a state agency responsible for health.
- The panel will make a recommendation about liability and compensation. The parties may then choose to settle or proceed to the tribunal.
- Each tribunal must be presided over by special judges with health care expertise, selected by the state. The opinion of the expert panel may be admitted before the tribunal. This judge will have the authority, granted by the state, to make binding rulings on standards of care, causation, compensation, and related issues.
- The legal standard for the tribunal will be gross negligence.
- If either party is unhappy with the tribunal's decision, that party may appeal the decision to a state court, to preserve a trial by jury. Any determinations made by the panel and the tribunal will be admissible in state court.
- Once one party appeals to a state court, any previous determinations are void. If the party that appeals to state court is unhappy with the state court's decision, the party may not receive the compensation that the tribunal determined to be appropriate.
- No state may preclude any party from obtaining legal representation during any review by the expert panel, administrative tribunal, or a state court.

Sec. 510. Authorization of Payment of Future Damages to Claimants in Health Care Lawsuits

- Provides for periodic payments of future damage awards over $50,000.
- Rather than reduce the amount a patient will receive, past and current expenses will continue to be paid at the time of judgment or settlement, while future damages can be funded over time to ensure payment without risking the bankruptcy of the defendant.

Sec. 511. Definitions

Sec. 512. Effect on Other Laws

- Exempts civil actions brought for vaccine-related injuries from this act to the extent that they are covered by the Public Health Service Act (PHSA).

Sec. 513. State Flexibility and Protection of States' Rights

- Preempts state law to the extent that it prevents the application of any provision of law established by this Act, but does not:
  - Preempt state law that provides greater protections for health care providers or organizations or that specifies particular damage limits; or
  - Affect any defenses available to a party under any other provision of state or federal law

Sec. 514. Applicability, Effective Date

- Provisions in the bill will be effective for any claim initiated on or after the date of enactment of the Act except that any lawsuit arising from an injury occurring prior to enactment will be governed by the applicable statute of limit provisions in effect at the time the injury occurred.

Title VI--Wellness and Prevention

Sec. 601. Providing Financial Incentives for Treatment Compliance

- Amend HIPAA wellness regulations to increase permissible variation for programs of health promotion and disease prevention from 20% allowance to 50% of the cost of coverage, effective one year after date of enactment.

Title VII--Transparency and Insurance Reform Measures

Sec. 701. Receipt and Response to Requests for Claim Information

- Sets forth requirements for the reporting of claim information under certain group health plans; providing administrative penalties.
  - 30 days after the date a health insurance issuer receives a request for a report of claim information from a plan, plan sponsor, or plan administrator, the health insurance issuer shall provide the requesting party the report.
- Limitations:
  - The health insurance issuer is not required to provide a report to an employer or group health plan more than twice in any 12-month period.
  - The employer must have 50 or more employees.
- The report must be a written report transmitted through an electronic file or available online to the requesting plan, plan sponsor, or plan administrator.
- A report of claim information provided must contain protected health information under time limits set by this provision. A report provided must include:
  - Aggregate paid claims experience by month, including claims experience for medical, dental, and pharmacy benefits, as applicable
  - Total premium paid by month
  - Total number of covered employees on a monthly basis by coverage tier, including whether coverage was for an employee only or an employee with dependents
  - Total dollar amount of claims pending as of the date of the report
  - A separate description and individual claims report for any individual whose total

paid claims exceed $15,000 during the 12-month period preceding the date of the report, including the following information related to the claims for that individual:
    - A unique identifying number, characteristic, or code for the individual
    - Amounts paid
    - Dates of service
    - Applicable procedure codes and diagnosis codes
  - For claims that are not part of the report described above, a statement describing precertification requests for hospital stays of five days or longer that were made during the 30-day period preceding the date of the report.
- In order to receive data on the following items, a plan sponsor must make to the health insurance issuer a certification that the plan documents comply with HIPAA requirements, and it will safeguard and limit the use and disclosure of protected health information that the plan sponsor may receive from the group health plan to perform the plan administration functions.
  - Request for additional Information:
    - After receiving the initial report the requesting entity may within 10 days make a written request to the health insurance issuer for additional information in accordance with this section for specified individuals.
- Privacy Protections: A health insurance issuer may not disclose protected health information if the health insurance issuer is prohibited from disclosing that information under another state or federal law that imposes more stringent privacy restrictions than those imposed under federal law.
  - To withhold information in accordance with this subsection, the health insurance issuer must:
    - Notify the entity requesting the report that information is being withheld.
    - Provide a list of categories of claim information that the health insurance issuer has determined are subject to the more stringent privacy restrictions under another state or federal law.
- Clarifies that a health insurance issuer that releases information as set out in this provision has not violated a standard of care and is not liable for civil damages resulting from, and is not subject to criminal prosecution for, releasing that information.
- Limitation on pre-emption: Nothing in this title is meant to limit states from enacting additional laws in addition to this, but not in lieu of.

Title VIII—Quality

Sec. 801. Prohibition on Certain Uses of Data Obtained from Comparative Effectiveness Research; Accounting for Personalized Medicine and Differences in Patient Treatment Response

- The Secretary of HHS is prohibited from using comparative effectiveness research, to deny coverage of an item or service under a Federal health care program.
- The Secretary must ensure that comparative effectiveness research conducted or supported by the Federal Government accounts for factors contributing to differences in the treatment response and treatment preferences of patients, including patient reported

outcomes, genomics and personalized medicine, the unique needs of health disparity populations, and indirect patient benefits.

- Prohibits findings from the Federal Coordinating Council for Comparative Effectiveness Research (FCCCER) from being released in final form until after consultation with and approved by relevant physician specialty organizations.
- This does not affect the authority of the Commissioner of Food and Drugs under the Federal Food, Drug, and Cosmetic Act or the Public Health Service Act.

Sec. 802. Establishment of Performance-Based Quality Measures

- Requires the Secretary to submit to Congress a proposal for a formalized process for the development of performance-based quality measures that could be applied to physicians' services under the Medicare program.
- Such proposal shall be in concert and agreement with the Physician Consortium for Performance Improvement (PCPI) and shall only utilize measures agreed upon by each physician specialty organization.

Title IX – Health Transparency Portal

Sec. 901 – State Transparency Plan Portal

- State-based portal: A state (or states) may contract with a private entity to establish a Health Plan and Provider Portal Website for the purposes of providing standardized information on certified plans available in that state as well as price and quality information on health care providers (including hospitals and other health care institutions). Authorizes appropriations for the development of such state portals and a national website.
- Pilot Program: Requires the Secretary to work with states to establish, no later than 2011, a website that will serve as a national portal for information structured in a manner so individuals may directly link to their state's plan portal. The Secretary will also work with states to develop portals for the state that follow applicable standards and regulations under this provision.
- Consultation: the Secretary shall work with stakeholders (including states, issuers of health insurance plans, the National Association of Insurance Commissioners, a qualified provider based entity, and a standards development organization) to develop standards for interoperability and consistency to be issued.
- Review: One year after the establishment of the pilot program the Secretary and stakeholders shall review and make additional changes as appropriate.
- Requirements for Plan Portals:
  - Plans:
    - Health plans meet state law requirements and the policies offered are qualified / certified in that state.
    - Provide all relevant information (co-payments, covered benefits, etc) in a uniform manner.
  - Providers:
    - Identifying and licensure information
    - Self-pay price
      - Information on variation in self-pay prices (the price charged by the

provider to individuals for items or services where the price is not established or negotiated through a health care program or third party).
    - The Secretary, after collaboration with states and providers, will submit recommendations to Congress for how to incorporate the Performance-Based Quality Measures established under Sec. 802 by 2011.
- Plan Portal shall also provide information to assist Medicaid / SCHIP individuals in finding information on options, eligibility and how to enroll.
- Limitation: Plan portal cannot assist in direct enrollment.
- Plan Portal shall provide for a way to incorporate information on the credits and deductions for the purchase of qualified insurance to enhance the individual's access to them.

Title X – Physician Payment Reform

Sec. 1001. Guaranteeing Freedom of Choice and Contracting for Patients under Medicare (H.R. 1700)

- Allows Medicare beneficiaries to enter into contracts with participating and non-participating Medicare eligible professionals.
- Beneficiaries can submit a claim for Medicare payment or allow the eligible professional to file claims on their behalf.
- Requires the eligible professional and the beneficiary to enter into a written contract that establishes all the terms of the contract.
- Provides that a contract cannot be entered into when the Medicare beneficiary is facing an emergency medical condition or urgent health care situation. Dual eligible beneficiaries also may not be parties to such contracts.
- Provides that Medicare limiting charges do not apply to Medicare charges by the eligible professional.

Sec. 1002. Preemption of State Laws Limiting Charges for Physician and Practitioner Services

- Provides that a state may not impose a limiting charge for services provided by eligible professionals for which Medicare payment is made.

Sec. 1003. Health Care Provider Licensure Cannot be Conditioned on Participation in a Health Plan

- Prohibits the Secretary or any state from conditioning a health care provider's licensure on participation in any health plan.

Sec. 1004. Bad Debt Deduction for Doctors to Partially Offset the Cost of Providing Uncompensated Care Required Under Amendments Made By the Emergency Medical Treatment and Labor Act

- Allows for physicians assisting emergency room patients to be fairly compensated for that care.
- This bill amends the Internal Revenue Code to allow certain physicians a bad debt tax deduction for their costs in providing uncompensated care as required under the Social Security Act to emergency room patients and pregnant women in labor.

Sec. 1005. Right of Contract with Health Care Providers

- Prohibits the Secretary from precluding any enrollee, participant, or beneficiary in a health benefits plan from entering into any contract or arrangement for health care with any health care provider. A health benefits plan does not include Medicaid and Tricare.

Title XI – Incentives to Reduce Physician Shortages

Subtitle A – Federally-Supported Student Loan Funds for Medical Students

Sec. 1101. Federally-Supported Student Loans for Medical Students

- Creates a new Health Professional Student Loan (HPSL) program for medical schools to offer loans to their medical students that allows for deferment of payments until after full residency and any fellowship training program.

Subtitle B—Loan Forgiveness for Primary Care Providers

Sec. 1111. Loan Forgiveness for Primary Care Providers

- The Secretary shall enter into contracts to provide loan repayment for providers who agree to, or have already served for at least 5 years (3 years in a medically underserved area) as a primary care provider.
- Secretary shall repay up to $50,000, at $10,000 a year, of the individual's graduate medical loan.

Title XII – Quality Health Care Coalition

Sec. 1201. Quality Health Care Coalition (H.R.1409)

- Exempts health care professionals engaged in negotiations with a health plan regarding the terms of any contract under which the professionals provide health care items or services from the Federal antitrust laws.
- Specifies that this section applies only to health care professionals excluded from the National Labor Relations Act. It also would not apply to negotiations relating to care provided under Medicare, Medicaid, SCHIP, the FEHBP, or the Indian Health Care Act as well as medical and dental care provided to members of the uniformed services and veterans.

Title XIII – Offsets

Subtitle A--Discretionary Spending Limits

Sec. 1301. Enforcing Discretionary Spending Limits

- Amends the Balanced Budget and Emergency Deficit Control Act of 1985 to bring the FY 2013-2021 budgets in-line with the Ryan budget numbers.

Subtitle B – Savings from Health Care Efficiencies

Sec. 1311. Medicare DSH Report and Payment Adjustments in Response to Coverage Expansion

- Requires a study on the extent to which, based upon the impact of the health care reforms created in this bill, there is a rate of insurance uptake in 2014.
- Reduces Medicare Disproportionate Hospital Share (DSH) funds beginning in 2015 if there is a decrease in the national uninsurance rate of 8% or more.

Sec. 1312. Reduction in Medicaid DSH

- Requires a study on the extent to which, based upon the impact of the health care reforms created in this bill, there is a rate of insurance uptake in 2014.
- Reduces Medicaid Disproportionate Hospital Share (DSH) funds beginning in 2015 if there is a decrease in the national uninsurance rate of 8% or more.

Subtitle C - Fraud, Waste, and Abuse

Sec. 1321. Provide adequate funding to HHS OIG and HCFAC

- Enhance efforts to detect and eliminate fraud and abuse in Medicare and Medicaid by providing funding for the Office of the Inspector General of the Department of Health and Human Services.

Sec. 1322. Improved enforcement of the Medicare secondary payor provisions

- Identify instances where Medicare should be, but is not, acting as a secondary payer to an individual's private coverage.

Sec. 1323. Strengthen Medicare provider enrollment standards and safeguards

- Establishes, as a condition of new providers or suppliers applying for a Medicare provider number, a screening for a criminal background or other financial or operational irregularities through fingerprinting, licensure checks, site-visits, other database checks with penalties for knowingly providing false information and other disclosure requirements.
- The Secretary may impose moratoria on approval of provider and supplier numbers under the Medicare program for new providers of services and suppliers as determined necessary to prevent or combat fraud. A period of delay for any one applicant cannot exceed 30 days unless cause is shown by the Secretary.

Sec. 1324. Tracking banned providers across State lines

- The Secretary shall:
  - Provide for improved information systems and increased coordination between CMS and its regional offices to ensure that providers of services and suppliers that have operated in one state and are excluded from participation in the Medicare program are unable to begin operation and participation in the Medicare program in another state.
  - Implement a database that includes claims and payment data for all components of the Medicare program and the Medicaid program.
  - Expand data matching and consolidate databases.
  - Establish a comprehensive database that includes information on providers of

services, suppliers, and related entities participating in Medicare and Medicaid. Such database shall include information on ownership and business relationships, history of adverse actions, and results of site visits or other monitoring by any program.

- Establish a comprehensive sanctions database on sanctions imposed on providers of services, suppliers, and related entities.
- Ensure that the Inspector General of the HHS and Federal law enforcement agencies have direct access to all claims and payment databases of the Secretary under the Medicare or Medicaid programs.

- Establishes civil money penalties for knowingly providing false information that serves as a basis for payment for that entity under Medicare or Medicaid.