## HIGHLIGHTS OF THE HEALTH REFORM RECONCILIATION BILL AS OF 3/15/2010

Health Insurance Expansion

- Makes the tax credits for health insurance premiums more generous for individuals and families with incomes between 250% and 400% of the federal poverty level (FPL)
- Reduces cost-sharing for individuals and families with incomes between 100% and 250% FPL
- Reduces the penalty for individuals and families that do not purchase health insurance, and phases in the penalty over a 3-year period
- Increases penalties for large employers that do not offer health insurance coverage to $2,000 per full time employee (FTE) vs. $750 per FTE in the Senate bill
- Large employers that *offer coverage* and have employees that receive a premium tax credit will pay penalties of $3,000 per employee receiving a premium credit.

Closes the Donut Hole

- Establishes a one-time rebate of $250 in 2010 for beneficiaries who reach the coverage gap
- Closes the coverage gap in the Part D benefit such that, by 2020, beneficiary coinsurance will be 25% for all drug spending in excess of the deductible and below the catastrophic limit

Promotes Low Cost and High Quality in Medicare Advantage

- Converts MA payment rates to be based on 100% of fee-for-service (FFS) costs, starting in 2013; in the interim, rates will consist of a blend of local benchmark rates and FFS costs
- Establishes a base payment rate, based on 100% of FFS costs, and adjusts it as follows:
    - Plans in the highest-cost quartile of areas in the country will receive 95% of the base rate, increasing to 115% of the base rate for the lowest-cost quartile of areas
    - Those amounts will be further adjusted based on quality scores, with plans scoring 4 stars or higher receiving a 5 percentage point increase in payments in 2013
    - Reduces proportion of rebates that can be passed back to beneficiaries as supplemental benefits, giving beneficiaries incentives to choose high-quality plans
- Raises the asset test threshold, making more beneficiaries eligible for Medicare Part D starting in 2012
- Establishes a minimum medical loss ratio of 0.85 for MA plans, with penalties for lower MLRs

Changes to Fee-for-Service Payments

- Reduces market basket updates for inpatient hospitals, long term acute care hospitals, and outpatient hospitals
- Modifies provisions creating an Independent Payment Advisory Board such that, in the event that the Board fails to submit a legislative proposal to reduce Medicare spending by the target amount, the Secretary has authority to cut payments to providers proportionally based on their share of total Medicare spending
- Congress can “buy down” a reduction order by passing other legislation that achieves the same level of savings through another mechanism
- Adds several new provisions to reduce fraud and abuse in Medicare

Changes to Industry Excise Taxes

- Delays implementation of the tax on high-cost insurance plans until 2018 and raises the amount of health insurance premiums that are exempt from the tax

- Increases the Hospital Insurance (HI) payroll tax for individuals with incomes over $200,000 and families with incomes over $250,000; adds a new tax of 3.8% of income from interest, dividends, annuities, royalties or rents
- Delays the start of the excise tax on brand pharmaceutical manufacturers from 2010 to 2011 and increases the industry's total excise tax liability from $2.3 billion to $3.85 billion
- Establishes an excise tax on medical devices equal to 2.9% of the price of the device, starting in 2013
- Delays the start of annual fees on health insurers from 2010 until 2014; increases the insurance industry's total liability for annual fees from $6.7 billion to $11.2 billion in 2014, 2015 and 2016

Changes to Economic Substance Doctrine
- Clarifies the application of the Economic Substance Doctrine such that transactions will be treated as having economic substance only if they change the taxpayer's economic position in a meaningful way and the taxpayer has a substantial purpose for the transaction, other than changing federal income tax liability

Additional Scrutiny of Insurance Premium Increases
- Requires health insurers to report data on rates, medical loss ratios, solvency and reserves to CMS and to state insurance commissioners, which will review premiums each year starting in 2011
- Requires insurers to justify premiums that are "potentially unreasonable" and allows CMS and states to take corrective actions, including applying penalties or denying or modifying the rate increase
- Eliminates penalties for unjustified premiums in 2014 and later years

Drug Purchasing
- Removes expansion of 340(B) prices to inpatient facilities
- Excludes orphan drugs from the 340(B) program when sold to a children's hospital, cancer hospital, sole community hospital, critical access hospital or rural referral center

Provisions NOT Included in the Reconciliation Bill
- No changes to abortion provisions in the Senate bill
- No changes to prohibition on legal immigrants' purchasing health insurance through the exchanges
- No changes to provisions creating a regulatory pathway for follow-on biologics
- No provision to eliminate "pay to delay" agreements between brand and generic drug manufacturers

**SUMMARY OF H.R. ____, RECONCILIATION BILL MODIFYING H.R. 3590, PATIENT PROTECTION AND AFFORDABLE CARE ACT, AS OF 3/15/2010**

**PLEASE NOTE: 1) IF A PROVISION IS IN ITALICS IT MEANS CONGRESS WILL BE MAKING ADDITIONAL CHANGES OR PROVIDING MORE LANGUAGE; 2) IF A PROVISION IS IN ITALICS AND UNDERLINED IT MEANS THAT THE CONGRESS AND CBO WILL BE MAKING ADDITIONAL CHANGES OR PROVIDING MORE LANGUAGE; AND 3) IF A PROVISION IS IN ITALICS, BOLDED, AND UNDERLINED IT MEANS THAT THE CONGRESS, ADMINISTRATION, AND CBO WILL BE MAKING ADDITIONAL CHANGES OR PROVIDING MORE LANGUAGE.**

**Title I: Health Insurance and Long-Term Care Coverage**

Subtitle A: Health Insurance Reform

*§ 1001 | Improving Affordability*

- Bridges differences between the House and Senate with regard to the maximum proportion of income that middle class individuals will spend on health insurance through the exchange
- Similar to both House and Senate bills, creates refundable tax credits for individuals with incomes between 133% and 400% of the federal poverty line (FPL) to cover the costs of health insurance premiums
- Ties premium credits to the second lowest cost silver plan available through the exchange
- The maximum proportion of income that individuals will pay for health insurance increases with income, on a sliding scale:
  - Up to 133% FPL → 2% of income (unchanged from Senate)
  - 133 – 150% → 3% - 4% (4% - 4.6% in Senate)
  - 150% - 200% → 4% - 6.3% (unchanged from Senate)
  - 200% - 250% → 6.3% - 8.05% (unchanged from Senate)
  - 250% - 300% → 8.05% - 9.5% (8.1% - 9.8% in Senate)
  - 300% - 400% → 9.5% (9.8% in Senate)

- Relative to the Senate bill, reduces cost-sharing for middle income individuals and families:
- Plans' total contribution toward an individual or family's health care costs declines with income, on a sliding scale:
  - 100% - 150% FPL → Plan covers 94% of costs (was 90% in Senate)
  - 150% - 200% FPL → Plan covers 87% of costs (was 80% in Senate)
  - 200% - 250% FPL → Plan covers 73% of costs (was 70% in Senate)
  - 250% - 400% FPL → Plan covers 70% of costs (unchanged)

*§ 1002 | Improving Individual Responsibility*

- Changes tax penalties for individuals who do not have qualifying health coverage, starting in 2014
- Penalty for an individual is the greater of a flat fee of $695 per year (vs. $750 in Senate) or 2.5% of income (was 2.0)
- Penalty for a family is the greater of 3 times the individual flat fee penalty ($2,085 vs. $2,250 in Senate) or 2.5% of household income
- The penalty will be phased in over time:
  - 2014 greater of a flat fee of $95 or 0.5% of taxable income
  - 2015 greater of a flat fee of $325 or 1.0% of taxable income

- 2016 greater of a flat fee of $695 or 2.0% of taxable income

- Individuals and families are exempt from the tax if they have annual income that is below the filing threshold for the appropriate family size. (was income below 100% FPL in Senate)

*§ 1003* | *Strengthening Employer Responsibility*

- Increases penalty from $750 per FTE to $2,000 per FTE for large employers (>50 employees) that *do not offer coverage* and have at least one FTE that receives a premium tax credit or cost-sharing subsidy
- Large employers that *offer coverage* and have at least one FTE that receives a premium tax credit will pay penalties of $3,000 per employee receiving a premium credit.
- New provision disregards the first 30 workers employed by the employer in calculating the amount of the penalty
- Repeals assessments on employers who require employees to wait more than 30 days to enroll in the employer's health insurance coverage
- Allows employers to count part-time workers' time as "full-time equivalents," based upon a 30-hour work week per FTE, for the purpose of calculating the penalties.

*§ 1004* | *Simplifying Income Definitions*

- Simplifies certain income definitions, consistent with other provisions of the tax code
- Clarifies the tax treatment of health insurance for adult dependents up to age 26 who are covered by their parents' insurance. For example, self-employed individuals who are able to claim health insurance costs as a tax deduction can count the costs of covering a dependent up to age 26.
- Changes method for states to determine Medicaid eligibility based on a 5% income disregard for individuals whose income increases above the eligibility cutoff

Subtitle B: Medicare

*§ 1101* | *Closing the Medicare Prescription Drug "Donut Hole"*

- Completely closes the coverage gap in the Medicare Part D benefit, as in the House bill
- Individuals who reach the coverage gap in 2010 will receive a one-time $250 rebate from the government; this payment does not count toward the "true out-of-pocket" (TrOOP) limit
- Closes the coverage gap in the Part D benefit such that, by 2020, the coinsurance for all Part D drugs will be 25 percent for all spending between the deductible and the catastrophic limit for both generic and brand name drugs
- Delays implementation of the coverage gap discount program from July 1, 2010, as in Senate bill, to January 1, 2011
- Requires manufacturers to have discount agreements, which will apply for the 2011 plan year; those discounts equal 50% of the drug component's negotiated price.
- Agreements must be in place within 30 days of the establishment of a model agreement, rather than May 1, 2010 as in Senate bill
- Manufacturers' payments will be applied to the beneficiary's cost-sharing at the point of sale
- Clarifies that manufacturers' payments for the coverage gap discount program are excluded from the definition of average manufacturer price (AMP)

*§ 1102* | *Medicare Advantage Payments*

- Repeals competitive bidding provisions in Senate bill.

- Payment to MA plans will be based upon 100% of FFS costs as in the House bill, starting in 2013. Changes phase in as follows:
    - 2011 2010 local benchmark + national per capita MA growth rate
    - 2012 ½ local benchmark + ½ FFS costs
    - 2013 ++ 100% FFS costs

- Adjusts the base payment rate depending upon how the local area's FFS costs compare to other areas in the country, as follows:
    - Highest-cost quartile of areas → 95% of base payment rate
    - Second-highest cost quartile of areas → 100% of base payment rate
    - Third-highest cost quartile of areas → 107.5% of base payment rate
    - Lowest-cost quartile of areas → 115% of base payment rate

- Plans whose rankings change from one quartile to another will have a one-year transition, with their base rate increased using a blended percentage that reflects the average of the two quartiles' increases (e.g., 100% to 95% quartile → one-year transition of 97.5%)
- *Plans whose cost-sharing for MA benefits is greater than the cost-sharing that would be imposed for the same benefit category in FFS Medicare will have the base payment rate reduced by 1 percent.*
- Plans' payment amounts will be further adjusted based upon quality scores. Plans scoring 4 stars or higher on quality and beneficiary satisfaction ratings will receive an additional increase in their base payment rates:
    - 2012 1.5 percentage point increase
    - 2013 3.0 percentage point increase
    - 2014 and later 5.0 percentage point increase

- The quality bonus payments will be *doubled* for plans whose quality scores are 4 stars or higher, if the plan operates in a county that meets all of the following:
    - MA capitation rate that, in 2004, was based on an MSA with population > 250,000
    - At least 25% of MA-eligible beneficiaries in the county enrolled in MA plans
    - Per-capita FFS spending in the county is less than national per-capita FFS spending
- The Secretary may make bonus payments to plans that have quality scores lower than 4 starts if the plan demonstrates "meaningful improvement" in its quality score, as defined by the Secretary
- *If, in 2011, the new payment methodology would, if it had been used in that year, resulted in a payment that was more than $30 below the local benchmark amount but less than $50, then the blended benchmark will be phased in as follows:*
    - *2012 3/4 local benchmark + 1/4 new payment rates*
    - *2013 ½ local benchmark + ½ new payment rates*
    - *2014 ¼ local benchmark + ¾ new payment rates*

- If, in 2011, the new payment methodology would, if it had been used in that year, resulted in a payment that was more than $50 below the local benchmark amount, then the blended benchmark will be phased in as follows:
    - 2012 5/6 local benchmark + 1/6 new payment rates
    - 2013 1/3 local benchmark + 2/3 new payment rates
    - 2014 ½ local benchmark + 1/2 new payment rates
    - 2015 1/3 local benchmark + 2/3 new payment rates
    - 2016 1/6 local benchmark + 5/6 new payment rates

- 2017+ 100% new payment rates

- Notwithstanding the effects of the quality bonus payments and the phase-in, the new payment rates are capped at the local benchmark amount that would have been paid under prior law.
- ***Beneficiary premium rebates will be adjusted to account for plans' quality scores, such that low-quality plans will have less ability to offer beneficiaries additional benefits, reduced cost-sharing, or reduced / zero premiums***
- ***In 2013, the beneficiary rebate will be calculated as follows:***
    - ***Plan scores 4.5 stars or more → 70% rebate***
    - ***Plan scores 3.5 to 4.5 stars → 65% rebate***
    - ***Plan scores below 3.5 stars → 50% rebate***

- The changes to the premium rebate also phase in over time:
    - 2011 2/3 (current law rebate of 75%) + 1/3 (quality-based rebate)
    - 2012 1/3 (current law rebate of 75%) + 2/3 (quality-based rebate)

- Extends the adjustment for coding intensity beyond 2010
- Requires CMS to analyze coding intensity on an annual basis and use the findings to adjust plans' risk scores, using updated data in each year
- Sets the coding intensity adjustment factor at a minimum of 5.7 percent in 2011 and subsequent years
- Continues the coding intensity adjustment until CMS implements risk adjustment based on MA diagnosis, cost and use data
- *Repeals the Comparative Cost Adjustment Program, a provision of the Medicare Modernization Act of 2003 that would have tested competitive bidding of MA plans*
- *Beginning in 2012, increases the dollar threshold for the asset test in Medicare Part D and the Medicare Savings Program, making more beneficiaries eligible for low income subsidies*

*Note: More language for this section is in the works.*

*§1103 | Savings from Limits on MA Plan Administrative Costs*

- Beginning in 2014, instates a minimum medical loss ratio (MLR) of 0.85 for MA plans; plans that have MLRs below 0.85 will be subject to penalties:
    - In one contract year, reimbursing the government for excess administrative costs
    - In 3 consecutive years, limitations on new enrollees
    - In 5 consecutive years, contract termination

*§1104 | Adjustments in Disproportionate Share Hospital (DSH) Payments*

- ***Relative to the Senate bill, accelerates the reduction in Medicare DSH payments to hospitals such that the cuts begin in 2014 rather than in 2015***
- ***Modifies the formula by which Medicare will pay DSH hospitals for the uncompensated care they expect to continue providing to uninsured individuals in 2014 and later years.***
- ***Relative to the Senate bill, makes additional changes to Medicare's payment rates, presumably for the purpose of altering the CBO score of the total package. Changes payments for the following providers:***
    - ***Inpatient hospitals***
    - ***Long-term care hospitals***
    - ***Inpatient rehabilitation facilities***

- ***Psychiatric hospitals***
- ***Outpatient hospitals***

*Note: More language for this section is in the works.*

*§1105 | Savings from Independent Payment Advisory Board*

- The Senate-passed version of the legislation creates an Independent Payment Advisory Board that will make recommendations to Congress and the President for changes to Medicare payments that will slow the rate of growth in Medicare spending to a specific target level.
- In the event that the Board fails to submit a legislative proposal by the required deadline, the Secretary of HHS is required to submit a proposal to lower the growth in Medicare spending by the required amount.
- The reconciliation bill directs the Secretary to cut Medicare payments to providers in a uniform way, proportional to the contribution of each provider to Medicare spending.
- Congress can "buy down" the amount of a reduction order by passing legislation that cuts Medicare spending by the required dollar amount, but by different means.

*§1106 | Medicare Effective Dates*

- *Contains provisions to reduce the payment rates for diagnostic imaging equipment to account for potential over-utilization of imaging procedures*
- Eliminates the Senate bill's delay of implementation for the RUG-IV payment system for skilled nursing facilities in 2011 and cuts the base per diem rate by 0.1 percent in 2011.

Subtitle C: Medicaid

*§1201 | Increasing Federal Funding for States*

- Increases federal medical assistance percentage (FMAP) paid to states for individuals newly enrolled in Medicaid as a result of the expansion of eligibility to 133% FPL, as follows:
    - 100% for 2014 – 2016
    - 95% in 2017
    - 94% in 2018
    - 93% in 2019
    - 90% for 2020 and later years
- Repeals the special FMAP for Nebraska and changes the formula for calculating the amount of increased FMAP that will be paid to states that had, prior to enactment of the Act, expanded Medicaid eligibility to adults with incomes up to 100% FPL

*§1202 | Improving Payments to Primary Care Physicians*

- In 2013 and 2014, sets Medicaid payment rates for primary care physicians equal to 100 percent of Medicare payment rates, including payments for office visits and immunizations.

*§1203 | Note: Language for this section has yet to be supplied.*

*§1204 | Increasing Funding for the Territories*

- Authorizes $1 billion in funding to U.S. territories to operate an insurance exchange within the territories

*§1205 | Delay in Community First Choice Option*

- Delays by one year the implementation of a program allowing states to add home and community based long-term care services to their Medicaid programs for beneficiaries who have incomes below 150% FPL or who are institutionalized.

Subtitle D: Reducing Waste, Fraud and Abuse

*§1301 | Registration and Background Checks of Billing Agencies and Individuals*
- Requires third-party billing agents that submit claims on behalf of providers or suppliers to register with CMS and receive a unique identification number, which must be included on all Medicare claims; requires CMS to perform background checks on billing agents
- Allows the Secretary of HHS to deny billing privileges if an entity's background check shows a history of actions that could be harmful to the Medicare program, such as bankruptcy, felony convictions, or civil judgments

*§1302 | Liability of Medicare Administrative Contractors for Claims Submitted by Excluded Providers*
- Requires CMS to modify contracts with Medicare Administrative Contractors such that MACs agree to reimburse the federal government for any claims paid for a provider that is excluded from Medicare

*§1303 | Community Mental Health Centers*
- Requires community mental health centers that treat a large proportion of non-Medicare patients to meet the new requirements for receiving Medicare billing privileges, in addition to having state licensure (as required under current law)

*§1304 | Limiting Debt Discharge in Bankruptcies of Fraudulent Health Care Providers*
- Restricts providers' ability to use bankruptcy as a way to avoid repaying monies owed to the federal government as a result of fraudulent activity

*§1305 | Modify Medicare Prepayment Review Limitations*
- Permits MACs to perform additional prepayment medical record reviews in cases where they suspect fraud and abuse

*§1306 | Establish a CMS-IRS Data Match to Identify Fraudulent Providers*
- Requires the Internal Revenue Service to share information with CMS on Medicare providers who have seriously delinquent tax debt, allowing CMS to use this information in determining providers' eligibility to gain or renew Medicare billing privileges
- Allows CMS to deduct unpaid tax debts from the Medicare reimbursements that would otherwise be paid to a provider or supplier

*§1307 | Increased Funding to Fight Waste, Fraud and Abuse*
- Authorizes additional funding for fraud and abuse prevention; authorizes $95 million in 2011, $55 million in 2012, $30 million in 2013 and 2014, and $20 million in 2015 and 2016.

*§1308 | 90-Day Period of Enhanced Oversight for Initial Claims of DME Suppliers*
- Requires CMS to withhold payment from DME suppliers during an initial 90 day period following the supplier's initial enrollment in the Medicare program.

Subtitle E: Revenue Provisions

*§ 1401 | High-Cost Plan Excise Tax*

- Delays implementation of the tax on high-cost insurance plans from starting in 2013 to starting in 2018
- Raises the amount of premiums that are exempt from the tax:
  - Individuals: threshold increases from $8,500 to $10,200
  - Families: threshold increases from $23,000 to $27,500
- Indexes the thresholds for inflation; raises the threshold in 2018 automatically if the per-employee cost of the Federal Employees Health Benefit Plan's standard option in 2018 exceeds that amount for 2010 by more than would have been expected if the threshold were indexed based on general inflation for the same time period
- Adjusts the threshold to account for instances in which the age / gender composition of the employer's covered workers differs significantly from the age / gender composition of the national workforce
- Increases the threshold for individuals who are retirees, or who work in certain high-risk fields such as installation and repair of electrical or telecommunications lines
- Excludes dental and vision benefits from the premium amounts subject to the tax

*§ 1402 | Broadening the Medicare Hospital Insurance (HI) Tax Base for High Income Taxpayers*

- Modifies HI payroll tax for high-income taxpayers, as described in the President's proposal
- Increases the HI payroll tax for individuals with incomes over $200,000 and families with incomes over $250,000, beginning on January 1, 2013
  - The additional tax is 0.9% of the amount by which the individual or family income exceeds the income thresholds
  - These tax payments will accrue to the HI trust fund
- Adds a new tax equal to 3.8% of the individual or family's total income from interest, dividends, annuities, royalties, or rents (except for income derived through the ordinary course of business that is not a passive activity, such as income from active participation in an S-corporation)
  - These funds will accrue to the SMI trust fund

*§ 1403 | Increase in Fees on Brand Name Pharmaceuticals*

- Delays the effective date of the excise tax on brand pharmaceutical manufacturers, from the 2010 tax year to the 2011 tax year
- Increases the industry's total excise tax liability from $2.3 billion to $3.85 billion

*§ 1404 | Conversion of Fee on Medical Device Manufacturers to an Excise Tax*

- Repeals provision in Senate bill establishing an annual fee on medical device manufacturers
- Starting in 2013, establishes an excise tax on medical devices sales equal to 2.9% of the price of the device
- Certain types of devices are exempt from the tax, including Class I devices, eyeglasses, contact lenses, hearing aids, and other devices that are sold to the general public at retail establishments
- The tax is paid at the time of the first taxable sale of the device, defined as the first sale, other than for resale, following the device's being manufactured or imported
- Manufacturers' sales of a device intended for resale by the purchaser are not considered the "first taxable sale"
- Sales of devices to health care providers who will use the device in the course of patient care are not considered resales, even if providers ultimately will sell the device to the patient
- Tax is payable on devices that are leased or that are used by a patient prior to the first taxable sale

- Intermediaries that purchase devices from manufacturers for sale to end users under a contract between the end user and the manufacturer are allowed to recoup the tax from the manufacturer

*§ 1405 | Fees on Health Insurance Providers*

- Delays start date for annual fees on health insurers from 2010 to 2014
- Reduces the fee that would otherwise apply to certain types of insurers, including nonprofits that receive over 80 percent of their revenue from government programs for the low-income, elderly and disabled
- Increases the health insurance industry's total liability for annual fees, as follows:
  - 2014, 2015, 2016 → from $6.7 billion to $11.2 billion
  - 2017 and after → from $6.7 billion to $12.2 billion

*§1406 | Delay of Elimination of Deduction for Expenses Allocable to Medicare Part D Subsidy*

- Extends by one year the tax deduction for expenses allocable to the Medicare Part D subsidy; the deduction will end in the 2012 tax year rather than in 2011, as in the Senate bill

*§1407 | Modification of Section 833 Treatment of Certain Health Organizations*

- Eliminates certain tax deductions for Blue Cross and Blue Shield plans if the plan's MLR exceeds 85%

*§1408 | Elimination of Unintended Application of Cellulosic Biofuel Producer Credit*

- Excludes from the Cellulosic Biofuel Producer Credit fuels that consist of more than 4% water and sediment, or more than 1% ash; reconciliation bill delays the change from 2010 to 2011

*§1409 | Codification of Economic Substance Doctrine and Penalties*

- Clarifies the application of the Economic Substance Doctrine such that a transaction will be treated as having economic substance only if 1) the transaction changes the taxpayer's economic position in a meaningful way, other than changing federal income tax effects, and 2) the taxpayer has a substantial purpose for the transaction (other than affecting federal tax liability)

*§1410 | No Impact on Social Security Trust Fund*

- *Authorizes quarterly transfers of general revenues into the Social Security trust fund, if needed, to prevent the costs of the Patient Protection and Affordable Care Act from harming the Social Security program's long term fiscal solvency*

Subtitle F: Other Provisions

*§1501 | Physician Ownership-Referral*
*Note: Language for this section has yet to be supplied but will follow previous versions.*

*§1502 | Administrative Funding*
*Note: Language for this section has yet to be supplied but will follow previous versions.*

*§1503 | Funding for State Demonstration Programs on Alternatives to Current Medical Tort Litigation*
*Note: Language for this section has yet to be supplied.*

**Title II: Health, Education, Labor and Pensions**

Subtitle A: Education reconciliation language was omitted from this summary

Subtitle B: Health

*§2301* **|** *Health Insurance Rate Authority*

- Establishes a uniform process whereby the federal government and states will review increases in rates for health insurance premiums, beginning in 2011
- Requires health insurers to report data to CMS and state insurance commissioners, including rates, medical loss ratios, complaints, solvency, and actuarial reserves
- In the case of a "potentially unreasonable premium," health insurers will be required to submit a justification for the premium prior to its implementation
- The Secretary or state Insurance Commissioner will review potentially unreasonable premiums and may take corrective actions, such as requiring the insurer to pay a penalty, denying or modifying the premium or ordering the plan to pay rebates to consumers
- Penalties for unjustified premiums cannot be imposed in 2014 or later years

*§ 2302* **|** *Insurance Reforms*

- Requires grandfathered plans that are group health plans to cover adult dependents up to age 26, if those individuals are not eligible to enroll in a different group health plan
- Starting in 2014, extends restrictions on certain health insurer practices, such as pre-existing condition exclusions and annual and lifetime limits, to grandfathered plans that are group health plans
- Replaces rating restriction for tobacco use with a voluntary surcharge ($200 maximum for an individual) that insurers may asses to enrollees who do not attempt to quit smoking

*§2303* **|** *Drugs Purchased by Covered Entities*

- Removes expansion of 340(B) prices to inpatient facilities
- Excludes orphan drugs from the 340(B) program when sold to a children's hospital, cancer hospital, sole community hospital, critical access hospital or rural referral center
- Requires the Secretary to enter into agreements with drug manufacturers that set the prices paid by 340(B)-eligible facilities. Limits prices to the average manufacturer price (AMP) for the drug, reduced by the average Medicaid rebate for the drug.
- Requires manufacturers to submit quarterly reports of the ceiling prices for each drug
- Prohibits 340(B) eligible facilities from "double dipping" by seeking Medicaid reimbursement for a drug that is subject to both a Medicaid rebate agreement and a 340(B) agreement
- Prohibits 340(B) eligible facilities from reselling, distributing or administering covered drugs to individuals unless the individual is a patient of the facility and lacks insurance coverage for the drug in the inpatient setting.
- Requires 340(B) eligible facilities to allow the Secretary and the drug manufacturer to perform audits of the facility's compliance; establishes sanctions against eligible facilities and civil monetary penalties for facilities and / or manufacturers that fail to comply with these requirements

*§ 2304* **|** *Community Health Centers*

- Increases funding for community health centers in 2011 through 2015; funding starts at $1 billion and increases to $3.6 billion by the end of that period

*§2305 | Employer Responsibilities of States*

- As a condition of receiving federal funds for healthcare programs, requires state and local governments to comply with the provisions of the Act with regard to their role as employers