"The Patient Protection and Affordable Care Act" (Pub. L. 111-148)

Enacted March 23, 2010

"The Health Care and Education Reconciliation Act of 2010" (Pub. L. 111-152)

Enacted on March 30, 2010*

Summary of Certain Insurance, Delivery System, and Payment Reforms			
#	Section & Section Title	Description	Effective Date
	Title I -- Quality, Affordable Health Care for All Americans		
	Subtitle A -- Immediate Improvements in Health Care Coverage for All Americans		
1	1001, 1201, 10101, 10103 (as amended by Reconciliation § 2301). Amending the Public Health Service Act (PHSA).	Eliminates lifetime limits on coverage for all plans (PHSA § 2711); eliminates annual limits for new and grandfathered group plans in 2014 (prior to 2014, plans are permitted to impose "restricted" annual limits to be defined by the Secretary); prohibits rescissions of coverage in all plans, new and grandfathered (PHSA § 2712); requires coverage and waiver of cost sharing services for preventive services to include at least United States Preventive Services Task Force (USPSTF) A or B rated services, CDC recommended immunizations, and pediatric "well-baby" visits (PHSA § 2713); extends dependent coverage to children age 26 for all plans new and grandfathered, unless a dependant in a grandfathered plan is eligible to enroll in employer-sponsored coverage (PHSA § 2714); extends certain quality reporting requirements for group plans (PHSA § 2717); improves transparency in insurance costs, including annual reporting to the Secretary of HHS on percentage of premium revenue spent on reimbursement for clinical care, activities related to quality and administrative expenses and rebates to consumers if the medical loss ratio exceeds a	Effective date for provisions on lifetime limits, rescissions, and dependent coverage is 6 months after enactment, except that the annual limits are eliminated in 2014 and restricted prior to 2014; and young adults in existing group health plans not eligible for employer coverage before 2014; and PHSA § 2793 (grants) is effective on the date of enactment.
	Subtitle B -- Immediate Actions to Preserve and Expand Coverage		
2	1101. Immediate Access to Insurance for Uninsured Individuals with a Preexisting Condition.	Requires the Secretary to establish a temporary high risk insurance pool program for individuals previously denied coverage on the basis of preexisting conditions and who do not have other creditable coverage.	90 days after enactment, program terminates 1/1/2014.
3	1102, 10102. Reinsurance for Early Retirees.	Requires HHS to establish a temporary reinsurance program for retirees, including retirees of state and local governments, to provide reimbursement to assist participating employment-based plans with the cost of providing health benefits to retirees and to eligible spouses, surviving spouses and dependents of such retirees. Eligible retirees must be older than 55, no longer employed, and not eligible for Medicare.	90 days after enactment, program terminates 1/1/2014.

#	Section & Section Title	Description	Effective Date
	Subtitle C -- Quality Health Insurance for All Americans		
4	1201. Amendment to the Public Health Service Act.	Requires the Secretaries of HHS, Treasury, and Labor to establish a 10-state demonstration project on wellness programs offered by individual insurance plans (subject to the same new prohibitions on rewards for participation in the wellness program based on health status factors). Demonstration program may be expanded if it is found to be effective.	7/1/2014; may be expanded beginning on 7/1/2017.
	Subtitle D -- Consumer Choices of Health Benefit Plans		
5	1311, 10101, 10104(a)-(k). Affordable Choices of Health Benefit Plans.	Requires the Secretary to award grants to states to establish American Health Benefit Exchanges to facilitate purchase of "qualified health benefit plans." Establishes certain criteria for Exchanges, including that state Exchanges must be self sufficient by 1/1/2015 and that Exchanges must certify that participating plans offer minimum benefits. One factor when certifying plans must be the "reasonableness" of premium rates. Plans participating in the state Exchange must periodically report to the Exchange their activities related to improving quality, including reimbursement policies to incentivize care coordination, chronic disease management, medication and care compliance initiatives, medical home models, reduction in hospital readmissions, and use of health information technology. Plans participating in the state Exchange must also publicly disclose, in plain language, information on claims payment policies, enrollment, denials, rating practices, cost-sharing, and enrollee rights.	Grants beginning 1 year after enactment through 1/1/2015; state Exchanges must be operational by 1/1/2014.
6	10104(q). Multi-State Plans.	Requires the Office of Personnel Management to contract with health insurers to offer at least two multi-state qualified health plans (at least one of which is non-profit) through the Exchanges in each state. Multi-state plans must cover the essential health benefits, meet standards for medical loss rations, profit margins, and premiums, and meet all other requirements for qualified health plans.	Not specified.
7	1322, 10104(l). Federal Program to Assist Establishment and Operation of Nonprofit, Member Run Health Insurance Issuers.	Creates the Consumer Operated and Oriented Plan (CO-OP) program which consists of grants and loans to member-run nonprofits to offer qualified health benefit plans. CO-OPs must repay loans within 5 years and grants within 15 years. CO-OP participants may form a private purchasing council to enter into collective purchasing arrangements for items and services, but may not set provider payment rates.	Grants awarded no later than 7/1/2013.
8	1331, 10104(o). State Flexibility to Establish Basic Health Programs for Low-Income Individuals not Eligible for Medicaid.	Allows States to contract, through a competitive process that includes negotiation of premiums, cost-sharing, and benefits, with standard health plans for individuals who are not eligible for Medicaid or other affordable coverage and have income below 200% of FPL. Offerers of this plan may include innovative features, such as care coordination and management for chronic diseases, incentives for use of preventive services, and incentives for appropriate utilization of services. Makes legal immigrants with incomes less than 133% FPL who are not eligible for Medicaid because of the 5 year waiting period, eligible for the Basic Health Program.	Not specified.

#	Section & Section Title	Description	Effective Date
9	1341, 10104(r). Transitional Reinsurance Program for Individual and Small Group Markets in Each State.	Requires States to establish a nonprofit reinsurance entity that collects payments from insurers in the individual markets and makes payments to such insurers in the individual market that cover high-risk individuals. Requires the Secretary to establish Federal standards for the determination of high-risk individuals, a formula for payment amounts, and the contributions required of insurers, which must total $25 billion over 3 years.	1/1/2014 to 12/31/2016.
	Subtitle E -- Affordable Coverage Choices for All Americans		
10	1402. Reduced Cost-Sharing for Individuals Enrolling in Qualified Health Plans.	Requires reduced cost-sharing for certain low-income enrollees in qualified health plans, and permits the Secretary of HHS to establish a capitated payment system.	Not specified.
11	1411 (as amended by Reconciliation §§ 1001, 1004). Procedures for Determining Eligibility for Exchange Participation, Premium Tax Credits and Reduced Cost-Sharing, and Individual Responsibility Exemptions.	Requires the Secretary to establish a program for determining whether an individual applying for coverage in the individual market through the Exchange, or who is claiming a premium tax credit or reduced cost-sharing, meets the criteria for eligibility for such coverage, tax credit or reduced cost-sharing. Authorizes civil monetary penalties for failure to provide required documentation or for knowingly providing false documentation.	Not specified.
12	1412. Advance Determination and Payment of Premium Tax Credits and Cost-sharing Reductions.	Allows for the advanced payment of premium assistance tax credits and cost-sharing reductions for eligible individuals seeking individual coverage through the Exchange; prohibits any Federal payments to individuals who are not lawfully present in the United States.	Not specified.
13	10103. Clinical Trials.	Requires group and individual plans to cover "routine costs" associated with participation in a clinical trials; prohibits insurers from dropping coverage because an individual chooses to participate in a clinical trial and from denying coverage for routine care that they would otherwise provide just because an individual is enrolled in a clinical trial. Applies to approved clinical trials that treat cancer or other life-threatening diseases.	Not specified.
	Subtitle G -- Miscellaneous Provisions		
14	1554. Access to Therapies.	Prevents the HHS Secretary from promulgating certain regulations limiting access to health care services.	Not specified.
15	10108. Free Choice Vouchers.	Requires employers that offer coverage and make a contribution to provide free choice vouchers to qualified employees for the purchase of qualified health plans through state Exchanges.	2014
	Title II -- Role of Pubic Programs		

#	Section & Section Title	Description	Effective Date
	Subtitle A -- Improved Access to Medicaid		
16	2001, 10201. Medicaid Coverage for the Lowest Income Populations.	Creates a new state option to allow Medicaid coverage of eligible individuals who are under 65, not otherwise eligible for Medicare or Medicaid, not pregnant, and whose income does not exceed 133% of FPL (e.g., uninsured, childless adults); for children ages 6-19, increases Medicaid income eligibility requirement to 133% of FPL. To incentivize states to expand coverage pursuant to the new option, provides for temporary FMAP increases for certain "expansion states" (states which offer coverage to the newly eligible uninsured, childless adults).	2010
17	10202. Community Based Services.	Creates financial incentives for states to shift Medicaid beneficiaries out of nursing homes and into home and community based services (HCBS) by increasing the FMAP for states which rebalance spending between nursing homes and HCBS.	FY2011-2015.
	Subtitle E -- New Options for States to Provide Long-Term Services and Supports		
18	2401, 2402, 2403, 2404 (as amended by Reconciliation § 1205). Various titles related to the provision of long term care services.	Establishes an optional Medicaid benefit through which states may offer home and community-based attendant services and supports (HCBS) to Medicaid beneficiaries with disabilities who would otherwise require the level of care offered in a hospital, nursing facility, or intermediate care facility for the mentally disabled (Sec. 2401); eliminates certain barriers to providing HCBS by requiring states to coordinate oversight and regulation of HCBS to improve the quality of such services and by establishing a state option to provide additional HCBS services under Medicaid to individuals with higher levels of need, rather than through a waiver, and to extend full Medicaid benefits to individuals receiving HCBS through Medicaid (sec. 2402); extends the Money Follows the Person Rebalancing Demonstration program (the demonstration program is intended to allow states the flexibility to spend Medicaid funds most appropriately for individuals receiving HCBS) through Sept. 30, 2016 and modifies the eligibility rules for participating in the demonstration program (sec. 2403); requires states to apply spousal impoverishment rules to beneficiaries who receive HCBS (sec. 2404).	1/1/2011 (sec. 2401, 2402); FY2010 to FY2016 (sec. 2403); 1/1/2014 to 1/1/2019 (sec. 2404).
	Subtitle F -- Medicaid Prescription Drug Coverage		
19	2501 (as amended by Reconciliation § 1206). Prescription Drug Rebates.	Increases the Medicaid base rebate to 23.1% of AMP for single-source and multiple source innovator drugs, except the rebate is only increased to 17.1% of AMP for clotting for factors and drugs approved exclusively for pediatric indications; increases the base rebate for multi-source non-innovator drugs to 13%; 100% of additional rebate amount accrues to federal government, not states; extends the Medicaid drug rebate to MCOs; creates a Medicaid rebate for new formulations of single source or multiple-source innovator drugs.	1/1/2010.
20	2502. Elimination of Exclusion of Coverage of Certain Drugs.	Requires Medicaid to cover smoking cessation drugs, barbiturates, and benzodiazepines.	1/1/2014.

#	Section & Section Title	Description	Effective Date
21	2503. Providing Adequate Pharmacy Reimbursement.	Requires the Secretary of HHS to calculate the Federal upper limit (FUL) as no less than 175 % of the weighted average (determined on the basis of utilization) of the most recently reported monthly AMP for pharmaceutically and therapeutically equivalent multiple source drugs available nationally through commercial pharmacies.	First calendar year quarter that begins at least 180 days after enactment.
	Subtitle H -- Improved Coordination for Dual Eligible Individuals		
22	2602. Providing Federal Coverage and Payment Coordination for Dual Eligible Beneficiaries.	Requires the Secretary to establish a Federal Coordinated Health Care Office within CMS to better coordinate care of Medicare/Medicaid dual eligible individuals.	3/1/2010.
	Subtitle I -- Improving the Quality of Medicaid for Patients and Providers		
23	2701. Adult Health Quality Measures.	Directs the Secretary of HHS to develop a set of quality measures for Medicaid eligible adults similar to CHIP quality measures. The Secretary and the States will report on the development of and improvements to the quality measurement program on a regular basis	Draft recommended quality measures by 1/1/2011; final recommended measures by 1/1/2012; report on measures by 1/1/2013.
24	2702. Payment Adjustment for Health Care-Acquired Conditions.	Extends the Medicare HAC rule to Medicaid by prohibiting Medicaid payment for certain healthcare acquired conditions; to be developed by the Secretary of HHS.	7/1/2011.
25	2703. State Option to Provide Health Homes for Enrollees with Chronic Conditions.	Allows state Medicaid plans to provide medical homes for coordinating care for patients with chronic diseases, and requires states to develop a payment methodology for the medical home model; grants to states for medical home models.	1/1/2011.
26	2704. Demonstration Project to Evaluate Integrated Care Around a Hospitalization.	Requires the Secretary of HHS to establish a Medicaid demonstration project in up to 8 states to evaluate the use of bundled physician and hospitals payments to encourage integrated care.	1/1/2012 to 12/31/2016.
27	2705. Medicaid Global Payment System Demonstration Project.	Requires the Secretary of HHS, through the CMS Innovation Center to establish a Medicaid demonstration project in up to 5 states on shifting from fee for service to a capitated payment model for safety net hospitals.	FY2010 to FY2012.
28	2706. Pediatric Accountable Care Organization Demonstration Project.	Requires the Secretary of HHS to establish a Medicaid demonstration project to allow pediatric providers to be recognized as ACOs under Medicaid and to share in savings for services which are provided at a lower cost by the ACO.	1/1/2012 to 12/31/2016.

#	Section & Section Title	Description	Effective Date
29	2707. Medicaid Emergency Psychiatric Demonstration Project.	Requires the Secretary of HHS to establish a Medicaid demonstration project under which an eligible State would reimburse certain mental health facilities for the provision of medical care to stabilize an emergency medical condition for certain individuals.	3 year demonstration project; funds are authorized from FY2011 and available for 5 years.
	Subtitle J -- Improvements to the Medicaid and CHIP Payment and Access Commission (MACPAC)		
30	2801. MACPAC Assessment of Policies Affecting All Medicaid Beneficiaries.	Clarifies the scope of MACPAC and authorizes $11 M in funding for FY2010.	FY2010.
	Title III -- Improving the Quality and Efficiency of Healthcare		
	Subtitle A -- Transforming the Healthcare Delivery System		
31	3001, 3006, 10301, 10335. Hospital Value-Based Purchasing Program.	Requires the Secretary to establish a hospital value-based purchasing (VBP) program under which a portion of the hospital MS-DRG payment is tied to the hospital's performance on quality measures related to common and high cost conditions. Clarifies that the hospital VBP program shall not include measures of hospital readmissions. Quality measures included in the program will be developed and chosen with input from external stakeholders. Requires demonstration projects on establishing VBP programs in critical access and other, small hospitals (Sec. 3001, 10335). Directs the Secretary to submit a plan to Congress outlining a SNF VBP program and a VBP program for Ambulatory Surgical Centers (Sec. 3006, 10301). Requires HHS to test value-based purchasing programs for inpatient rehab facilities, inpatient psychiatric hospitals, long-term care hospitals, certain cancer hospitals, and hospice providers no later than Jan. 1 2016 (Sec. 10326, see also below, Sec. 10327).	FY2013 (Hospital VBP); 10/1/2011 (plan due for SNF VBP); 1/1/2016 (test VBP for other sites of care).
32	10303, 10304, 10305. Outcomes Measures.	Requires the Secretary of HHS to develop and publicly report on patient outcomes measures, including efficiency measures.	Not specified.
33	3002, 3004, 3005, 10327. Titles related to various Medicare provider quality reporting initiatives.	Improves the physician quality reporting initiative (PQRI), including reducing physician payments for failure to report on PQRI conditions beginning in 2015, and providing an additional 0.5% Medicare payment bonus to physician who successful report quality measures to CMS via a qualified Maintenance of Certification Program (Sec. 3002, 10327). Requires the Secretary to implement quality measure reporting programs for long-term care hospitals, inpatient rehab facilities, hospices (Sec. 3004), and PPS-exempt cancer hospitals (Sec. 3005) or risk reduction in the annual market basket update (see also, above Sec. 10326).	Measures published by 10/1/2012; reporting begins in 10/1/2013.

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34	10329, 10330, 10331. Value Assessments; Modernization; Transparency.	Requires the Secretary of HHS to develop a methodology to measure health plan value (Sec. 10329); requires the Secretary to develop a plan to utilize HIT at CMS to support improvements in care delivery (Sec. 10330); requires the Secretary of HHS to develop a "physician compare" website to enable Medicare beneficiaries to compare physician quality (Sec. 10331).	18 months after date of enactment (methodology to assess health plan value); 9 months after date of enactment (HIT); 1/1/2011 (physician compare website).
35	3007. Value-Based Payment Modifier Under the Physician Fee Schedule.	Directs the Secretary of HHS to develop and implement a budget-neutral payment system that will adjust Medicare physician payments under the physician fee schedule based on the quality and cost of the care they deliver. Quality and cost measures will be risk-adjusted and geographically standardized.	Phased in 2015-2016.
36	3008. Adjustment for Conditions Acquired in Hospitals.	Reduces Medicare payments to hospitals with high rates of certain health care acquired conditions; requires a report to Congress on extending this policy to other facilities.	FY2015; report due 1/1/2012.
37	3011, 10302. National Strategy for Quality Improvement.	Requires the Secretary of HHS to develop a national strategy to improve the delivery of health care services, patient health outcomes, and population health; clarifies that the limitations on use of comparative effectiveness data apply to the development of the national strategy.	1/1/2011.
38	3021, 10306. Establishment of Center for Medicare and Medicaid Innovation within CMS.	Requires establishment of a Medicare and Medicaid Innovation Center within CMS to test innovative payment and service delivery models to reduce program expenditures under Medicare, Medicaid, and CHIP while preserving or enhancing the quality of care furnished to individuals under such titles. Indicates that the CMS Innovation Center is explicitly permitted to test payment reform models, among other things and requires the Center to focus on models that both improve quality and reduce cost.	1/1/2011.
39	3022, 10307. Medicare Shared Savings Program.	Rewards accountable care organizations (ACOs) that take responsibility for the costs and quality of care received by their patient panel over time. ACOs can include groups of health care providers (including physician groups, hospitals, nurse practitioners and physician assistants, and others). ACOs that meet quality-of care targets and reduce the costs of their patients relative to a spending benchmark are rewarded with a share of the savings they achieve for the Medicare program.	1/1/2012
40	3023, 10308. National Pilot Program on Payment Bundling.	Directs the Secretary of HHS to develop a national, voluntary pilot program encouraging hospitals, doctors, and post-acute care providers to improve patient care and achieve savings for the Medicare program through bundled payment models; provides the Secretary with authority to expand the payment bundling pilot if it is found to improve quality and reduce costs.	1/1/2013 for 5 years; may be extended if Secretary submits justification for extension to Congress before 1/1/2016.
41	3024. Independence at Home Demonstration Program.	Authorizes the Secretary to establish a Medicare demonstration program to test an “independence at home” reimbursement model. The program would be targeted at high-need Medicare beneficiaries and is designed to reduce preventable hospital admissions and emergency department visits, and to otherwise improve quality and reduce costs.	Funds authorized for FY2010-FY2015.

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42	3025, 10309. Hospital Readmissions Reduction Program.	Establishes a methodology for reducing MS-DRG payments to certain hospitals for "excess readmissions" that occur for certain conditions, as selected by the Secretary and MedPAC.	On or after 10/1/2012.
43	3026. Community Based Care Transitions Program.	Requires the Secretary of HHS to establish a Community-Based Care Transitions Program under which the Secretary provides funding to eligible entities that furnish improved transitions in care to high-risk Medicare beneficiaries.	1/1/2011 for 5 years.
44	3027. Extension of Gainsharing Demonstration.	Extends the Medicare gainsharing demonstration project to improve the quality and efficiency of care provided to beneficiaries. The gainsharing demonstration program is designed to test and evaluate new payment methodologies and financial arrangements between hospitals and physicians to improve the quality and efficiency of care provided to beneficiaries and to develop improved operational and financial hospital performance. Through the innovative hospital-physician financial agreements, physicians are rewarded with a share of the hospital savings achieved by the physician's delivery of more efficient and higher quality care.	Extends through FY2014.
	Subtitle B -- Improving Medicare for Patients & Providers		
45	3103. Extension of Exceptions Process for Medicare Therapy Caps.	Extends the exception process for Medicare therapy caps to 12/31/2010.	Date of enactment to 12/31/2010.
46	3113. Treatment of Certain Complex Diagnostic Laboratory Tests.	Requires the Secretary of HHS to establish a demonstration program allowing direct laboratory billing for certain complex laboratory tests; requires a report to Congress on the demonstration project.	7/1/2011 for 2 years.
47	3134. Misvalued Codes Under the Physician Fee Schedule.	Requires the Secretary to periodically identify misvalued services and make appropriate adjustments to the relative values.	Not specified.
48	3135 (as amended by Reconciliation § 1107). Modification of Equipment Utilization Factor for Advanced Imaging Services.	Increases the practice expense units for "advanced diagnostic" imaging services from a presumed utilization rate of 50% to 75% beginning in 2011. Excludes low-tech imaging such as ultrasound, x-rays and EKGs from this adjustment. Effective 7/1/2010, adjusts the technical component discount on single session imaging studies on contiguous body parts from 25% to 50%.	2011 (practice expense adjustment); 7/1/2010 (single session discount).
49	3139. Payment for Biosimilar Biological Products.	Provides for separate billing codes for Part B biosimilar products; physician administration fee of a biosimilar to equal 6% of ASP of reference product.	First day of the second calendar quarter after enactment.
50	3140. Medicare Hospice Concurrent Care Demonstration Program.	Directs the Secretary to establish a three-year demonstration program in 15 hospice programs that would allow patients who are eligible for hospice care to also receive all other Medicare covered services during the same period of time.	Not specified.

#	Section & Section Title	Description	Effective Date
	Subtitle D -- Improvements for Prescription Drug Plans and MA-PD Plans		
51	3301, 3307, 3310, 3314, 3315 (as amended by Reconciliation § 1101). Various titles related to reduction in Part D coverage gap and other Part D reforms.	Requires drug manufacturers to provide a discount to Part D beneficiaries for brand-name and generic drugs and biologics purchased during the coverage gap and implements a $250 rebate for beneficiaries entering the coverage gap in 2010 (Sec. 3301, Reconciliation § 1101); provides the Secretary with authority to identify drug classes of clinical concern through rulemaking and codifies the current 6 classes as Medicare covered (Sec. 3307); requires Part D plans to develop drug dispensing techniques to reduce prescription drug waste in long-term care facilities (Sec. 3310); allows costs incurred under Ryan White state AIDS Drug Assistant Programs and the Indian Health Service to count toward annual out of pocket Part D thresholds (Sec. 3314).	1/1/2011 (donut hole discount); 1/1/2010 ($250 donut hole rebate); Plan year 2011 (protected classes); 1/1/2012 (dispensing techniques); 1/1/2011 (ADAP/IHS).
52	10328. Medication Therapy Management Programs.	Requires Part D prescription drug plans to include a comprehensive review of medications for individual beneficiaries and a written summary of the review to improve medication adherence, as part of their medication therapy management plans.	Plan years beginning on or after 2 years after date of enactment.
	Subtitle E -- Ensuring Medicare Sustainability		
53	3401, 10319 (as amended by Reconciliation § 1105). Revision of Certain Market Basket Updates and Incorporation of Productivity Improvements into Market Basket Updates That Do Not Already Incorporate Such Improvements.	Reduces the market basket up date by a "productivity adjustment" for the following facilities, services and products: inpatient and outpatient hospitals (effective FY2012), skilled nursing facilities (effective FY2012), long-term care hospitals (effective rate year 2010), inpatient rehab facilities (effective FY2012), home health agencies (effective 2015), inpatient psychiatric hospitals (effective rate year 2010), hospice care (effective FY2013), dialysis providers (effective 2012), ambulance services (effective 2011), ambulatory surgical centers (effective 2011), lab services (effective 2011), durable medical equipment (effective 2011), prosthetic devices (effective 2011), all other fee schedules (effective 2011). Makes certain other payment adjustments to the annual market basket update for fee schedules.	Various effective dates from rate year 2011 to 2019 (but in no case may the provision be effective before 4/1/2010).
54	3402. Temporary Adjustment to the Calculation of Part B Premiums.	Freezes the income thresholds at 2010 levels for higher-income beneficiaries who pay a higher Part B premium rate.	1/1/2011 to 12/31/2019.
55	3403, 10320. Independent Payment Advisory Board.	Creates a 15-member independent Payment Advisory Board (IPAB) which is required to make annual recommendations to the President and Congress on actions they can take to reduce the rate of cost growth in Medicare while maintaining beneficiary quality of care. Requires the Secretary to implement the recommendations unless Congress enacts an alternative that achieves the same amount of savings. In years where Medicare growth is below the targeted growth rate, requires the Board to make non-binding Medicare recommendations to Congress. Prohibits the Board from making recommendations that would reduce premium supports for low-income Medicare beneficiaries, or that prior to 2018 would reduce payment rates for providers, such as hospitals, that are already subject to productivity adjustments. Beginning in 2020, requires the Board to make binding biennial recommendations to Congress if the growth in overall national health spending exceeds growth in Medicare spending.	IPAB may submit annual reports to the President and Congress beginning 1/15/2014.

#	Section & Section Title	Description	Effective Date
	Subtitle F -- Health Care Quality Improvements		
56	3502. Establishing Community Health Teams to Support the Patient-Centered Medical Home.	Requires the Secretary of HHS to establish a program to provide grants to eligible entities to establish community based, interdisciplinary, interprofessional team ("health teams") to support primary care practices which provide patient-centered medical homes.	Not specified.
57	3503. Medication Management Services in Treatment of Chronic Disease.	Requires the Secretary of HHS to establish a program, through the new Patient Safety Research Center, to provide grants and contracts to eligible entities to offer collaborative, interprofessional, interdisciplinary medication management services.	No later than 5/1/2010.
58	3504. Design and Implementation of Regionalized Systems for Emergency Care.	Requires the Secretary of HHS to establish a grant program to support pilot projects on innovative models of regionalized, comprehensive emergency and trauma care.	Funding authorized for FY2010-FY2014.
59	3506. Program to Facilitate Shared Decision Making.	Requires the Secretary of HHS to establish a program and develop "patient decision aid" tools to improve "shared decision making" between patients and providers to improve patients' understanding of their medical treatment options and incorporate patient preferences into treatment plans.	As soon as practicable after enactment, funds authorized for FY2010 and beyond.
60	3507. Presentation of Prescription Drug Benefit and Risk Information.	Requires the FDA to determine whether use of a "drug facts box" in promotional labeling or advertising to clearly communicate a summary of drug risks and benefits to patients and providers is warranted.	Depending on Commissioner's determination, 3 years after date of enactment.
61	10609. Generic Drug Labeling.	Modifies requirements for approval of certain generic drug labeling.	Not specified.
62	3508. Demonstration Program to Integrate Quality Improvement and Patient Safety Training into Clinical Education of Health Professionals.	Establishes a program at AHRQ to give grants to academic institutions to develop and implement academic curricula that integrate quality improvement and patient safety into health professionals' clinical education.	Not specified.
	Title IV -- Prevention of Chronic Disease and Improving Public Health		
	Subtitle A -- Modernizing Disease Prevention and Public Health		
63	4001, 4002, 10401. National Prevention, Health Promotion, and Public Health Council.	Requires the President to establish, within HHS, the National Prevention, Health Promotion, and Public Health Council to coordinate prevention and wellness activities and to develop and implement a national prevention and health promotion strategy (Sec. 4001); establishes the Prevention & Public Health Fund (Sec. 4002).	1 year after date of enactment. (Council); FY2010-FY2015 (fund).

#	Section & Section Title	Description	Effective Date
	Subtitle B -- Increasing Access to Clinical Preventive Services		
64	4101, 10402(a). School-Based Health Centers.	Authorizes a grant program for the operation and development of School-Based Health Clinics which provide preventive and primary care services to underserved children and families, including vision services.	Funds authorized for FY2010-FY2012.
65	4103, 4104, 4105, 4106, 4206, 10402(b), 10406. Various titles related to expanding Medicare and Medicaid Coverage of Preventive Services.	Requires Medicare coverage of an annual wellness visit which including an initial preventive physical exam in the first year of Medicare coverage and a personalized prevention plan annually thereafter (Sec. 4103, 10402(b)) and a demonstration program to evaluate the use of personalized prevention plans for high risk, non-Medicare populations (Sec. 4206); eliminates Medicare cost sharing in outpatient settings for United States Preventive Services Task Force (USPSTF) A or B rated preventive services and clarifies that this applies to all settings of care (Sec. 4104, 10406); allows the Secretary of HHS to modify Medicare coverage of preventive services, consistent with the USPSTF (Sec. 4105); requires Medicaid coverage of USPSTF A or B rated preventive services and CDC recommended vaccines (Sec. 4106).	1/1/2011 (Sec. 4103, 4104); 1/1/2010 (Sec. 4105); 1/1/2013 (Sec. 4106).
66	4108. Incentives for Prevention of Chronic Diseases in Medicaid.	Requires the Secretary of HHS to award grants to states to carry out initiatives to provide incentives to Medicaid beneficiaries who participate in healthy behavior programs (e.g., tobacco cessation or weight loss programs).	3 year program, to begin between 1/1/2011 and 1/1/2016
67	10407. Diabetes Report Card.	Directs the Secretary of HHS to develop a national report card on diabetes to be updated every two years and to work with health professionals and states to improve data collection related to diabetes and other chronic diseases. Requires an IOM study on the impact of diabetes on medical care.	Not specified; IOM Study due 2 years after enactment.
68	10408. Small Business Grants for Employer Wellness.	Authorizes a 5-year, $200 million grant program to small businesses to establish employer wellness programs.	FY11-FY15.
69	10409. Cures Acceleration Network.	Creates the Cures Acceleration Network (CAN) within the Office of the Director of the NIH to award grants and contracts to develop "high need" cures. The CAN is directed to work with eh FDA to streamline premarket review and approval of high need cures.	FY2010 and beyond.
	Subtitle C -- Creating Healthier Communities		
70	4201, 4202, 10403. Healthy Aging, Living Well; Evaluation of Community Based Prevention and Wellness Programs for Medicare Beneficiaries.	Requires the Secretary of HHS to award grants to eligible entities, including in rural areas, for programs that promote individual and community health and prevent the incidence of chronic disease (Sec. 4201, 10403). Requires the Secretary of HHS to award grants to state or local health departments to carry out 5 year pilot programs to provide public health community interventions, screenings and clinical referrals for those between 55 and 64 (Sec. 4202).	Not specified.
71	4204. Immunizations.	Requires the Secretary to establish a demonstration program to award grants to states to improve immunization rates.	Funds authorized for FY2010-FY2014.

#	Section & Section Title	Description	Effective Date
	Subtitle D -- Support for Prevention & Public Health Innovation		
72	4303 - 4306, 10404. Childhood Obesity Demonstration Program.	Authorizes funding for a childhood obesity demonstration project.	Funds authorized for FY2010-FY2014.
	Title V -- Health Care Workforce		
	Subtitle D -- Enhancing Health Care Workforce Education and Training		
73	5313. Grants to Promote the Community Health Workforce.	Requires the CDC to award grants to eligible entities to promote positive health behaviors and outcomes in medically underserved communities.	Funds authorized for FY20101-FY2014.
74	10501(g). National Diabetes Prevention Program.	Establishes a national diabetes prevention program at the CDC to award grants for community-based diabetes prevention activities, training and outreach, and evaluation.	FY2010-FY2014
	Subtitle F -- Strengthening Primary Care and Other Workforce Improvements		
75	5501. Expanding Access to Primary Care Services and General Surgery Services.	Provides primary care practitioners, as well as general surgeons practicing in health professional shortage areas, with a 10% Medicare payment bonus for five years; provision must be budget neutral and is offset in part by across-the-board reduction in payment for all other services.	1/1/2011 to 12/31/2015
76	5502, 10501(i). Federally Qualified Health Centers.	Expands Medicare covered preventive services available at Federally Qualified Health Centers (FQHC) and requires establishment of a prospective payment system and annual market basket update for Medicare services delivered at FQHCs.	1/1/2011 (preventive services); FY2015 (PPS)
77	5507, 5509. Various demonstration programs to address health care workforce shortages.	Requires the Secretary of HHS to establish a demonstration program to provide grants to provide aid and supportive services to low-income individuals to obtain education and training for high-demand, low-supply occupations in the health care field; authorizes a demonstration project to develop training and certification programs for home health aids (Sec. 5509); authorizes a Medicare demonstration program to reimburse hospitals for providing qualified clinical training to certain nurses.	Funds authorized for FY2010-FY2014
78	10503 (as amended by Reconciliation § 2303). Community Health Centers and National Health Service Corps Fund.	Establishes a Community Health Centers and National Health Services Corps Fund within HHS to create an expanded and sustained national investment in community health centers and the National Health Services Corps.	FY2011-FY2015
79	10504. Affordable Care Demonstration Project.	Directs the Secretary of HHS to establish a 3-year, 10-state demonstration project in States to provide comprehensive health care services to the low-income uninsured at reduced fees.	Not specified.
	Title VI -- Transparency & Program Integrity		

#	Section & Section Title	Description	Effective Date
	Subtitle A -- Physician Ownership and Other Transparency		
80	6002, 6004. Transparency Reports and Reporting of Physician Ownership or Investment Interests.	Requires drug, device, biological and medical supply manufacturers to report transfers of value (including information about drug samples) made to a physician, physician medical practice, a physician group practice, and/or a teaching hospital; express preemption of duplicative state laws.	3/31/2013.
	Subtitle B -- Nursing Home Transparency and Improvement		
81	6112. National Independent Monitor Demonstration Project.	Requires the Secretary of HHS, in consultation with the Inspector General to establish a 2 year demonstration project to develop, test, and implement use of an independent monitor to oversee interstate and large intrastate chains of skilled nursing facilities and nursing facilities.	Not later than 1 year after enactment.
82	6114. National Demonstration Projects on Culture Change and Use of Information Technology in Nursing Homes.	Requires the Secretary of HHS to conduct two demonstration projects to develop best practices in SNFs and other nursing facilities who are involved in the "culture change" movement and to develop best practices on the use of information technology in SNFs and other nursing homes.	Not later than 1 year after enactment.
	Subtitle C -- Nationwide Program for National and State Background Checks on Direct Patient Access Employees of Long-Term Care Facility Providers		
83	6201. Nationwide Program for National and State Background Checks on Direct Patient Access Employees of Long-Term Care Facility Providers.	Requires the Secretary of HHS to establish a program to identify efficient, effective, and economical procedures for long term care facilities or providers to conduct background checks on prospective direct patient access employees on a nationwide basis.	Funds authorized for FY2010-FY2012.
	Subtitle D -- Patient-Centered Outcomes Research		
84	6301, 10602. Patient Centered Outcomes Research.	Establishes a private, non-profit corporation to assist patients, clinicians, purchasers, and policy makers in making health decisions by conducting research that would compare the clinical effectiveness, risk and benefits of two or more medical treatments, services or items. Defines treatment, services and items as health care interventions, protocols for treatment, care management and delivery, procedures, medical devices, diagnostics tools, pharmaceuticals and any strategies or items used in the treatment, management and diagnosis of or prevention of illness or injury, in patients. Prohibits the Secretary from using the research in determining coverage for a treatment in ways that discriminate based on age, disability, or diagnosis of terminal illness, and prohibits the Secretary from using CER information as the sole basis of coverage decisions.	FY2013. Board must be appointed no later than 6 months after enactment; Methods Committee must have standadrs 18 months after the Institute is established.
	Subtitle E -- Medicare, Medicaid, and CHIP Program Integrity Provisions		

#	Section & Section Title	Description	Effective Date
85	6411. Expansion of the Recovery Audit Contractor (RAC) Program.	Extends the RAC program to Medicaid and Medicare Parts C and D.	12/31/2010.
	Title VII -- Improving Access to Innovative Medical Therapies		
	Subtitle A -- Biologics Price Competition and Innovation		
86	7001, 7002, 7003. Approval Pathway for Biosimilar Biological Products.	Amends the Federal Food, Drug, and Cosmetic Act to establish a new FDA-approval pathway for biosimilar products.	Not specified.
87	7101, 7102, 7103 (as amended by Reconciliation § 2302). Various titles related to improving the 340B program.	Extends access to 340B prices to certain children's hospitals, cancer hospitals, critical access and sole community hospitals, and rural referral centers, but exempts orphan drugs from 340B prices for new entities (Sec. 7101); strengthens HHS oversight of manufacturer compliance with respect to 340B pricing (Sec. 7102); requires a GAO report which must include recommendations on whether to expand the 340B program (Sec. 7103).	1/1/2010; report due 18 months after date of enactment.
	Title VIII -- CLASS Act		
88	8001, 8002, 10801. Establishment of National Voluntary Insurance Program for Purchasing Community Living Assistance Services and Support.	Establishes a national voluntary insurance program for purchasing community living assistance services and supports for disabled adults, financed by payroll deductions; requires the Secretary of HHS to promulgate regulations to implement the CLASS Act.	Not specified.
	Title IX-- Revenue Provisions		

#	Section & Section Title	Description	Effective Date
89	9001 - 9017, 10901-10909 (as amended by Reconciliation §§ 1401-1406). Various titles related to taxes and offsets.	• 9001, 10901, Reconciliation § 1401: Effective in 2018, imposes excise tax on health coverage in excess of $10,200 (individual)/$27,500(family) indexed to inflation • 9002: Requires employer W-2 reporting of value of health coverage • 9003, Reconciliation § 1403: Conforms definition of qualified medical expenses for HSA, FSAs, HRAs to the definition used for itemized medical expense deductions • 9004: Increases penalty for nonqualified HSA distributions to 20% • 9005, 10902: Limits health flexible spending arrangements in cafeteria plans to $2,500, indexed to inflation to the CPI update beginning in 2012 • 9006: Requires information reporting on payments to corporations • 9007, 10903: Establishes additional requirements for section 501(c)(3) nonprofit hospitals • 9008, Reconciliation § 1404: Imposes annual fee on manufacturers & importers of branded drugs, effective 2011 • 9009, 10904, Reconciliation § 1405: Repeals and replaces Sec. 9009; imposes excise tax on sale of a taxable medical devices; exempts certain devices from tax; effective in 2013 • 9010, 10905, Reconciliation § 1406: Imposes annual fee on health insurance providers beginning in 2014 • 9011: Study and report of effect on veterans health care • 9012: Eliminates deduction for expenses allocable to Medicare Part D subsidy • 9013: Raise 7.5% AGI floor on medical expenses deduction to 10% • 9014: $500,000 deduction limitation on taxable year remuneration to health insurance officials ($0.6 billion) • 9015, 10906: Imposes additional 0.9% hospital insurance tax on wages > $200,000 ($250,000 joint) • 9016, 10907: Modifies section 833 treatment of certain health organizations • 10907: strikes the 5% excise tax on cosmetic surgery and instead imposes a 10% tax on indoor tanning services, effective 7/1/2010 • 10908: excludes from gross income payments made under any state loan repayment or loan forgiveness program that is intended to provide for the increased availability of health care services in health professional shortage areas • 10909: increases the adoption tax credit and adoption assistance exclusion and makes the credit refundable, through 2011	Various effective dates.
90	9023. Qualifying Therapeutic Discovery Project Credit.	Creates a two year temporary tax credit subject to an overall cap of $1 billion to encourage investments in new therapies to prevent, diagnose, and treat acute and chronic diseases.	60 days after enactment.

* Red text refrlect changes made by the Reconciliation Act.