

H.R. 2300

EMPOWERING PATIENTS FIRST ACT

Section-by-Section Overview

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

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

Title I – Tax Incentives for Maintaining Health Insurance Coverage

(Makes it financially feasible for all to purchase coverage they want for themselves and their families – not that Washington forces them to buy)

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 families¹).
 - \$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.

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

- 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 for the advance payment to be sent to the insurer or issuer for the plan of the individuals choosing.
- Standards of confidentiality are included to protect disclosure of individual earnings.
- Insurers and issuers report to Treasury to ensure effective/efficient process

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

- Allows individual to opt out of Medicare, Medicaid, TRICARE, and VA benefits and receive tax credit to purchase personal health plan instead.
- Allows 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 receive a credit instead.

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 individual purchase of health coverage in the individual market.
- Caps deduction equal to average value of national health exclusion for employer-sponsored insurance, with 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 private right of action with actual or threatened violation of this section.

Sec. 107. Equal Employer Contribution Rule to Promote Choice

- Allows employer, voluntarily, to grant all employees a pre-tax benefit through a monetary ('defined') contribution. The employee could select their own plan – stay with the current employer-sponsored plan or choose an option from individual market.
 - If 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 "defined contribution" option, if employee changes jobs, they may keep coverage.
- Those moving to 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

- Employers may institute auto-enrollment for health insurance for those plans with a federal nexus, provided employee may opt out of coverage. States may not preclude this.

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, to offset administrative burden to institute auto-enrollment or a defined contribution.
 - This credit is available on a one time basis.
 - The ability to claim a credit expires two years after date of enactment.

Sec. 110. HSA Modification and Clarification

- Treatment of capitated primary care payments for medical care clarified:
 - HSA may be used for pre-paid physician fees, including “concierge” or “direct practice” medicine.

Title II--Health Insurance Pooling Mechanisms for Individuals

Subtitle A—Federal Grants for State Insurance Expenditures

Sec. 201. Federal Grants for State Insurance Expenditures

- Each State may receive grants for providing health benefits coverage through a high-risk pool, a reinsurance pool, or other risk-adjustment mechanism used for the purpose of subsidizing the purchase of personal health insurance.
- Extends funding currently available under the PHSA (established in 2002 under the TAA) to implement and run high-risk or reinsurance pools for those rejected by individual market insurers or whose premium offers are above a certain level.
 - Levels set by states. Those receiving a quote above the premium charged by the high risk pool would, usually, make one 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.
- New annual funding may only go toward:
 - Current qualified high-risk and reinsurance pools that only cover “high-risk” populations. Individuals under the Health Care Tax Credit (TAA) may be exempted.
 - 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 deductible HSA plan
 - Offer multiple competing plan options
 - Reinsurance Pools
 - Cover only high-risk populations (with the aforementioned exemption)
 - Structures pool on prospective basis (to encourage cost containment measures) under which a health insurance issuer cedes covered lives to pool in exchange for payment of reinsurance premium
- Bonus grants are awarded to states that provide:

- Guaranteed issue to individuals with prior group coverage
- A reduction in actual or premium trends, or other cost-sharing requirements
- An expansion/broadening of pool of high-risk individuals eligible for coverage
- Adoption of the NAIC Model Health Plan for Uninsurable Individuals Act
- This Section shall sunset on October 1, 2016.

Subtitle B—Health Care Access and Availability

Sec. 211. Expansion of Access and Choice Through Individual Membership and Small Employer Membership Associations (IMAs)

- Amends Public Health Service Act allowing 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:
 - Non-discrimination 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 an 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 C—Small Business Health Fairness

Sec. 221-226. 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 to prevent unpaid claims in 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 above 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 other insurance products – online, by mail, by phone, or in consultation with an insurance agent
- 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.
- Establishes a trigger provision so that an individual may only shop across state lines if the state premium (with respect to the individual) exceeds 10% above the national average, starting no sooner than two years after date of enactment.

Title IV --Safety Net Reforms

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

- State Plans shall demonstrate 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 shall be grandfathered into 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 may not require enrollment in the program.

- 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 multiplied by the Enhanced FMAP rate for the state. Any further costs shall be borne by 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 shall not be 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 reimbursement limit
 - 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 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 shall make available the purchase of private insurance as an option to their Medicaid and SCHIP populations, but may not require enrollment.
 - Exception: If the SCHIP or Medicaid program provides those enrolled under the plan, a cash out or health savings account type option, as of the date of enactment.
- States shall 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 shall 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 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 may be deposited into that individual's account.

Title V—Lawsuit Abuse Reforms

Sec. 501. Change in Burden of Proof Based on Compliance with Best Practice Guidelines

- 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 the evaluation and/or 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 resources for physicians.
- Secretarial review and approval: The Secretary shall issue, by regulation, after notice and opportunity for public comment, best practice measures endorsed by medical specialty societies.
 - Limitation: the Secretary may not make a rule that includes guidelines other than those approved and submitted by physician specialty organizations
- Guidelines shall be publicly available
- Guidelines shall be updated regularly, at least every two years
- Guidelines may:
 - Be used by a defendant as an affirmative defense in a lawsuit relating to medical treatment
 - By a preponderance of the evidence, demonstrate that the treatment provided was consistent with those guidelines
 - If followed, allow a defendant to not be held liable unless clear and convincing evidence establishes liability otherwise
- Best practices will be held to a higher defense in a court of law ('clear and convincing evidence') if:
 - 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. 502. 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 dissatisfied 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 dissatisfied with their 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. 503. 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 plaintiff will receive, past and current expenses will continue to be paid at the time of judgment or settlement, while future damages may be funded over time to ensure payment without risking bankruptcy of the defendant.

Sec. 504. Definitions

Sec. 505. 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. 506. 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 or Patient-Centered Outcomes Research; Accounting for Personalized Medicine and Differences in Patient Treatment Response

- The Secretary of HHS is prohibited from using comparative effectiveness or patient-centered outcomes research, to deny coverage of an item or service under a Federal health care program
- The Secretary must ensure that comparative effectiveness or patient-centered outcomes 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 (FCCER) or the Patient-Centered Outcomes Research Initiative (PCORI) from being released in final form until after consultation with and approval 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 – State Transparency Plan 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.
- 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 may not assist in direct enrollment.
- Plan Portal shall provide for a way to incorporate information on available credits and deductions for purchase of qualified insurance to ease individual access to them.

Title X – Patient Freedom of Choice

Sec. 1001. Guaranteeing Freedom of Choice and Contracting for Patients under Medicare (H.R. 1310)

- Allows Medicare beneficiaries to voluntarily enter into contracts with participating and non-participating Medicare eligible professionals without penalty.
- 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 may not 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 (H.R. 969)

- 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 completion of a 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 serve, 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 education loan.

Title XII – Quality Health Care Coalition

Sec. 1201. Quality Health Care Coalition

- 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.
- Allows non-economically aligned physicians to negotiate together for higher quality care for their patients.
- 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 with an additional 1% reduction to non-defense discretionary spending.

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.
- Reduces Medicare Disproportionate Hospital Share (DSH) funds beginning in 2017 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.
- Reduces Medicaid Disproportionate Hospital Share (DSH) funds beginning in 2017 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 HCFA

- 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 personal 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 may not 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.