



American Hospital  
Association

# SPECIAL BULLETIN

Sunday, December 20, 2009

## Reid Unveils Revised Senate Health Reform Bill

### *First vote to take place tonight*

Senate Majority Leader Harry Reid (D-NV) yesterday filed his “manager’s amendment” revising major portions of the Senate’s health care reform bill, the “Patient Protection and Affordable Care Act” (H.R. 3590). With the revisions, the bill is estimated to cost \$871 billion and would extend coverage to 31 million people by 2019, leaving 23 million without coverage.

Senator Reid is expected to bring the manager’s amendment up for an initial procedural vote at 1 a.m. Monday morning. That vote, if successful, will clear the way for a series of procedural votes, culminating in a vote on final passage later this week.

### **Health Insurance Exchanges and Public Plan**

**Public Plan Option:** The manager’s amendment eliminates the public plan option, including the so-called state opt-out, as well as the option for nation-wide health plans, and replaces them with multi-state qualified health plans (MSQHP) administered through the federal Office of Personnel Management (OPM). OPM is required to contract with health insurers to offer at least two multi-state qualified health plans through the exchanges. One MSQHP must be non-profit. OPM negotiates the contracts with the MSQHPs similar to the process established for the Federal Employees Health Benefits Program (FEHBP). Provider rates would be negotiated by the MSQHP. The FEHBP program would be maintained as a separate program with a separate risk pool.

**Plan Oversight:** The exchanges must consider the reasonableness of premium increase when certifying plans participation in the exchange. The Government Accountability Office (GAO) is required to study the cost and affordability of plans offered in the exchanges.

**Individual Mandate:** Beginning in January 1, 2014, all U.S. citizens and legal residents would be required to maintain minimum essential coverage, defined as any plan offered through the individual market, public programs such as Medicare, Medicaid, TRICARE and the Veteran’s Health Care Program, employer-sponsored health plans, and other plans. The manager’s amendment increases the tax penalty for individuals that fail to secure coverage. The

penalties are the great of \$95 in 2014, \$495 in 2015, and \$750 in 2016, or up to 2 percent of income by 2016, capped at the national average bronze premium. Families will pay half of the penalty for children up to a \$2,250 cap for the entire family. After 2016, the dollar amounts for the penalties will be increased by an annual cost of living adjustment.

**Medical Home Plans:** Plans that provide coverage through a qualified direct primary care medical home plan that meets criteria determined by the Secretary can participate in plans offered through the exchange.

**Federally Qualified Health Centers (FQHCs):** FQHCs participating in plans offered through the exchange will be reimbursed at least as high as Medicaid FQHC payment levels.

**Legal Immigrants:** Legal immigrants with incomes less than 133 percent of FPL and who are not eligible for Medicaid because of the five-year waiting period are eligible for the Basic Health Program. The Basic Health Program is available to states as an option to offer a standard health plan to individuals under 200 percent of FPL who are not eligible for the state Medicaid program. The basic health plan operates outside the exchange.

**Abortion:** States may prohibit abortion coverage in plans offered through the exchange if a state enacts a law to prohibit such coverage. Plans within the exchange can elect to not cover abortion. Public subsidies managed by the exchange must be segregated from funds that are used to pay for individuals enrolled in plans that provide abortion coverage. State insurance commissioners must ensure compliance with the process to establish segregated funds.

## **Medicare**

**Hospital Payment Updates:** The manager's amendment slightly reduces update reductions in fiscal years (FY) 2012 and 2013 over Reid's original bill. Total Medicare payment update reductions would drop from approximately \$105.5 billion under the original bill to approximately \$102.7 billion over 10 years. The table below outlines market basket reductions in both Reid's original bill, and the manager's amendment. Each year from 2014 through 2019, 0.2 percent of the overall reduction will not occur if certain coverage targets are not met.

	<b>Sen. Reid's Nov. 19 Bill</b>	<b>Manager's Amendment</b>
<b>2010</b>	MB minus 0.25	Same
<b>2011</b>	MB minus 0.25	Same*
<b>2012</b>	MB minus 0.2 + productivity	<i>MB minus 0.1 + productivity</i>
<b>2013</b>	MB minus 0.2 + productivity	<i>MB minus 0.1 + productivity</i>
<b>2014</b>	MB minus 0.2 + productivity	MB minus 0.2 + productivity
<b>2015-2019</b>	Same as above	Same as above
<b>2020 and Beyond</b>	MB minus productivity	MB minus productivity
<b>10-Year Savings:</b>	\$105.5 billion	\$102.7 billion

\*MB minus 0.5 percent for LTCHs

*The chart above applies to services provided by PPS hospitals for inpatient services, hospital outpatient services, inpatient psychiatric hospitals, inpatient rehabilitation facilities, and long-term care hospitals.*

**Medicare DSH:** The manager's amendment increases Medicare disproportionate share hospital (DSH) payment reductions from \$20.6 billion over 10 years in Reid's original bill to \$24.4 billion under the amendment. The bill first reduces Medicare DSH payments by 75 percent in FY 2015 and beyond to eliminate DSH payments that are above the "empirically justified" level, as determined by the Medicare Payment Advisory Commission. A portion of the 75 percent would then be returned to hospitals depending on the amount of uncompensated care they provide. This amount is subject to a trigger, and would be phased down if coverage increases.

**Readmissions:** The manager's amendment retains the provision penalizing hospitals with readmission rates that exceed their expected level of readmissions. This provision, which is similar to the House bill, would start with the readmission measures of heart attack, heart failure and pneumonia currently displayed on the Hospital Compare Web site. Hospitals with readmission rates that exceed their expected readmission rate will have all of their Medicare inpatient payments reduced by an amount approximately equal to the dollar value of the payments made for the excessive number of readmissions. The AHA and others sought a more sensible approach to dealing with readmissions overall.

**Accountable Care Organizations (ACOs):** The manager's amendment expands the ACO shared savings program by allowing the HHS Secretary to use other payment methodologies including, but not limited to, partial capitation where ACOs would be at risk for some, but not all, of the items and services covered under parts A and B of the Medicare program. It also allows the Secretary to give preference to ACOs that are participating in similar programs

with private payers. Finally, it would allow new entrants into the physician group practice demonstration project. The provision allowing hospitals to take a leadership role in ACOs is retained.

**Bundling:** The manager's amendment increases from eight to 10 the number of conditions selected for a voluntary pilot program to test bundled payment by 2013. Entities comprised of groups of providers including a hospital, a physician group, a skilled-nursing facility and a home health agency may apply to participate. At any point after Jan. 1, 2016, the HHS Secretary may expand the pilot program if the pilot has reduced costs, while maintaining or improving quality. Additionally, the manager's amendment requires the Secretary to separately pilot test the continuing care hospital (CCH) model. The CCH bundle could test bundling for conditions not included in the 10 selected by the Secretary and would include the stay in the CCH and 30 days post discharge. A continuing care hospital provides traditional services of an inpatient rehabilitation facility, long term care hospital and skilled nursing facility under common management.

**340B Program:** The manager's amendment maintains the Senate bill's expansion of the existing 340B hospitals to cover inpatient drugs, and the addition to the inpatient and outpatient programs children's, cancer and critical access hospitals, as well as certain sole-community hospitals and rural referral centers.

**Independent Medicare Advisory Board:** The manager's amendment expands and modifies the Independent Medicare Advisory Board and renames it the Independent Payment Advisory Board. The amendment requires the board to send proposals to the Congress at the same time they are sent to the President. The bill also expands the board to review, and make non-binding recommendations on, system-wide health care costs, patient access to care, utilization, and quality-of-care that allows for comparison by region, types of services, types of providers, and both private payers and Medicare. The amendment did not affect language that excludes providers like hospitals through 2019.

**Physician Self-Referral:** As in the previous version, the exception for physician-owned hospitals under the Stark law would be eliminated. However, the manager's amendment would extend the grandfathering date from February 1, 2010 to August 1, 2010, thus providing more time for physician-owned hospitals under development to be completed and certified by the Medicare program. The extension of the trigger date reduces the projected savings of the provision from \$0.7 billion to \$0.5 billion. The amendment also extends the time available for the HHS Secretary to establish a process for approving growth applications for grandfathered facilities.

**Physician Payment:** The manager's amendment repeals the one-year fix to physician payment that was contained in the bill. Congress has included a two-month fix for the reductions in physician payment in separate legislation.

**Graduate Medical Education (GME):** The manager's amendment contains no reductions in IME payments. Like Reid's bill, it redistributes 65 percent of unused residency training positions as a way to encourage increased training of primary care physicians and general surgeons. Qualified hospitals would be able to request up to 75 new slots. It maintains the same priority scheme, which allocates the majority of positions to hospitals in states with low resident-to-population ratios and hospitals in rural and high health professional shortage areas.

**Special Rural Hospital Provisions:**

- The manager's amendment extends Section 508 reclassifications through September 30, 2010, effective April 1, 2010, and requires the HHS Secretary to make up the difference in payment for the first six months of FY 2010 no later than December 31, 2010. The provision also prevents any Sec. 508 hospital from seeing a reduction in payment because their current wage index is higher than the reclassification.
- The manager's amendment also extends the rural community hospital demonstration program for five years, instead of one year as in the original bill. In addition, the amendment sets the base year for determining cost payments for hospitals included in the first five years of the demonstration to be the first cost report beginning on or after the first day of the five-year extension period.
- The amendment also expands and improves the Medicare inpatient PPS adjustment for low-volume hospitals and increases the size of a low-volume hospital from 1,500 discharges per year to 1,600 discharges per year.

**Frontier States:** The manager's amendment creates, in FY 2011 and beyond, a wage index floor of 1.0 for inpatient and outpatient hospital PPS payment systems and sets a floor of 1.0 for the physician practice expense index in frontier states where at least 50 percent of the counties in the state have fewer than six people per square mile. Those states are North Dakota, South Dakota, Montana, Wyoming and Nevada. The amendment increases payments to PPS hospitals and physicians in those states by \$2 billion over 10 years.

**Medicare Federally Qualified Health Center (FQHC):** The manager's amendment establishes a prospective payment system (PPS) for services in Medicare FQHCs for cost-reporting period beginning on October 1, 2014 and establishes an annual FQHC market basket update. It also adds certain Medicare-covered preventive services to the list of covered FQHC services.

**Budget Neutrality Requirements Related to Primary Care/General Surgery Bonus:** The manager's amendment eliminates provisions that would have paid

for half of the cost of the bonuses for primary care and general surgery through an across-the-board reduction to the conversion factor for all physicians.

**Long-Term Care Hospitals (LTCH):** The manager's amendment increases the extension, from a one-year extension to a two-year extension, for the LTCH protections and moratorium in the "Medicare, Medicaid and SCHIP Extension Act of 2007." This provision is paid for by increasing the market basket reduction for FY 2012.

**Home Health:** The amendment delays for an additional year to 2014 provisions in the original Senate bill to rebase home health payments. Also, it directs the HHS Secretary to study improving access to home health care for certain patients, including those with high-severity levels of illness, low-income and living in underserved areas, and provides the Secretary authority to conduct a demonstration program based on the results of the study.

**Skilled Nursing Facilities:** The amendment delays the implementation of certain skilled nursing facility "RUGs-IV" payment system changes by one year to October 1, 2011. The amendment requires the Secretary to implement on October 1, 2010 the concurrent therapy change and changes to the lookback period to ensure that only those services furnished after admission are included in determining case mix classification.

**Innovation Center:** The manager's amendment would allow the Center for Medicare and Medicaid Innovation (CMI) within the Centers for Medicare & Medicaid Services by 2011 to limit tests of innovative payment and service delivery models within certain geographic areas. The amendment instructs the HHS Secretary, when determining which models to expand, to focus on models and demonstration projects that are expected to reduce program expenditures and improve quality.

**Value-Based Purchasing:** The VBP section has been amended to exclude any measures related to hospital readmissions. This would prevent duplicative payment penalties, which could have occurred if readmission measures were included both in the VBP program and the separate readmissions provision.

**Pilot Programs for Value-Based Purchasing for Psychiatric Hospitals, IRFs, LTCHs, Cancer Hospitals, and Hospice:** The manager's amendment contains a new provision that would implement VBP pilot programs, beginning in 2016, for psychiatric hospitals, inpatient rehabilitation facilities, long-term care hospitals, cancer hospitals, and hospice providers. The HHS Secretary could expand the duration and scope of the pilot programs beginning in 2018.

**Quality Reporting for IRFs, LTCHs, and Hospice:** The amendment establishes a payment-for-reporting quality program for inpatient rehab hospitals,

LTCHs, and hospice and reduces the annual update by 2 percentage points for non-reporters. It saves \$0.2 billion over 10 years.

**Quality Reporting for Inpatient Psychiatric Hospitals and Units:** The manager's amendment requires inpatient psychiatric hospitals and units to report quality measures beginning in 2014. For psychiatric hospitals that do not report, their market basket updates would be reduced by 2 percentage points.

**Hospital-Acquired Infections:** The amendment mandates that the HHS Secretary publicly report on hospital-acquired infections using the claims data generated through the hospital-acquired conditions policy that was initiated last year. Under that policy, certain infections and other complications that arise during hospitalization and are considered by CMS to be preventable cannot be a reason that the patient moves from a lower-paying to a high-paying DRG. Because these data are generated from claims, and not clinical records, and because CMS would have only Medicare data with which to make this calculation, these reported infection rates would likely differ significantly from other sources of infection information.

### **Medicaid**

**Medicaid DSH:** Under provisions in the manager's amendment, Medicaid DSH reductions would begin when a state experiences a reduction in the percentage of individuals with no health care insurance of at least 45 percent based the most recent U.S. Census Bureau data compared to the state insurance levels for FY 2009. States are divided onto four groups:

- Low DSH states that have spent less than 99.9 percent of their DSH allotment will have a reduction of 25 percent;
- Low DSH states that have spent more than 99.9 percent of their DSH allotment will have a reduction is 17.5 percent;
- DSH states that have spent less than 99.9 percent of their DSH allotment will have a reduction of 50 percent; and
- DSH states that have spent more than 99.9 percent of their DSH allotment will have a reduction of 35 percent.

Future reductions will then be based on the most recent U.S. Census Bureau data that continues to show the percentage of uninsured individuals is less than the previous fiscal year. The further reductions would be calculated as follow:

- Low DSH states that have spent less than 99.9 percent of their DSH allotment will have a reduction that is equal to the product of the percentage reduction in the state's uninsured and 27.5 percent.
- Low DSH states that have spent more than 99.9 percent of their DSH allotment will have a reduction that is equal to the product of the percentage reduction in the state's uninsured and 20 percent.

- DSH states that have spent less than 99.9 percent of their DSH allotment will have a reduction that is equal to the product of the percentage reduction in the state's uninsured and 55 percent.
- DSH states that have spent more than 99.9 percent of their DSH allotment will have a reduction that is equal to the product of the percentage reduction in the state's uninsured and 40 percent.

No state DSH allotment would fall below 50 percent of the FY 2012 DSH allotment levels, up from 35 percent in the previous version. Hawaii's DSH allotment would be raised to \$7.5 million for FY 2012 and beginning in FY 2013 will be treated like a low DSH state.

**Medicaid Coverage Expansion:** Beginning in 2014, states must cover foster children up to age 26 who have aged out of foster care services. Beginning April 1, 2010, states, at their option, can cover adults at or below 133 percent of FPL.

**FMAP and Newly Eligible:** The manager's amendment makes several changes to the Medicaid expansion up to 133 percent of FPL and the enhanced FMAP provided to states to help defray the cost of the expansion. The amendment clarifies:

- The definition of expansion states (states that cover, on the date of enactment, parents and childless adults at 100 percent of FPL or above) is clarified to mean the benefit package, in an expansion state, must include inpatient hospital services.
- Clarifies that the definition of current coverage levels for the newly eligible is tied to state coverage levels as of December 1, 2009 rather than date of enactment.
- Vermont will receive an increase to its enhanced FMAP of an additional 2.2 percentage points for the period between January 1, 2014 and September 30, 2019. The state also will receive a 0.5 percentage point increase for the enhanced FMAP for the period between January 1, 2014 and December 2016. (Vermont expanded Medicaid eligibility above 133 percent of FPL and would not have any newly eligibles based on the underlying bill's Medicaid expansion criteria.)
- Nebraska will receive 100 percent FMAP for the newly eligible populations.
- A state that has political subdivisions (counties) that help fund the state share of FMAP would have to share the benefits of the enhanced FMAP with the political subdivisions.

**Children's Health Insurance Program (CHIP):** Federal CHIP funding authorization terminates as of FY 2015, at which point children would be eligible for coverage through Medicaid or the exchange. States would continue to receive an enhanced FMAP of 23 percentage points for FY 2016 through FY 2019. Children of qualifying state and local public employees can enroll in CHIP. The HHS Secretary must approve all transitioning coverage from CHIP to the

exchanges. Children blocked from CHIP enrollment because of state enrollment caps will be eligible for coverage through the exchanges with public subsidy support. Insurers in the exchanges must report to the Secretary on pediatric quality measures

**Rebalancing Long-Term Care:** States are encouraged to rebalance long-term care services between institutional settings and home and community-based settings. FMAP increases are available to states that undertake the rebalancing initiative.

### **Liability**

**State Tort Reform Demonstrations:** The amendment authorizes the HHS Secretary to award demonstration grants to states for the development, implementation, and evaluation of alternatives to current tort litigation. Each state desiring a grant shall develop an alternative to current tort litigation that allows for the resolution of disputes over injuries allegedly caused by health care providers or health care organizations; and promotes a reduction of health care errors by encouraging the collection and analysis of patient safety data related to disputes. States would need to develop patient notification measures and allow patients to opt out of the alternative system. States and the Secretary would evaluate and report on the effectiveness of the alternative systems.

### **Insurance Market Reforms**

**No Annual Lifetime Limits:** The manager's amendment clarifies that no health care plan could establish lifetime limits or annual limits beginning in 2014. For the period prior to 2014, plans would be permitted to impose annual limits on the dollar value of benefits with respect to the essential health benefits package as defined by the underlying bill. The HHS Secretary is required to ensure access to needed services during this period with minimal impact on premiums, with minimal impact on providers.

**Expanded Health Plan Transparency Related to Health Costs:** The manager's amendment expands health plan transparency by requiring that all plans, including grandfathered health plans, must annually report to the HHS Secretary annual full disclosure of health care costs. Such a report will include payment claims payment policies and rating practices, expenditures for clinical services, health care quality improvement expenditures, non-claims based costs and premium revenues. All reports will be made available to the public. Beginning in 2014, all plans, including grandfathered plans, must provide a rebate to their enrollees if the ratio of premium revenue exceeds expenses for clinical services and activities to improve health care quality. The medical loss ratio for the large group market is 85 percent and the medical loss ratio for the small group market is 80 percent. The National Association of Insurance Commissioner's (NAIC) is tasked with developing the need methodology.

**Hospital Transparency Related to Health Costs:** Hospitals must report annually and make public a list of hospital charges, including Medicare DRGs. The HHS Secretary will establish the guidelines for the public reporting.

**Consumer Protections:** The manager's amendment strengthens consumer appeal rights by requiring that insurance plans have an effective internal appeals process and comply with the state's external review process. The HHS Secretary shall establish an external review process for state that do not have such a process and for self-insured plans. Plan enrollees are allowed to select, from participating providers, a primary care provider or pediatrician for a child. Plans cannot impose prior-authorization or increased cost sharing for emergency services, whether provided by in-network or out-of-network providers. Plans cannot require authorization or referral for a female patient seeking OB/GYN services.

**Medical Reimbursement Data Centers:** The manager's amendment establishes medical reimbursement data centers to collect reimbursement data from health insurers and make such information available to the public. The data centers shall develop fee schedules and other data based tools to reflect market rates for services within geographic areas. Such centers can be non-profit or academic institutions.

**Limitations on the Application of Rating Bands, Waiting Periods and Wellness Programs:** The manager's amendment clarifies that the insurance reform rating bands that limit premium rating to the following (family size, geography, actuarial value of the benefit, tobacco use and age) would not apply to self-insured plans. The prohibition that restricts insurers from applying a waiting period that exceeds 90 days does not apply to the individual market. Gun ownership cannot be a factor in restricting employees' participation in employer-sponsored wellness programs.

**Coverage for Approved Clinical Trials:** Prohibits insurers from dropping coverage when an individual chooses to participate in a clinical trial and requires that the insurer cover routine care associated with the clinical trial.

**Grandfathered Plans:** The manager's amendment clarifies that all individuals enrolled in group health coverage or individual coverage on the date of enactment can maintain that coverage through a grandfathered plan. The medical loss ratio requirements apply to grandfathered plans. It appears that other insurance reforms such as rating bands, lifetime and annual limits and pre-existing condition exclusions do not apply to grandfathered plans.

**Administrative Simplification:** The manager's amendment would expand the administrative simplification provisions included in the earlier bill. The new provisions would require HHS to consider developing additional transaction

standards and operating rules based on a periodic review of whether there could be greater uniformity resulting in improved operation of the health care system and reduced administrative costs. The initial evaluation must start on January 1, 2012 and be conducted every three years thereafter. The process requires input from the National Committee on Vital and Health Statistics, the Health Information Technology Policy Committee, the Health Information Technology Standards Committee, standard setting organizations, and stakeholders. The HHS Secretary would be required to consider standardizing electronically the provider enrollment process in health plans; application of the HIPAA transaction standards to automobile liability insurance, worker's compensation and other programs not currently subject to HIPAA; standardizing forms for financial audits by health plans, federal and state agencies, and others; whether there could be greater transparency and consistency of methodologies and processes used to establish claim edits used by health plans; and whether health plans should be required to publish their timeliness of payment rules.

**Excessive Waiting Periods:** The manager's amendment clarifies that for an employer with 50 or more employees and who requires a waiting period in excess of 60 days, they will face a \$600 penalty for each full time employee for which the waiting period applies.

**Free Choice Vouchers:** The manager's amendment requires that employers that offer coverage make a contribution to provide a free choice premium voucher for qualified employees to purchase coverage through the exchanges. Employees qualify for the voucher if the cost of the employer provided coverage is between eight percent and 9.8 percent of their income. The value of the voucher must be equal to the premium contribution the employer makes to their own health plan. The voucher helps individuals with incomes too high for the individual mandate exemption and too low to qualify for the hardship waiver that qualifies employees for exchange subsidies.

**Small Business Tax Credits:** The manager's amendment expands the small business tax credits for the purchase of employee health insurance coverage in the following way: the tax credit starts a year earlier in 2010; the full tax credit is extended to firms with average wages up to \$25,000 (up from the previous \$20,000 threshold); and extends the credit for firms with average wages up to \$50,000 (up from the previous \$40,000 threshold).

### **Revenue Provisions**

**Medical Device Manufacturers Fee:** The manager's amendment would eliminate the annual \$2 billion fee on the medical devices manufacturing sector in 2010 and increase the fee to \$3 billion per year beginning in 2018. The overall reduction remains at \$20 billion over 10 years.

**Health Insurance Fee:** The manager's amendment eliminates the fee for 2010 and sets different fee amounts: \$2 billion for 2011, \$4 billion for 2012, \$7 billion for 2013, \$9 billion for years 2014 through 2016 and \$10 billion for years after 2016. The amendment creates a limited exemption from the fee for certain non-profit insurers with a medical loss ratio of 90 percent or more.

**Hospital Insurance (HI) Tax for High-Wage Workers:** The manager's amendment modifies the increased HI tax rate for single taxpayers with income in excess of \$200,000 and couples filing jointly with incomes in excess of \$250,000 from 0.5 percentage points to 0.9 percentage points.

**Excise Tax on Indoor Tanning Services:** The manager's amendment imposes a 10 percent tax on amounts paid for indoor tanning services and eliminates the tax on cosmetic surgery included in Senator Reid's bill. Indoor tanning services are services that use an electronic product with one or more ultraviolet lamps to induce skin tanning. The tax would be effective for services on or after July 1, 2010.

### **Other Provisions of Interest**

**Minority Health:** The manager's amendment includes several additional provisions including:

- Elevating the Office of Minority Health (currently within the Office of Public Health and Science) to the Secretary's office, to be headed by a new Deputy Assistant Secretary for Minority Health reporting directly to the Secretary of HHS. It also would establish a network of new minority health offices in agencies under HHS. These offices will monitor health, health care trends, and quality of care among minority patients and evaluate the success of minority health programs and initiatives.
- Elevating the Office of Minority Health at the NIH from a Center to an Institute.
- Expanding the quality incentive program for health plans under the insurance exchange to include incentives for the implementation of activities to reduce health and health care disparities, including the use of language services, community outreach, and cultural competency training.

Another provision would provide assistance to minority populations through grant funding to community-based collaborative care networks that provide comprehensive coordinated and integrated health care services to low-income populations. The funds would support efforts to help low-income individuals access appropriate services, enroll in health coverage programs and obtain a regular primary care provider or medical home. Funds also could be used to provide case management and care management, perform health outreach,

provide transportation, expand capacity through such approaches as telehealth, after-hours services or urgent care, and other direct patient care services.

**Comparative Effectiveness Research:** Similar to Senator Reid’s original bill, the manager’s amendment creates an Institute to conduct comparative clinical effectiveness research. Its 21-member board would include the directors of the Agency of Healthcare Research and Quality (AHRQ) and the National Institutes of Health (NIH), and a hospital representative. It also establishes several limitations around the use of research findings, including that they may not be used to mandate coverage or reimbursement decisions. The Institute would be financed in a public/private manner, including a fee on health plans through 2019.

**Workplace Wellness:** Similar to the House bill, the manager’s amendment would provide grants to small businesses for offering comprehensive workplace wellness programs. Beginning in FY 2011, the bill provides \$200 million over five years to eligible employers with fewer than 100 employees who work 25 hours or more a week and who do not offer a workplace wellness program as of date of enactment. Qualified programs would have four components: health awareness, employee engagement, behavioral change and a supportive environment.

**Cures Acceleration Network:** The manager’s amendment appropriates \$500 million in FY 2010 (and such funds as necessary in subsequent years) to establish a new office within NIH called the Cures Acceleration Network, which would award grants and contracts to accelerate the development of “high need cures,” defined as drugs, devices and biological products for which incentives in the commercial market are unlikely to result in their adequate or timely development.