AFFORDABLE HEALTH CARE FOR AMERICA ACT (H.R. 3962)

The Affordable Health Care for America Act was introduced in the U.S. House of Representatives on October 29, 2009. The following summary of H.R. 3962 describes key components of this health reform legislation focusing on provisions to expand health coverage, control health care costs, and improve the health care delivery system. This summary will be updated to reflect changes made during the legislative process.

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Date plan announced	October 29, 2009
Overall approach to expanding access to coverage	Require individuals to have health insurance. Create a Health Insurance Exchange through which individuals and smaller employers can purchase health coverage, with premium and cost-sharing credits available to individuals/families with incomes up to 400% of the federal poverty level (or $73,240 for a family of three in 2009). Require employers to provide coverage to employees or pay into a Health Insurance Exchange Trust Fund, with exceptions for certain small employers, and provide certain small employers a credit to offset the costs of providing coverage. Impose new regulations on plans participating in the Exchange and in the small group insurance market. Expand Medicaid to 150% of the poverty level.
Individual mandate	• Require all individuals to have "acceptable health coverage". Those without coverage pay a penalty of 2.5% of their adjusted income above the filing threshold up to the cost of the average national premium for self-only or family coverage under a basic plan in the Health Insurance Exchange. Exceptions granted for those with incomes below the filing threshold (in 2009 the threshold for taxpayers under age 65 is $9,350 for singles and $18,700 for couples), religious objections and financial hardship. (Effective January 1, 2013)
Employer requirements	• Require employers to offer coverage to their employees and contribute at least 72.5% of the premium cost for single coverage and 65% of the premium cost for family coverage of the lowest cost plan that meets the essential benefits package requirements or pay 8% of payroll into the Health Insurance Exchange Trust Fund. (Effective January 1, 2013) • Eliminate or reduce the pay or play assessment for small employers with annual payroll of less than $750,000: – Annual payroll less than $500,000: exempt – Annual payroll between $500,000 and $585,000: 2% of payroll; – Annual payroll between $585,000 and $670,000: 4% of payroll; – Annual payroll between $670,000 and $750,000: 6% of payroll. (Effective January 1, 2013) • Require employers that offer coverage to automatically enroll into the employer's lowest cost premium plan any individual who does not elect coverage under the employer plan or does not opt out of such coverage. (Effective January 1, 2013) • Require a government study of the impact of employer responsibility requirements and recommend to Congress whether an employer hardship exemption is appropriate. (Report due January 1, 2012)
Expansion of public programs	• Expand Medicaid to all individuals under age 65 (children, pregnant women, parents, and adults without dependent children) with incomes up to 150% FPL. Provide Medicaid coverage for all newborns who lack acceptable coverage and provide optional Medicaid coverage to low-income HIV-infected individuals (with enhanced matching funds) until 2013 and for family planning services to certain low-income women. In addition, increase Medicaid payment rates for primary care providers to 100% of Medicare rates by 2012. Require states to submit a state plan amendment specifying the payment rates to be paid under the state's Medicaid program. The coverage expansions (except the optional expansions) and the enhanced provider payments will be financed with 100% federal financing through 2014 and 91% federal financing beginning in year 2015. (Effective January 1, 2013)

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Expansion of public programs (continued)	• Repeal the Children's Health Insurance Program (CHIP) and require CHIP enrollees with incomes above 150% FPL to obtain coverage through the Health Insurance Exchange beginning in 2014. CHIP enrollees with incomes between 100% and 150% FPL will be transitioned to Medicaid and states will receive the CHIP enhanced match rate for children above current levels and up to 150% FPL. Require a report to Congress with recommendations to ensure that coverage in the Health Insurance Exchange is comparable to coverage under an average CHIP plan and that there are procedures to transfer CHIP enrollees into the exchange without interrupting coverage or with a written plan of treatment. (Report due by December 31, 2011)
Premium and cost-sharing subsidies to individuals	• Provide affordability premium credits to eligible individuals and families with incomes up to 400% FPL to purchase insurance through the Health Insurance Exchange. The premium credits will be based on the average cost of the three lowest cost basic health plans in the area and will be set on a sliding scale such that the premium contributions are limited to the following percentages of income for specified income tiers: 133-150% FPL: 1.5 - 3% of income 150-200% FPL: 3 - 5.5% of income 200-250% FPL: 5.5 - 8% of income 250-300% FPL: 8 - 10% of income 300-350% FPL: 10 - 11% of income 350-400% FPL: 11 - 12% of income (Effective January 1, 2013) • Index the affordability premium credits after 2013 to maintain the ratio of government to enrollee shares of the premiums over time. • Provide affordability cost-sharing credits to eligible individuals and families with incomes up to 400% FPL. The cost-sharing credits reduce the cost-sharing amounts and annual cost-sharing limits and have the effect of increasing the actuarial value of the basic benefit plan to the following percentages of the full value of the plan for the specified income tier: 133-150% FPL: 97% 150-200% FPL: 93% 200-250% FPL: 85% 250-300% FPL: 78% 300-350% FPL: 72% 350-400% FPL: 70% (Effective January 1, 2013) • Lower the out-of-pocket spending limits established in the essential benefits package ($5,000/individual and $10,000/family) for eligible individuals and families with incomes up to 400% FPL to the following amounts: 133-150% FPL: $500/individual; $1,000/family 150-200% FPL: $1,000/individual; $2,000/family 200-250% FPL: $2,000/individual; $4,000/family 250-300% FPL: $4,000/individual; $8,000/family 300-350% FPL: $4,500/individual; $9,000/family 350-400% FPL: $5,000/individual; $10,000/family (Effective January 1, 2013) • Limit availability of premium and cost-sharing credits to US citizens and lawfully residing immigrants who meet the income limits and are not enrolled in qualified or grandfathered employer or individual coverage, Medicare, Medicaid (except those eligible to enroll in the Exchange), TRICARE, or VA coverage (with some exceptions). Individuals with access to employer-based coverage are eligible for the premium and cost-sharing credits if the cost of the employee premium exceeds 12% of the individuals' income. • Require verification of both income and citizenship status in determining eligibility for the federal premium and cost-sharing credits.
Premium subsidies to employers	• Provide small employers with fewer than 25 employees and average wages of less than $40,000 with a health coverage tax credit for up to two years. The full credit of 50% of premium costs paid by employers is available to employers with 10 or fewer employees and average annual wages of $20,000 or less. The credit phases-out as firm size and average wage increases and is not permitted for employees earning more than $80,000 per year. (Effective January 1, 2013)

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Premium subsidies to employers (continued)	• Create a temporary reinsurance program for employers providing health insurance coverage to retirees over age 55 who are not eligible for Medicare. Program will reimburse employers for 80% of retiree claims between $15,000 and $90,000. Payments from the reinsurance program will be used to lower the costs for enrollees in the employer plan. Appropriate $10 billion over ten years for the reinsurance program. (Effective 90 days after enactment)
Tax changes related to health insurance and to financing health reform	• Impose a tax on individuals without acceptable health care coverage of 2.5% of adjusted income above the filing threshold up to the cost of the average national premium for self-only or family coverage under a basic plan in the Health Insurance Exchange. (Effective January 1, 2013) • Permit only prescribed drugs to be reimbursable through a health savings account, Archer medical savings account, health reimbursement arrangement, or flexible spending arrangement for medical expenses. (Effective January 1, 2011) • Increase the tax on distributions from a health savings account that are not used for qualified medical expenses to 20% (from 10%) of the disbursed amount. (Effective January 1, 2011) • Limit the amount of contributions to a flexible spending arrangement for medical expenses to $2,500 per year. (Effective January 1, 2013) • Impose a tax of 2.5% of the price on the first taxable sale of any medical device. (Effective January 1, 2013) • Impose a tax of 5.4% on individuals with modified adjusted gross income exceeding $500,000 and families with modified adjusted gross income exceeding $1,000,000. (Effective January 1, 2011)
Creation of insurance pooling mechanisms	• Create a National Health Insurance Exchange, through which individuals and employers (phasing-in eligibility for employers starting with smallest employers) can purchase qualified insurance, including from private health plans and the public health insurance option. • Restrict access to coverage through the Exchange to individuals who are not enrolled in qualified or grandfathered employer or individual coverage, Medicare, Medicaid, TRICARE, or VA coverage. • Create a new public health insurance option to be offered through the Health Insurance Exchange that must meet the same requirements as private plans regarding benefit levels, provider networks, consumer protections, and cost-sharing. Require the public plan to offer basic, enhanced, and premium plans, and permit it to offer premium plus plans. Finance the costs of the public plan through revenues from premiums. Require the public health insurance option to negotiate rates with providers so that the rates are not lower than Medicare rates and not higher than the average rates paid by other qualified health benefit plan offering entities. Health care providers participating in Medicare are considered participating providers in the public plan unless they opt out. Permit the public plan to develop innovative payment mechanisms, including medical home and other care management payments, value-based purchasing, bundling of services, differential payment rates, performance based payments, or partial capitation and modify cost-sharing and payment rates to encourage use of high-value services. • Create four benefit categories of plans to be offered through the Exchange: – *Basic plan* includes essential benefits package and covers 70% of the benefit costs of the plan; – *Enhanced plan* includes essential benefits package, reduced cost-sharing compared to the basic plan, and covers 85% of benefit costs of the plan; – *Premium plan* includes essential benefits package with reduced cost-sharing compared to the enhanced plan and covers 95% of the benefit costs of the plan; – *Premium plus plan* is a premium plan that provides additional benefits, such as oral health and vision care. • Require guarantee issue and renewability; allow rating variation based only on age (limited to 2 to 1 ratio), premium rating area, and family enrollment. • Require plans participating in the Exchange to be state licensed, report data as required, implement affordability credits, meet network adequacy standards, provide culturally and linguistically appropriate services, contract with essential community providers and Indian health care providers, and participate in risk pooling. Require participating plans to offer one basic plan for each service area and permit them to offer additional plans. Require plans to provide information related to end-of-life planning to individuals and provide the option to establish advance directives and physician's order for life-sustaining treatment. • Require risk adjustment of participating Exchange plans. • Provide information to consumers and small employers to enable them to choose among plans in the Exchange, including establishing a telephone hotline and maintaining a website, and provide information on open enrollment periods and how to enroll.

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Creation of insurance pooling mechanisms (continued)	• Prohibit plans participating in the Exchange from discriminating against any provider because of a willingness or unwillingness to provide abortions. • Create a Consumer Operated and Oriented Program (CO-OP) to facilitate the establishment of non-profit, member-run health insurance cooperatives to provide insurance through the Exchange. (Effective six months following enactment) • Allow states to operate state-based exchanges if they demonstrate the capacity to meet the requirements for administering the exchange. • Unless otherwise noted, provisions relating to the Health Insurance Exchange are effective January 1, 2013.
Benefit design	• Create an essential benefits package that provides a comprehensive set of services, covers 70% of the actuarial value of the covered benefits, limits annual cost-sharing to $5,000/individual and $10,000/family, does not require cost-sharing for preventive services, and does not impose annual or lifetime limits on coverage. The Health Benefits Advisory Council, chaired by the Surgeon General, will make recommendations on specific services to be covered by the essential benefits package as well as cost-sharing levels. Prohibit abortion coverage from being required as part of the essential benefits package; require segregation of public subsidy funds from private premiums payments for plans that choose to cover abortion services beyond those for which public funding is permitted (public funding of abortions is permitted to save the life of the woman and in cases of rape or incest); and require there be no effect on state or federal laws on abortions. (Health Benefits Advisory Council report due one year following enactment; essential benefits package becomes effective January 1, 2013) • All qualified health benefits plans, including those offered through the Exchange and those offered outside of the Exchange (except certain grandfathered individual and employer-sponsored plans) must provide at least the essential benefits package. (Effective January 1, 2013) • Require a report on including oral health benefits in the essential benefits package. (Report due one year following enactment)
Changes to private insurance	• Establish a temporary national high-risk pool to provide health coverage to individuals (and spouses and dependents) with pre-existing medical conditions. Individuals who have been denied coverage, offered unaffordable coverage, have an eligible medical condition or who have been uninsured for at least six months will be eligible to enroll in the national high-risk pool. Premiums for the high-risk pool will be set at not higher than 125% of the prevailing rate for comparable coverage in the state and could vary by no more than 2:1 due to age; annual deductibles will be limited to $1,500 for an individual; and maximum cost-sharing will be limited to $5,000 for individuals. (Effective January 1, 2010 and until the Health Insurance Exchange is established) • Individuals eligible for COBRA continuation coverage may retain COBRA coverage until the Exchange is established or they obtain acceptable coverage. (Effective upon enactment) • Limit health plans' medical loss ratio to not less than 85% to be enforced through a rebate back to consumers and prohibit plans from imposing aggregate dollar lifetime limits on coverage. (Effective January 1, 2010) Prohibit insurers from rescinding coverage except in cases of fraud. (Effective July 1, 2010) • Adopt standards for financial and administrative transactions to promote administrative simplification. (Effective upon enactment) • Require review of increases in health insurance premiums prior to implementation of the increases. (Effective upon enactment) • Provide dependent coverage for children up to age 27 for all individual and group policies. (Effective January 1, 2010) • Limit pre-existing condition exclusions for group policies prior to implementation of the insurance market reforms by shortening the period plans can look back for pre-existing conditions from six months to 30 days and shortening the period plans can exclude coverage of certain benefits from 12 months to three months. (Effective January 1, 2010) • Prohibit reductions to retiree benefits unless reductions also apply to current employees. (Effective upon enactment) • Prohibit coverage purchased through the individual market from qualifying as acceptable coverage for purposes of the individual mandate unless it is grandfathered coverage. Individuals can purchase a qualifying health benefit plan through the Health Insurance Exchange. (Effective January 1, 2013)

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Changes to private insurance (continued)	• Impose the same insurance market regulations relating to guarantee issue, premium rating, and prohibitions on pre-existing condition exclusions in the insured group market and in the Exchange. (See creation of insurance pooling mechanisms) (Effective January 1, 2013) • Improve consumer protections by establishing uniform marketing standards, requiring fair grievance and appeals mechanisms and accurate and timely disclosure of plan information. (Effective January 1, 2013) • Create the Health Choices Administration to establish the qualifying health benefits standards, establish the Exchange, administer the affordability credits, and enforce the requirements for qualified health benefit plan offering entities, including those participating in the Exchange or outside the Exchange. • Permit states to form Health Care Choice Compacts to facilitate the purchase of individual insurance across state lines. (Effective January 1, 2015) • Remove the anti-trust exemption for health insurers and medical malpractice insurers. (Effective upon enactment)
State role	• Implement the Medicaid eligibility expansions and the specified changes with respect to provider payment rates, benefit enhancements, quality improvement, and program integrity. • Maintain Medicaid and CHIP eligibility standards, methodologies, or procedures that were in place as of June 16, 2009 as a condition of receiving federal Medicaid or CHIP matching payments. End CHIP maintenance of eligibility at the end of 2013. • Establish a Memorandum of Understanding with the Health Insurance Exchange to coordinate enrollment of individuals in Exchange-participating health plans and under the state's Medicaid program. • May determine eligibility for affordability credits through the Health Insurance Exchange.
Cost containment	• Simplify health insurance administration by adopting standards for financial and administrative transactions, including timely and transparent claims and denial management processes and use of standard electronic transactions. (Effective upon enactment) • Reduce market basket updates in Medicare payment rates for providers and incorporate adjustment for expected productivity gains. (Effective dates vary) • Reduce Medicare payments for potentially preventable hospital readmissions. (Effective October 1, 2011) • Restructure payments to Medicare Advantage plans (except for PACE plans), phasing down to equal 100% of fee-for-services payments by 2013, with bonus payments for higher-quality and improved-quality plans in qualifying counties. (Effective FY 2011) • Increase the Medicaid drug rebate percentage to 23.1% and extend the prescription drug rebate to Medicaid managed care plans. Require drug manufacturers to provide drug rebates for dual eligibles enrolled in Part D plans to help close the Part D coverage gap. (Effective January 1, 2010) • Require the Secretary to negotiate drug prices directly with pharmaceutical manufacturers for Medicare Part D plans. (Effective upon enactment; applies to drug prices beginning on January 1, 2011) • Reduce Medicaid DSH allotments by a total of $10 billion ($1.5 billion in 2017; $2.5 billion in 2018; and $6 billion in 2019), imposing the largest percentage reductions in state DSH allotments in states with the lowest uninsured rates and those that do not target DSH payments. Reduce Medicare DSH payments to account for reductions in the national rate of uninsurance as a result of the Act, based on recommendation by the Secretary. (Medicare DSH reductions effective 2017) • Require the Institute of Medicine to conduct a study on geographic variation in health care spending across all providers and recommend changes to Medicare payments that promote high-value care; require the Secretary to develop an implementation plan and issue regulations to implement the Medicare payment changes unless Congress acts to stop implementation. (Report due April 15, 2011; final implementation plan due 240 days following receipt of report; regulations issued by May 31, 2012) • Authorize the Food and Drug Administration to approve generic versions of biologic drugs and grant biologics manufacturers 12 years of exclusive use before generics can be developed. (Effective upon enactment) • Enhance competition in the pharmaceutical market by stopping agreements between brand name and generic drug manufacturers that limit, delay, or otherwise prevent competition from generic drugs. (Effective upon enactment) • Require hospitals and ambulatory surgical centers to report on health care-associated infections to the Centers for Disease Control and Prevention (effective one year following enactment) and refuse Medicaid payments for certain health care-associated conditions. (Effective January 1, 2010) • Reduce waste, fraud, and abuse in public programs by allowing provider screening, enhanced oversight periods, and enrollment moratoria in areas identified as being at elevated risk of fraud in all public programs, and by requiring Medicare and Medicaid program providers and suppliers to establish compliance programs. (Effective dates vary)

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Improving quality/health system performance	• Support comparative effectiveness research by establishing a Center for Comparative Effectiveness Research within the Agency for Healthcare Research and Quality to conduct, support, and synthesize research on outcomes, effectiveness, and appropriateness of health care services and procedures. An independent CER Commission will oversee the activities of the Center. Provides that comparative effectiveness research findings may not be construed as mandates for payment, coverage, or treatment or used to deny or ration care. Establish the Comparative Effectiveness Research Trust Fund. (Effective FY 2010) • Provide incentive payments to states that enact alternative medical liability laws that make the medical liability system more reliable through the prevention of or prompt and fair resolution of disputes, encourage the disclosure of health care errors, and maintain access to affordable liability insurance. (Effective upon enactment) • Strengthen primary care and care coordination by increasing Medicaid payments for primary care providers to 100% of Medicare rates (phased-in beginning in 2010 through 2012) and providing Medicare bonus payments to primary care practitioners (with larger bonuses paid to primary care practitioners serving in health professional shortage areas) beginning January 1, 2011. • Require the Secretary to develop a plan to reform Medicare payments for post-acute services, including bundled payments, to improve the coordination, quality and efficiency of such services and improve outcomes. (Effective January 1, 2011) • Conduct Medicare and Medicaid pilot program to test payment incentive models for accountable care organizations and to assess the feasibility of reimbursing qualified patient-centered medical homes. Adopt these models on a large scale if pilot programs prove successful at reducing costs. (Implementation of medical home pilots upon enactment; implementation of accountable care organization pilots by January 1, 2012) • Establish the Center for Medicare and Medicaid Innovation to test payment and service delivery models to improve quality and efficiency. Evaluate all models and expand those models that improve quality without increasing spending or reduce spending without reducing quality, or both. (Effective January 1, 2011) • Require the Institute of Medicine to conduct a study on geographic adjustment factors in Medicare and require the Secretary to issue regulations to revise the geographic adjustment factors based on the recommendations. (Report due one year following enactment; proposed regulations issued following submission of report) • Require the Secretary to improve coordination of care for dual eligibles through a new office or program within the Centers for Medicare and Medicaid Services. (Report of activities due within one year of enactment) • Establish the Center for Quality Improvement to identify, develop, evaluate, disseminate, and implement best practices in the delivery of health care services. Develop national priorities for performance improvement and quality measures for the delivery of health care services. (Effective dates vary) • Establish the Community-based Collaborative Care Network Program to support consortiums of health care providers to coordinate and integrate health care services, manage chronic conditions, and reduce emergency department use for low-income uninsured and underinsured populations. (Funds appropriated for five years beginning FY 2011) • Require disclosure of financial relationships between health entities, including physicians, hospitals, pharmacists, and other providers, and manufacturers and distributors of covered drugs, devices, biologicals, and medical supplies. (Effective March 2011) • Reduce racial and ethnic disparities by conducting a study on the feasibility of developing Medicare payment systems for language services, providing Medicare demonstration grants to reimburse culturally and linguistically appropriate services and developing standards for the collection of data on race, ethnicity, and primary language. (Report due to Congress one year following enactment)
Prevention/wellness	• Develop a national strategy to improve the nation's health through evidenced-based clinical and community-based prevention and wellness activities. Create task forces on Clinical Preventive Services and Community Preventive Services to develop, update, and disseminate evidenced-based recommendations on the use of clinical and community prevention services. • Improve prevention by covering only proven preventive services and eliminating cost-sharing for preventive services in Medicare and Medicaid. (Effective July 1, 2010) Increase Medicare payments for certain preventive services to 100% of actual charges or fee schedule rates. (Effective January 1, 2011) • Provide wellness grants for up to three years to small employers for up to 50% of costs incurred for a qualified wellness program. (Effective July 1, 2010)

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Prevention/wellness (continued)	• Establish a grant program to support the delivery of evidence-based and community-based prevention and wellness services aimed at reducing health disparities. Train community health workers to promote positive health behaviors in medically underserved communities. Provide grants to plan and implement programs to prevent obesity among children and their families. (Funds appropriated for five years beginning FY 2011) • Require chain restaurants and food sold from vending machines to disclose the nutritional content of each item. (Proposed regulations issued within one year of enactment)
Long-term care	• Establish a national, voluntary insurance program for purchasing community living assistance services and supports (CLASS program). Following a five-year vesting period, the program will provide individuals with functional limitations a cash benefit of not less than an average of $50 per day to purchase non-medical services and supports necessary to maintain community residence. The program is financed through voluntary payroll deductions: all working adults will be automatically enrolled in the program, unless they choose to opt-out. (Effective 2010) • Establish a three-year demonstration program in four states to evaluate the effectiveness of recommended core competencies for personal and home care aides and training curriculum and methods to provide long-term services and supports. (Demonstration program established within 180 days of issuance of recommendations) • Improve transparency of information about skilled nursing facilities and nursing facilities. (Disclosure reporting regulations issued within two years of enactment; reporting of information required 90 days after regulations are issued)
Other investments	• Make improvements to the Medicare program: – Modify the initial coverage limit and catastrophic thresholds to reduce the coverage gap by $500 in 2010 and eventually eliminate the Medicare Part D coverage gap by 2019; require drug manufacturers to provide a 50% discount on brand-name prescriptions filled in the coverage gap. (Effective January 1, 2010). – Increase the asset test threshold for Medicare Savings Program and Part D Low-Income Subsidies to $17,000 per individual and $34,000 per couple. (Effective 2012) – Cover through Medicaid the Part B deductible and cost-sharing for Medicare beneficiaries under age 65 with incomes below 150% FPL (and resources at or below two times the SSI level); finance these costs with 100% federal funding in 2013 and 2014 and 91% federal funding in subsequent years. (Effective January 1, 2013) • Improve workforce training and development: – Establish a multi-stakeholder Advisory Committee on Health Workforce Evaluation and Assessment to develop and implement a national health workforce strategy. (Funds appropriated beginning FY 2011) – Reform Graduate Medical Education to increase training of primary care providers by redistributing residency positions and promote training in outpatient settings, including through a Teaching Health Center demonstration project. (Effective July 1, 2011) – Support training of health professionals through scholarships and loans; establish a primary care training and capacity building program; establish a loan repayment program for professionals who work in health professions needs areas; establish a public health workforce corps; promote training of a diverse workforce; and provide cultural competence training for health care professionals. Support the development of interdisciplinary mental and behavioral health training programs and establish a training program for oral health professionals. (Funds appropriated beginning FY 2011) – Address the projected shortage of nurses and retention of nurses by increasing the capacity for education, supporting training programs, providing loan repayment and retention grants, and creating a career ladder to nursing. – Support the development of interdisciplinary health training programs that focus on team-based models, including medical home models and models that integrate physical, mental, and oral health services. (Funds appropriated beginning FY 2011) • Establish the Public Health Investment Fund for financing designated public health provisions. (Initial appropriation in FY 2011) • Establish a new trauma center program to strengthen emergency department and trauma center capacity and to establish new trauma centers in urban areas with substantial trauma related to violent crimes. Create an Emergency Care Coordination Center within HHS; develop demonstration programs to design, implement, and evaluate innovative models for emergency care systems. (Funds appropriated for five years beginning in FY 2011)

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Other investments (continued)	• Improve access to care by increasing funding by $12 billion over five years for community health centers; establish new programs to support school-based health centers (effective July 1, 2010) and nurse-managed health centers (effective 2011), and set criteria for the certification of federally qualified behavioral health centers. • Provide grants to each state health department to address core public health infrastructure needs. (Funds appropriated for five years beginning FY 2011) • Reauthorize and amend the Indian Health Care Improvement Act. (Effective dates vary)
Financing	The Congressional Budget Office estimates the net cost of the proposal (less payments from employers and uninsured individuals) to be $894 billion over ten years. These costs are financed through a combination of savings from Medicare and Medicaid and new taxes and fees. The net savings from Medicare and Medicaid are estimated to be $426 billion over ten years and the primary sources of these savings include incorporating productivity improvements into Medicare market basket updates, reducing payments to Medicare Advantage plans, changing the Medicaid drug rebate provisions, and cutting Medicaid and Medicare DSH payments. (See descriptions of cost savings provisions in Cost containment.) The largest source of new revenue will come from a 5.4% surcharge imposed on families with incomes above $1,000,000 and individuals with incomes above $500,000, which is projected to raise $461 billion in revenue. Additional revenue provisions will generate $97 billion over the same time period. (See Tax changes related to health insurance.) CBO estimates the proposal will reduce the deficit by $104 billion over ten years.
Sources of information	Ways and Means Committee: http://waysandmeans.house.gov Energy and Commerce Committee: http://energycommerce.house.gov Education and Labor Committee: http://edlabor.house.gov/