

**Summary of Senate HELP Committee Draft Legislation  
*Affordable Health Choices Act***

Issue	Summary of Policy Options
<p><b><u>General Approach</u></b></p>	<p>On June 9, 2009, Senate Health, Education, Labor and Pensions (HELP) Committee Chairman Edward M. Kennedy (D-MA) unveiled the <i>Affordable Health Choices Act</i>. The legislation is expected to be marked-up by the Senate HELP Committee beginning on June 16<sup>th</sup>. The legislation includes the following elements:</p> <ul style="list-style-type: none"> <li>• Individual mandate requiring individuals to obtain health insurance coverage;</li> <li>• <u>Placeholder</u> for an employer “play or pay” mandate;</li> <li>• <u>Placeholder</u> for a new public health insurance option;</li> <li>• Federal minimum benefit requirements for health insurance coverage, with many details left to an expert advisory panel;</li> <li>• Premium subsidies up to 500% FPL for individuals/families and small business tax credits;</li> <li>• Medicaid expansion up to 150% FPL;</li> <li>• Health insurance market reforms, including creating state/regional gateways;</li> <li>• Comparative effectiveness research;</li> <li>• Expansion of the 340B program and a <u>placeholder</u> for providing an abbreviated pathway for approval of follow-on biologics; and</li> <li>• Health-system related reforms (including prevention/wellness, chronic care management, health workforce development, etc.).</li> </ul>

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<p><b><u>Comparative Effectiveness- Center for Health Outcomes Research and Evaluation</u></b></p> <p><i>(pg. 314-324)</i></p>	<p>Establishes, within AHRQ, a Center to “collect, support, and synthesize research with respect to comparing health outcomes, effectiveness, and appropriateness of health care services and procedures.”</p> <p>The Center will “coordinate, conduct, support, and synthesize research relevant to the comparative health outcomes and effectiveness of the full spectrum of health care treatments, including pharmaceuticals, devices, medical and surgical procedures, screening and diagnostics, behavioral health care, and other health interventions.”</p> <p>In addition, the Center will conduct, support, and synthesize research that:</p> <ul style="list-style-type: none"> <li>○ Identifies advances in personalized medicine;</li> <li>○ Reduces health disparities;</li> <li>○ Uses a broad range of methods; and</li> <li>○ Creates informational tools that organize information and disseminate findings to providers, patients, and public and private payers.</li> </ul> <p>Within 1 year, the Center will develop methodological standards to be used when conducting studies of comparative health outcomes and value.</p> <p>A 21 member advisory council is created through AHRQ’s National Advisory Council. Membership includes the Director and CMO of CMS, as well as 19 additional members representing stakeholders. One member will represent each of the following: consumers, practicing physicians, nurses, employers, public payers, insurance plans, “clinical researchers who conduct research on behalf of pharmaceutical or device manufacturers,” “clinical researchers who conduct research related to personalized medicine,” and clinical researchers who conduct research related to health disparities.</p> <p>Establishment of research agenda and conduct of the research shall be insulated from undue political or stakeholder influence.</p> <ul style="list-style-type: none"> <li>○ All aspects will be transparent to all stakeholders.</li> <li>○ Process and methods for conducting research shall be publicly documented and available to all stakeholders.</li> </ul> <p>Dissemination: the Center shall disseminate research results to patients, providers, HIT vendors, professional associations and federal and private health plans. The Center shall establish a process to receive feedback from these recipients on the value of information disseminated.</p> <p>The Center shall assist users of HIT in promoting timely incorporation of research findings into clinical</p>

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	<p>practice.</p> <p>The Center’s reports and recommendations shall not be construed as mandates for payment, coverage or treatment.</p> <p>By 2011, the Secretary shall submit a report to Congress addressing whether the Center should expand to include studies of the health care delivery system.</p>
<p><b>Program to Facilitate Shared Decision-Making</b> <i>(see pages 301-312)</i></p>	<p>Establishes a program within AHRQ to develop and encourage use of patient decision aids by patients and providers. Decision aids will help patients decide with their provider what treatments are best for them based on their beliefs and preferences, options, scientific evidence, and other circumstances. Decision aids will be targeted to “preference sensitive care.”</p> <p>“Preference sensitive care” is defined as care for which “the clinical evidence does not clearly support one treatment option such that the appropriate course of treatment depends on the values of the patient or the preferences of the patient....”</p> <p>Standards for decision aids will be developed by the Secretary through a contract with the qualified consensus-based entity defined in the Act to support measure development.</p> <p>The Secretary shall award grants or contracts for development of decision aids concerning the “safety, relative effectiveness (including possible health outcomes and impact on functional status), and relative cost of treatment or, where appropriate, palliative care options.” Grants also will support evaluation of materials to ensure they are “balanced and evidence-based” and education of providers on use of the decision aids.</p> <p>AHRQ will support dissemination of decision aids to health providers, and provide grants to providers for development and implementation of “shared decision making techniques.”</p> <p>Quality measures related to utilization of these tools as well as patient and caregiver experiences will be developed.</p>

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<p><b>Presentation of Drug Information</b></p> <p><i>(see pages 312-314)</i></p>	<p>The bill would amend the FDCA to give FDA the authority “to determine whether the addition of standardized, quantitative summaries of the benefits and risks of drugs” in a “drug facts box format” would “improve health care decision making by clinicians and patients and consumers.”</p> <p>In making the determination, FDA shall review “all available scientific evidence and consult with drug manufacturers, clinicians, patients and consumers, experts in health literacy, experts in geriatric and long-term care, and representatives of racial and ethnic minorities.”</p> <p>In a report to Congress within one year post-enactment, FDA shall provide its determination and “the reasoning and analysis underlying that determination.” If FDA determines summaries of the benefits and risks of drugs in a “drug facts box format” “would improve health care decision making,” the FDA “shall promulgate regulations as necessary to implement such format.”</p> <p>In developing regulations, the FDA is directed to ensure information presented is “objective and up-to-date, and is the result of a review process that considers the totality of published and unpublished data.”</p> <p>Information presented in the new format also must be posted on the FDA website.</p>
<p><b>Health Benefit Requirements</b></p> <p><i>(see pages 13-17; pages; 68-69; 79-85)</i></p>	<p>Establishes minimum federal requirements for health insurance coverage through “essential health benefits” that plans must cover for premiums to be eligible for credits/subsidies, including coverage in the following categories:</p> <ul style="list-style-type: none"> <li>• Ambulatory patient services;</li> <li>• Emergency services;</li> <li>• Hospitalization;</li> <li>• Maternity and newborn care;</li> <li>• Mental health and substance abuse services;</li> <li>• Prescription drugs;</li> <li>• Rehabilitative and laboratory services;</li> <li>• Preventive and wellness services; and</li> <li>• Pediatric services, including oral and vision care as determined appropriate by the Medical Advisory Council.</li> </ul> <p>Group and individual health insurance plans would be <u>prohibited</u> from imposing annual or lifetime limits on benefits. Health insurers would also be <u>required</u> to cover preventive care services (based on recommendations of the U.S. Preventive Services Taskforce and the CDC’s Advisory Committee on</p>

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	<p>Immunization Practices), implement care coordination programs, engage in activities to reduce hospital re-admissions, improve patient safety and reduce medical errors through the “appropriate use of best clinical practices” and “evidence based medicine.”</p> <p>The bill also establishes three tiers of actuarial values (defined as the percentage of total allowed costs of the benefit provided) for qualified health plans:</p> <ul style="list-style-type: none"> <li>• highest tier: 93% actuarial value;</li> <li>• middle tier: 84% actuarial value;</li> <li>• lowest tier: 76% actuarial value.</li> </ul> <p>All of the qualified health plans would include annual out-of-pocket limits – with the lowest actuarial plan value’s (76% actuarial value) out-of-pocket cap equal to out-of-pocket maximums for high-deductible/HSA plans (\$5,800 for self-only coverage and \$11,600 for family coverage in 2009).</p>
<p><b>Medical Advisory Council</b>  (see pages 62-71)</p>	<p>Establishes a <b>Medical Advisory Council</b> – which would include experts from the National Institutes of Health, the Centers for Disease Control and Prevention, and other centers of excellence. The Council would have broad authority to make recommendations on health benefits coverage, including:</p> <ul style="list-style-type: none"> <li>• Defining the essential health care benefits eligible for credits (described above);</li> <li>• The criteria that coverage must meet to be considered minimum qualified coverage; and</li> <li>• The conditions under which coverage shall be considered affordable and available for individuals/families at varying income levels.</li> </ul> <p>The Council’s recommendations would be binding unless disapproved by a joint resolution of Congress.</p> <p>The Council would also be responsible for assuring that benefits are not “unduly weighted toward any one category”, that the medical needs of diverse segments of the population are properly taken into account, and allowing for alternative benefit design/criteria for health coverage for young adults.</p> <p>The advisory panel would be <u>required</u> to ensure that the “actuarial gross value” of the essential benefits package is equal to the benefits provided under “a typical employer plan, as determined by the [HHS] Secretary.”</p>

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<p><b>Public Plan Option</b>  (see pages 110))</p>	<p>The bill includes a <u>placeholder</u> for the creation of a new public health insurance option. A separate HELP Committee section-by-section summary has 3 options for a public plan, including:</p> <ul style="list-style-type: none"> <li>• <b>Option A:</b> A public health insurance plan operated by the Federal government with a payment schedule set in statute and based on Medicare rates + 10%.</li> <li>• <b>Option B:</b> A health insurance plan that, though operated under contract from DHHS, would play by the same rules as commercial health insurance carriers.</li> <li>• <b>Option C:</b> Drop public plan option [document notes that this is the position supported by Republicans].</li> </ul> <p>The Committee section by section summary also provides as an option that providers must participate in the public insurance option if they want to receive Medicare reimbursement.</p>
<p><b>Individual Responsibility</b>  (see pages 103-107)</p>	<ul style="list-style-type: none"> <li>• Requires individuals to obtain qualified health insurance coverage or be subject to financial penalties established by the Secretary of the Treasury, assessed through the tax code and enforced by the IRS.</li> <li>• Penalties would be set at the “minimum practicable amount that can accomplish the goal of enhancing participation in qualifying coverage.”</li> <li>• Exceptions to the individual mandate would be provided to individuals/families where “affordable healthcare coverage is not available” and where payments would “represent an exceptional financial hardship.” The Medical Advisory Council decides the conditions under which coverage shall be considered affordable (see above).</li> </ul>
<p><b>Shared Responsibility for Employers</b>  (see page 110)</p>	<p>The bill includes a <u>placeholder</u> for “shared responsibility of employers.” A separate HELP Committee section-by-section summary has 5 options on requiring shared responsibility from employers:</p> <ul style="list-style-type: none"> <li>• <b>Option A:</b> Play or Pay: Employers (not including small employers) that do not offer coverage that meets certain criteria must pay a per-worker fee.</li> <li>• <b>Option B:</b> A Free Rider Penalty: There is no requirement that employers offer coverage, nor are standards applicable, but any large employer whose employees are on Medicaid must repay the Federal government some fraction of the Federal cost for that employee’s Medicaid coverage.</li> <li>• <b>Option C:</b> For any employee not offered affordable coverage by an employer, where the employee enrolls in a publicly subsidized plan through a Gateway, that employer must remit to the government the amount the employer would have paid for that employee’s coverage had they remained in employer-sponsored insurance.</li> <li>• <b>Option D:</b> Drop the employer mandate [identified in summary as Republican option].</li> <li>• <b>Option E:</b> Allow employers to incentivize healthy behaviors, such as increasing the 20 percent limitation on premiums, and the gift tax that applies to prizes/rewards to employees for better behavior/participation in programs, etc. [Republican option].</li> </ul>

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<p><b>Medicaid Expansion</b></p> <p><i>(see pages 37-38)</i></p>	<p>The bill “assumes that the provisions of the Affordable Health Choices Act” will include the following policies:</p> <ul style="list-style-type: none"> <li>• All individuals currently eligible for Medicaid will remain eligible for Medicaid.</li> <li>• All individuals will be eligible for Medicaid at income levels <u>up to 150% FPL</u>.</li> <li>• Improvements will be made in processes to facilitate enrollment in Medicaid.</li> <li>• States will be required to maintain levels of eligibility with regard to beneficiaries currently enrolled in Medicaid.</li> <li>• Criteria used to establish income eligibility for premium credits in the Gateway will also be used for Federal programs.</li> <li>• States will receive a 100% FMAP until 2015 for the expanded Medicaid population.</li> <li>• Beginning in 2015, the 100% FMAP will “phase down to the percentage otherwise applicable by 2020.</li> <li>• An increased FMAP will be provided to states that have increased Medicaid eligibility and enrollment prior to enactment.</li> </ul>
<p><b>340B Program Expansion and Changes</b></p> <p><i>(see pages 596-615)</i></p>	<p><b>Expansion of Entities Eligible for 340B Discounts</b></p> <ul style="list-style-type: none"> <li>• Expands 340B drug discount program to certain children’s hospitals, rural referral centers, sole community hospitals with DSH share greater than 8%, and critical access hospitals.</li> <li>• Expands program to include drugs used in connection with inpatient services by enrolled hospitals. 340B hospitals required to share savings from obtaining inpatient drugs under 340B program with state Medicaid programs through credit mechanism.</li> <li>• Permits hospitals to obtain inpatient drugs through GPO agreement or 340B Prime Vendor program. For outpatient drugs, authorizes Secretary to create exceptions to general prohibition against GPO purchase under broad circumstances.</li> </ul> <p><b>Changes to Medicaid Rebate Statute</b></p> <ul style="list-style-type: none"> <li>• Creates a new best price exemption for “any prices charged for a covered drug as defined in section 340(b)(2) of the Public Health Service Act.” Creates new definition of AMP for drugs that are not distributed to the retail pharmacy class of trade at all, as may be the case with a drug used exclusively in the hospital setting. Legislation would require that manufacturers calculate an alternative AMP, based on prices to the acute care class of trade, for purposes of determining the ceiling price.</li> </ul> <p><b>Compliance</b></p> <ul style="list-style-type: none"> <li>• Authorizes the Secretary to impose additional compliance obligations on drug manufacturers, including establishment of procedures for manufacturers to issue refunds to covered entities in the event of overcharges and a mechanism to provide appropriate credits and refunds to covered entities if rebates</li> </ul>

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	<p>and discounts are provided by a manufacturer to other purchasers subsequent to a sale to a covered entity. Establishes internet website to give access to covered entities to “applicable” ceiling prices for covered drugs. Explicitly authorizes selective audits of manufacturers and wholesalers.</p> <ul style="list-style-type: none"> <li>• Establishes new civil monetary penalties to prevent overcharges and other violations of the discounted pricing requirements.</li> <li>• Authorizes Secretary to impose new compliance obligations on covered entities. Secretary is directed to develop compliance program to prevent diversion and violations of duplicate discount provision. Would require covered entities to pay penalties for certain violations of 340B statute. Would authorize the Secretary to remove a covered entity from the drug discount program for certain systematic and egregious violations of program requirements.</li> </ul>
<p><b>Biologics Price Competition and Innovation</b>  <i>(See page 596)</i></p>	<p>Includes a placeholder for follow-on biologics with “policy under discussion.”</p>
<p><b>Subsidies for Individuals/Families</b>  <i>(see page 79-94)</i></p>	<ul style="list-style-type: none"> <li>• Provides sliding scale premium subsidies for individuals/families up to 500% FPL.</li> <li>• Premium subsidies would be set as a percentage of a reference premium – the weighted average of the 3 lowest cost qualified health plans available in the region/community—annually adjusted and indexed to the medical care component of the consumer price index (CPI) for urban consumers.</li> <li>• The bill contemplates minimum standard ranges for actuarial values and cost-sharing for individuals/families at varying income levels: for those with incomes up to 200% FPL, the subsidy would be linked to the benefit options with an actuarial value of 93%; for those with incomes between 200%-300% FPL, the subsidy would be linked to the benefit options with an actuarial value of 84%; for those with incomes between 300%-500% FPL, the subsidy would be linked to the benefit options with an actuarial value of 76%.</li> <li>• Subsidies would be paid to the state/regional Gateway on behalf of an eligible individual/family.</li> <li>• Gateways would be responsible for administering the subsidies including remitting payments from the government to the qualified health plans.</li> </ul>

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<p><b>Small Business Credit</b>  (see pages 78-85)</p>	<ul style="list-style-type: none"> <li>• Provides small businesses (up to 50 workers) with a tax credit for providing healthcare coverage.</li> <li>• Subsidies equal to \$1,000 for each employee with self-only coverage through employer/\$2,000 for each employee with family coverage through employer, for employers with 10 or fewer employees.</li> <li>• Subsidies gradually phase down for larger employees (with partial subsidies available for firms with up to 50 workers).</li> <li>• Employers would be required to contribute at least 60% of the cost of coverage.</li> <li>• Similar tax credits would be available to self-employed workers.</li> <li>• Credits would be adjusted annually based on the index of wage inflation as determined by BLS.</li> </ul>
<p><b>American Health Benefit Gateways</b>  (see pages 40-62)</p>	<ul style="list-style-type: none"> <li>• Provides grants to states to establish American Health Benefit Gateways.</li> <li>• American Health Benefit Gateways – analogous to state connectors/exchanges – would be responsible for: (1) facilitating the purchase of health insurance, (2) establishing procedures for certifying qualified plans, (3) making information on health benefits options available to consumers, (4) administering premium subsidies and risk-adjustment payments, (5) facilitating enrollment and outreach, (6) certify qualified health plans that meet specific criteria, and (7) assessing surcharges on insurers to pay for administrative and operation expenses of the Gateway.</li> <li>• Provides flexibility for states to establish regional or other interstate Gateways</li> <li>• Requires Secretary of HHS to issue regulations on standards for certifying qualified health insurance plans, including rules addressing marketing practices, coverage of essential health care benefits, grievance and appeals procedures, non-discrimination standards, and similar requirements.</li> <li>• Requires Secretary of HHS to develop plan to facilitate enrollment in qualifying coverage.</li> <li>• Maintains state regulatory authority and oversight over health insurance coverage and states explicitly that state laws on market conduct or related consumer protections are not preempted.</li> <li>• Provides grants for states to establish navigators to facilitate enrollment in qualified health plans, conduct public education, and distribute fair and impartial information about benefit options.</li> <li>• “Sense of the Senate” that Congress should “establish a means for all Americans to enjoy affordable choices in health benefit plans, in the same manner that Members of Congress have such choices through the Federal employees’ health benefits program.”</li> </ul>

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<p><b>Individual and Group Market Reforms</b></p> <p><i>(see pages 7-36)</i></p>	<p>Establishes comprehensive insurance market regulations in the group and individual market, including:</p> <ul style="list-style-type: none"> <li>• <u>Guaranteed availability and renewability</u> of coverage in the group and individual market.</li> <li>• <u>Modified community rating</u> in the group and individual market (with age bands not to exceed 2:1).</li> <li>• <u>Prohibits pre-existing condition exclusions</u> for group and individual health insurance coverage.</li> <li>• <u>Prohibits annual or lifetime limits</u> for group and individual health insurance coverage.</li> <li>• Requires health insurance issuers offering group or individual health insurance coverage to disclose total premium revenue spending on: (1) reimbursement for clinical services; (2) activities to improve healthcare quality; and (3) all other non-claims costs (e.g. administrative costs).</li> <li>• Health insurance issuers would be required to provide an “annual rebate” for administrative costs that exceed certain thresholds, as determined by the Secretary of HHS through regulation.</li> <li>• Prohibits discrimination against individuals based on health-status, including establishing rules for eligibility based on any of the following health status-related factors: (1) health status, (2) medical condition, (3) claims experience, (4) receipt of health care, (5) medical history, (6) genetic information, (7) evidence of insurability, and (8) disability.</li> <li>• Health insurance issuers would be required to cover preventive services (services with ‘A’ or ‘B’ rating from USPSTF, immunizations recommended by Advisory Committee on Immunization Practices, and services recommended for infants, children, and adolescents in the guide supported by HRSA), implement programs to improve quality of care (e.g. care coordination, wellness and health promotion, etc), and cover dependents up to age 26.</li> <li>• Requires a group health plan and a health insurance issuer offering group or individual coverage to develop “a reimbursement structure for making payments to health care providers” that provides incentives for high quality health care and that “substantially reflects the payment policy of the Medicare program under title XVIII of the Social Security Act and Children’s Health Insurance Program under title XXI of such Act with respect to any generally implemented incentive policy to promote high quality health care.”</li> <li>• Prohibits group health plans from establishing eligibility rules based on total hourly or annual salary of the employee.</li> </ul>
<p><b>Improving the Use of Health Information Technology for Enrollment</b></p> <p><i>(see page 137-142)</i></p>	<ul style="list-style-type: none"> <li>• Requires Secretary of HHS in consultation with HIT Policy and Standards Committees, to develop interoperable and secure standards and protocols that facilitate enrollment in Federal and State health and human service programs.</li> <li>• Standards and protocols would include electronic matching against Federal and State data, including vital records, employment history, enrollment systems, tax records, and other data.</li> <li>• Provides grants to states to adopt appropriate enrollment technology and eliminate or update legacy systems.</li> </ul>

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<p><b>Community Living and Assistance Services and Supports</b>  <i>(see page 154-211)</i></p>	<p>Establishes a voluntary national insurance program for purchasing community living assistance services and support (CLASS Program) to provide care for 10 million Americans with severe disabilities.</p>
<p><b><i>Title II: Improving Quality and Efficiency</i></b>  <i>(See pages 211-346)</i></p>	<ul style="list-style-type: none"> <li>• Establishes an HHS-led “national strategy for quality improvement in health care” that addresses the health care provided to patients with high-cost, chronic disease, reduces health disparities, addresses gaps in quality, and improve Federal payment policy to emphasize quality.</li> <li>• Facilitates the development of consensus-based quality measures for public reporting through new federal grants.</li> <li>• Grants to establish community health teams to support a medical home model.</li> <li>• Grants to implement <b>medication management services</b> in treatment of chronic disease to improve quality of care and reduce overall cost. MTM services would be targeted at those who take 4 or more medications, take any “high-risk” medicines (not defined), or have 2 or more chronic conditions. HHS Secretary would be required to submit an evaluation of the program that assesses, in part, “the impact of patient cost sharing requirements on <b>medication adherence</b> and recommendations for modifications.”</li> <li>• Requires hospitals to confidentially report on hospital re-admission rates.</li> <li>• Improve the availability of trauma centers and services.</li> </ul>
<p><b><i>Title III: Improving the Health of the American People</i></b>  <i>(See pages 346-421)</i></p>	<ul style="list-style-type: none"> <li>• Establishes a National Prevention, Health Promotion, and Public Health Council to provide coordination and leadership with respect to prevention, wellness, and health promotion practices.</li> <li>• Establishes a Prevention and Public Health Investment Fund for “expanded and sustained national investment in prevention and public health programs to improve health and restrain the rate of growth in private and public sector health care costs. Appropriates \$10 billion each of the fiscal years 2010-2019.</li> <li>• Establishes clinical and community preventive services taskforces.</li> <li>• Provides grants to states to establish “Right Choices” programs for uninsured individuals/families to receive preventive care and related services, to sunset when federal or state gateways become available.</li> <li>• Grants to states and local communities to implement “evidence-based community preventive health activities in order to reduce chronic disease rates, address health disparities” and related activities.</li> <li>• Directs CDC to promote and provide technical support for employer-based wellness programs.</li> </ul>

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<p><b><i>Title IV: Health Care Workforce</i></b>  (See pages 421-581)</p>	<ul style="list-style-type: none"> <li>• Establishes a national health care workforce commission and creates state workforce development grants.</li> <li>• Increases grants for nursing student loan program.</li> <li>• Establishes a loan repayment program for pediatric sub-specialists and providers of mental health services in under-served areas.</li> <li>• Establishes public health and allied health recruitment and retention programs.</li> <li>• Increases funding for the National Health Service Corps.</li> <li>• Creates a grant program to support nurse-managed health clinics.</li> <li>• Increases funding for training in general, pediatric, and public health dentistry.</li> <li>• Creates a grant program to nursing schools to strengthen nurse education and training programs and to improve nurse retention.</li> <li>• Addresses workforce shortages in state and local health departments in applied public health epidemiology and public health science.</li> </ul>
<p><b><i>Title V: Preventing Fraud and Abuse</i></b>  (See pages 581-615)</p>	<ul style="list-style-type: none"> <li>• Establishes new HHS and DOJ Health Care Fraud Senior Level Positions to advise the Secretary and the Attorney General on policy and program development with respect to fraud and issues and coordinate efforts within DOJ, the OIG, HHS, and other agencies on fraud and abuse prevention, detection, investigation, and prosecution for both public and private health insurance coverage.</li> <li>• Establishes a new coordinating council to coordinate strategic planning among federal agencies involved in health care integrity and oversight. The Council includes the Secretary of HHS, the Attorney General, the OIG from HHS, the Secretary of Labor, Secretary of Defense, the Director of the Office of Personnel Management, Undersecretary for Veterans Health Administration of the VA, the Commissioner of Social Security Administration, the President of the National Association of Insurance Commissioners (NAIC), and the President of the National Association of Medicaid Fraud control Units.</li> <li>• Enhanced criminal penalties and oversight for multiple employer welfare arrangements.</li> <li>• Requests that the NAIC develop a uniform model reporting for health insurance issuers to refer suspected cases of fraud and abuse to state insurance departments or other responsible state agencies.</li> </ul>