

House Passes Health Reform Bill

Highlights

- ✓ Employer mandate
- ✓ Small business temporary credit
- ✓ Individual mandate
- ✓ Insurance exchanges
- ✓ Providing financial incentives to increase the number of primary care providers in the Medicare and Medicaid programs
- ✓ Eliminating cost sharing for preventive services
- ✓ Increasing health care fraud and abuse enforcement
- ✓ Increasing incentives for the provision of quality, cost efficient, health care

Inside

Employers	1
Core Concepts	2
Individuals	3
Market Reforms	3
Common Provisions.....	4
Medicare and Medicaid	4
Medicare Part A.....	4
Medicare Part B.....	5
Medicare Parts A and B	5
Medicare Part C	5
Medicare Part D	5
Medicaid	6
Quality.....	6
Fraud and Abuse	6
Miscellaneous.....	7

House lawmakers made good on their promise to pass a sweeping overhaul of the nation's health insurance system, approving the Affordable Health Care for America Act (HR 3962) by a vote of 220 to 215 on November 7, 2009. Democratic lawmakers characterized the measure, which they claim will provide insurance for 96 percent of Americans, as the single most important step in 100 years to address the health care needs of American families.

As expected, the Act passed the House along party lines with only one GOP member supporting the bill. Consideration of health care reform now moves to the Senate, which is in the process of merging two competing committee bills: one passed by the Senate Finance Committee (SFC) and another passed by the Senate Health, Education, Labor, and Pensions (HELP) Committee.

Employers

Employer mandate. The House-passed Affordable Health Care for America Act (House Act) requires employers to satisfy certain minimum coverage requirements. Generally, the "employer mandate" requires employers to contribute at least 72.5 percent of premium costs for individuals and 65 percent of premium costs for families. Employers that elect not to offer qualified coverage to their employees would be liable for an additional payroll tax of up to eight percent of the employee's average annual salary.

Small employer exemption. Small employers (generally employers with annual payrolls below \$500,000) would be exempt from the additional payroll tax. A graduated additional payroll tax (starting at two percent and rising to six percent) would apply to employers with annual payrolls between \$500,000 and \$750,000.

Comment: *The SFC bill does not mandate employer coverage. But under its "play-or-pay" strategy, employers with more than 50 employees that do not offer coverage would be assessed a fee for each full-time employee who secures individual coverage. Generally, the maximum fee would be \$400 per employee or an amount determined by the US Department of Health and Human Services (HHS). Additionally, employers with 200 employees would be able to opt out of automatic enrollment if they can show other qualifying coverage.*

The Senate HELP Committee, on the other hand, would impose a blanket \$750 annual fee per full-time employee and \$375 for each part-time employee (exempting the first 25 employees) on employers who choose to "pay" instead of "play."

Employer-sponsored plans. Insurance plans offered by larger employers would be generally unaffected under the House-passed Act, particularly during the first five years. After that, employer-sponsored health insurance plans

Core Concepts

Although many details still need to be worked out before Congress passes a final bill, the core concepts that are emerging would fundamentally alter the health care landscape.

- All individuals would be required to obtain health care coverage. Employer-provided coverage would generally satisfy the universal-coverage requirement. Individuals without employer-provided coverage would be allowed to shop among private insurers and a “Health Insurance Exchange.” Individuals who do not obtain qualifying coverage would be subject to a penalty. Low-income individuals would receive a credit or voucher to help pay for health insurance.
- Employers currently offering health insurance could elect to continue offering coverage so long as their plans meet certain acceptable minimum requirements. Employers electing not to offer qualifying coverage would be subject to an additional payroll tax to help finance the health care coverage for their employees. Exceptions would be made for small businesses.

would generally be required to meet the same minimum standards as basic plans in a Health Insurance Exchange that would be established.

The Exchange would be open to employers, starting with small firms and growing over time. Businesses with 25 or fewer employees would be permitted to purchase through the exchange in 2013; businesses with 50 or fewer employees in 2014; and businesses with at least 100 employees in 2015 with discretion permitted to open the Exchange to larger businesses in 2015 and in the future.

Small businesses temporary credits. The House Act provides a temporary credit for up to 50 percent of qualified health coverage expenses for the tax year for qualified small employers. The credit phases out for employers with average annual wages of \$20,000 to \$40,000 and also for small employers with 10 to 25 employees. The credit is part of the general business credit. No credit is allowed with respect to highly compensated employees, which the House-passed Act defines as individuals with annual compensation of \$80,000 or more.

Comment: *The SFC bill would provide tax credits to small businesses with fewer than 25 employees to help offset the cost of offering health insurance to employees. In certain cases, hours worked by seasonal employees would be excluded from computation for the credit. Tax-exempt employers would get a reduced credit.*

The Senate HELP Committee bill targets tax credits to employers with 50 or fewer full-time employees and that pay 60 percent or more of their employee's health insurance premiums. Credits would be available for up to three consecutive years.

Flexible spending arrangements. The House Act would prohibit taxpayers from using health flexible spending arrangement (FSA) dollars to pay for over-the-counter medications (unless prescribed by a health professional). The House Act and the SFC bill would also cap annual contributions to a health FSA offered under an employer-sponsored cafeteria plan at \$2,500. The \$2,500 threshold would be indexed for inflation.

Comment: *The House-passed Health Care Act expressly includes insulin as a covered expenditure.*

The SFC bill generally tracks the Health Care Act.

The House Act and the SFC bill would also extend to health savings accounts (HSA), health reimbursement arrangements (HRA) and Archer Medical Savings Accounts (Archer MSA). The dollar limits on HSAs may be higher in any final bill to fully cover, pre-tax, the high deductible requirements for using HSAs.

Health savings accounts. Generally, the House-passed Health Care Act provides that individuals under age 65 must pay an additional tax for unqualified distributions from a health savings account (HSA) and increases the additional tax from 10 percent to 20 percent.

Exclusion. The House-approved Health Care Act extends the exclusion from gross income for employer-provided health coverage for employees' spouses and dependent children to coverage provided to domestic partners.

Impact: *Domestic partners are not treated as spouses for federal tax purposes. Consequently, an employee currently pays tax on the fair market value of the cost of coverage for the employee's domestic partner.*

Comment: *The SFC bill does not include a similar provision.*

Retiree prescription drug subsidy. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 created a retiree drug subsidy program to encourage employers to provide prescription drug coverage to their retirees. Employers receive a tax-favored subsidy. The subsidy, which is excluded from an employer's income, is equal to 28 percent of the allowable costs, including administrative costs, attributable to covered prescription drug costs incurred by a qualifying retiree of between \$295 and \$6,000 in 2009. The House's Health Care Act and the SFC bill eliminate the exclusion and deny businesses a deduction for related federal subsidies starting in 2013.

Cafeteria plans. Under the House-approved Health Care Act, coverage purchased through the exchange could not be purchased on a pre-tax salary reduction basis.

Comment: *In the only tax cut (\$4 billion) in its tax title, the SFC bill would relax the cafeteria plan rules to encourage more small employers to offer tax-free benefits to employees, including those related to health insurance coverage. Additionally, there would be a safe harbor from the nondiscrimination requirements for cafeteria plans for qualified small employers.*

Individuals

Individual mandate. The House Health Care Act would generally require all individuals to get coverage, either through their employer or the Exchange. Individuals without acceptable health care coverage would pay an additional tax, subject to a hardship exemption. The additional tax to enforce the so-called "individual mandate" could equal as much as 2.5 percent of the taxpayer's modified adjusted gross income that exceeds the taxpayer's applicable exemption amount plus the standard deduction for the year. This added tax would be in addition to both the regular income tax and the alternative minimum tax. The additional tax would not be allowed to exceed the applicable national average premium for the tax year.

Impact: *The additional tax would not apply to any individual properly claimed as a dependent. However, parents or guardians claiming qualified children as dependents would be required to maintain health care coverage for them. Parents can also choose to keep their children age 26 and under on their insurance policy.*

Individuals with Medicare, Medicaid, Veterans Administration or other government-sponsored coverage would be treated as having acceptable coverage. The House-passed Act includes a religious objection provision.

Comment: *Under the SFC proposal, individuals without qualifying coverage would pay an annual nonrefundable excise tax. Depending on income, the excise tax would start at \$200 per year for individuals in 2014 and climb to \$750 per year for individuals by 2017. The Senate HELP Committee would impose a similar penalty; generally remaining fixed at \$750 per year for an individual without coverage, with a maximum \$3,000 penalty for a family of four. The SFC and Senate HELP bills also include a reinsurance program for employer-provided retiree coverage.*

The SFC bill provides that children enrolled in the Children's Health Insurance Program (CHIP) would be exempt from the individual mandate.

Health insurance exchanges. For individuals who are not currently covered by their employer, and some small businesses, the House Act establishes a new Health Insurance Exchange in which consumers can comparison shop from among health care options that will include private plans, health co-ops, and a new public health insurance option.

Affordability credits. The House-approved version of health care reform provides low-income individuals with "affordability credits" to help pay for the cost of coverage purchased through the exchange. The credits would be available on a sliding scale linked to the federal poverty limit. For example, a family of four earning up to \$88,000 would be entitled to a subsidy.

Comment: *The average premiums and cost-sharing payments for enrollees in health exchanges under the House-passed bill would be slightly higher than those for enrollees in the exchanges under the SFC's version, according to the Congressional Budget Office.*

Reinsurance program. The House's Health Care Act also creates a reinsurance program for employer-sponsored retiree coverage. Payments made under the reinsurance program for retirees would be excluded from gross income. Additionally, health services provided or purchased by the Indian Health Service would be expressly excluded from gross income.

Market Reforms

Rating and spending limits. The House-passed Act would prohibit insurance rating based on health status or pre-existing conditions, and limit age rating to 2:1 (premiums for older adults may be twice as high as premiums for younger individuals). The House Act also

prohibits annual or lifetime limits on medical spending and would grandfather current individual policies. These reforms would be applied to the entire market (inside and outside the Exchange), although employers have a five-year grace period to come into compliance.

Consumer protections. The House Health Care Act would establish important consumer protections, including internal and external appeal requirements, provider network adequacy requirements, and greater transparency by insurance companies.

Public health insurance option. A public health insurance option would be available within the Health Insurance Exchange under the House-passed Act to ensure choice, competition and accountability. Like other private plans, the public option would have to survive on its premiums. The Secretary of HHS would administer the public option and negotiate rates for participating providers. The public health insurance option would have startup administrative funding, but would be required to amortize these costs into future premiums to ensure operation on a level playing field with private insurers.

Medicare and Medicaid

This analysis focuses on the highlights of Medicare and Medicaid changes in the Affordable Health Care for America Act (HR 3962). While the Senate Finance Committee (SFC) and the Senate Health, Education, Labor and Pensions (HELP) Committee have both approved health care reform legislation, specific comparisons between the House bill and Senate bills are not included, since a combined Senate bill is expected to be released shortly.

Medicare Part A

Market basket updates. A productivity adjustment is incorporated into the market basket update for inpatient and outpatient hospital services, skilled nursing facilities, inpatient rehabilitation hospitals, psychiatric hospitals, home health and hospice care, starting in 2010.

Comment: *Hospitals already face possible reductions to their Medicare payments if they do not report certain quality measures or do not adapt meaningful use of electronic medical records. This provision would set a floor for the market basket update so that it would not go below zero in any given year.*

DSH adjustment. If the uninsured rate drops a certain percentage between 2012 and 2014, disproportionate share hospital (DSH) payments would be adjusted starting in FY 2017.

Physician assistants. PAs would be allowed to order skilled nursing care and may be chosen by patients to act as attending physicians for hospice care.

Graduate medical education. The HHS Secretary would be required to redistribute residency positions that have been unfilled for the prior three cost reports, and direct those slots for the training of primary care physicians. Time spent by residents in a nonprovider setting shall be counted toward direct graduate medical education and indirect medical education, if the hospital incurs the expenses of benefits.

Comment: *Over the past ten years, nearly all of the graduate medical expansion in teaching hospitals has been in subspecialty medicine. Family practice residency programs and three-year training programs that emphasize a generalist training have decreased or have closed. In the case of residency redistributions under this bill, special preference will be given to programs that have reduced residency slots, have formal arrangements to train residents in ambulatory settings or shortage areas, operate three-year primary care residency programs, currently operate residency programs over their residency cap, or are located in states with low resident-to-population ratios.*

Common Provisions

The House and Senate health reform bills share some similar provisions regarding Medicare and Medicaid, including:

- preventable hospital readmissions
- prescription drug rebates under Medicaid
- one-year Medicaid overpayment deadline for states
- denial of federal Medicaid payments for the treatment of health care-acquired conditions; the establishment of accountable care organizations
- the establishment of a Center for Medicare and Medicaid Innovation within CMS

Medicare Part B

Physician payments. Under current law, physicians face a 21-percent decrease in Medicare payments starting January 1, 2010. When considering HR 3962, the House also considered H.R. 3961, a bill which would restructure the Medicare sustainable growth rate (SGR) payment system for determining annual updates to the Medicare physician fee schedule. Under H.R. 3961, the update for 2010 would be the percentage increase in the Medicare economic index (MEI), which is 1.2 percent. Beginning in 2011, there would be separate target growth rates and conversion factor updates for two categories of service: (1) evaluation, management, and preventive services, and (2) all other services.

The Secretary of HHS would be required to regularly review fee schedule rates for physician services paid by Medicare, including services that have experienced high growth rates. Physicians practicing in areas that are identified as being among the most cost-efficient in the country would receive incentive payments.

The House did not take a final vote on HR 3691, so the SGR payment system issue is still unresolved.

Wheelchairs and other durable medical equipment. Medicare would no longer purchase power-driven wheelchairs with a lump-sum payment at the time supplied. Medicare would continue to pay for wheelchairs over a 13-month period. Beneficiaries would have the option, after a 13-month rental period for certain durable medical equipment expires, to return the equipment to the original supplier or to purchase it.

Comment: *Many wheelchairs purchased by Medicare during the first month of use are not used beyond the 13-month rental period. By eliminating the first month full-purchase option, the provision reduces waste in the Medicare program. This change also protects beneficiaries from the burden of paying the cost-sharing associated with the wheelchair in one lump sum.*

Ambulatory surgical centers. The Secretary of HHS would be required to develop a cost report for ASCs within two years of enactment of this legislation.

Comment: *The Medicare Payment Advisory Commission (MedPAC) uses cost data to analyze the adequacy of Medicare payments. However, cost data is not available for ASCs, limiting MedPAC's ability to assess payment adequacy. Under this provision, ASCs would be required to submit reports on their facility costs as a condition for agreeing to participate in Medicare; that data will allow MedPAC to properly*

assess Medicare's payment adequacy for ASCs. No later than three years from enactment, an ASC cost-reporting form would be developed.

Medicare Parts A and B

Preventable hospital readmissions. Beginning in fiscal year 2012, Medicare payments would be adjusted based on the dollar value of each hospital's percentage of potentially preventable Medicare readmissions for three conditions with risk-adjusted readmission measures that are endorsed by the National Quality Forum. The policy may be expanded to cover more conditions in future years.

Comment: *Studies have demonstrated that almost 20 percent of Medicare beneficiaries who had been discharged from a hospital were rehospitalized within 30 days and accounted for almost \$15 billion in spending in a year. Researchers have suggested that supportive palliative care and increased efforts to coordinate prompt and reliable follow-up care with primary care physicians by hospital providers would reduce readmissions and increase patient satisfaction.*

Physician referrals to hospitals. Physician ownership of hospitals would be prohibited in hospitals that are new as of January 1, 2009; existing physician-owned hospitals are grandfathered and these would be allowed to expand under certain circumstances.

Medicare Part C

Payment based on fee-for-service. Payments to Medicare Advantage (MA) plans would be reduced over three years to match Medicare fee-for-service payments.

Comment: *Medicare health maintenance organizations were originally paid at about 95 percent the cost of Medicare fee-for-service in a given county. Under Medicare policies enacted in 1997, 2000 and 2003, MA plans now get paid an average of 14 percent more than fee-for-service Medicare.*

Beneficiary protection. MA plan beneficiaries would not face higher cost-sharing than under fee-for-service Medicare. Dual eligibles would not face higher cost sharing than they would under Medicaid if they were not enrolled in Medicare. CMS would have more authority to recover overpayments to Part C plans discovered by audits. The authority for insurance companies to offer special needs plans would be extended through 2012.

Medicare Part D

“Donut hole” elimination. The Part D donut hole would be eliminated over time, to be fully phased out by 2019. Discounts of up to 50 percent for brand-name drugs used by Part D enrollees in the donut hole would go into effect in 2010. The Secretary of HHS would be required to negotiate with drug manufacturers for lower Part D drug prices. No mid-year drug formulary changes would be permitted.

Comment: *Currently, almost all Part D plans include a coverage gap in their benefit designs. CMS estimates that 31.7 percent (8.3 million) of Part D enrollees reached the initial coverage limit of their drug plans in 2007.*

Medicaid

Expanded eligibility. State Medicaid programs would be required to cover non-disabled, childless adults under age 65 not eligible for Medicare with incomes at or below 150 percent of the federal poverty level (FPL). State programs would also be able to cover individuals with HIV with incomes below state eligibility levels.

Undocumented aliens. Medicaid and CHIP coverage would not be extended to undocumented aliens.

Children’s Health Insurance Program. The Children’s Health Insurance Program (CHIP) would expire starting with the beginning of fiscal year 2014, October 1, 2013.

Comment: *The Children’s Health Insurance Program Reauthorization Act of 2009 (PubLNo 111-3) reauthorized the CHIP program until September 30, 2013. That deadline for sunsetting the program is left in place.*

Reduction in Medicaid DSH. Federal Medicaid disproportionate share hospital (DSH) payments would be reduced by \$10 billion starting in fiscal year 2017.

Preventive services and optional services. State Medicaid plans would be required to cover, without cost-sharing, specific preventive services. State plans also would be required to cover services offered by podiatrists and optometrists. State plans would have the option of covering nurse home visitation services, family planning services, and services offered by free-standing birthing centers.

Primary care. State Medicaid programs would be required to reimburse for primary care services provided by physicians and other practitioners at 100 percent of Medicare rates by 2012.

Prescription drugs. The minimum manufacturer rebate for brand-name drugs purchased by state Medicaid programs would be increased from 15.1 percent of average manufacturer price to 23.1 percent of AMP.

Overpayments. State Medicaid programs would have up to one year to return the federal share of overpayments due to fraud; currently, overpayments have to be returned within 60 days.

Health care-acquired conditions. Federal matching payments would be prohibited for the cost of health care-acquired conditions that are determined to be non-covered under Medicare.

Comment: *The definition of health care-acquired conditions under Medicaid would be similar to the existing definition of hospital-acquired conditions under Medicare, but the Medicaid definition would not be limited to conditions acquired in hospitals.*

Quality

Quality infrastructure. HHS would be required to develop, test, and update new patient-centered and population-based quality measures for the assessment of health care services.

Comparative Effectiveness Research. A new center for CER would be established at the Agency for Healthcare Research and Quality. An independent commission would recommend to the center research priorities, study methods, and ways to disseminate research.

Nursing home transparency. Several provisions would require improved communication of information, such as ownership details and reporting of expenditures, for skilled-nursing facilities, nursing facilities, and other long-term care facilities. The Secretary of HHS would have more authority to impose civil money penalties in instances where a nursing facility’s deficiency is the direct proximate cause of death of a resident.

Maternity and adult health services. The Secretary of HHS would be required to develop a set of measures for the quality of maternity care and other adult care provided under Medicaid or CHIP.

Fraud and Abuse

Increased funding. The legislation would provide an additional \$100 million annually for the Health Care Fraud and Abuse Control Fund.

Physician payments. Requires manufacturers or distributors to report to the HHS Office of Inspector General any

payments or other transfers above \$5 made to a “covered recipient” and requires hospitals, manufacturers, distributors and group purchasing organizations to report any ownership share by a physician.

Enhanced penalties. The legislation provides for increased penalties and enforcement action for various acts of fraud and abuse, including: (1) civil money penalties (CMPs) of \$50,000 for violations relating to making false statements or misrepresentations of material fact on enrollment applications for Medicare; in support of a claim for payment; or in relation to Medicare Advantage of Medicare Part D plans; (2) a CMP of \$15,000 per day for delaying access to HHS or the OIG for audits, investigations, or evaluations; (3) immediate action taken in relation to violation in a hospice that jeopardizes the health and safety of patients; (4) a CMP of \$50,000 for anyone who prescribes an item or service while excluded from Medicare; and (5) new criteria for determining Medicare Advantage and Part D marketing violations.

CMS authority. The HHS Secretary may designate program areas of significant risk in which enhanced oversight can be applied to prohibit waste, fraud, and abuse.

Claims submission. The maximum period for Medicare claims submission is set at 12 months, to reduce “gaming” of payment systems.

Overpayments. Providers, suppliers, or MA or Part D plans have 60 days to report and return an overpayment after it is discovered.

Miscellaneous

Accountable care organizations. Within Medicare, groups of physicians would be allowed to establish accountable care organizations (ACOs) that would take responsibility for the costs and quality of coordinated care provided by the ACO. Any savings to Medicare created by ACOs could be shared by members of the ACO. Within Medicaid, state plans could establish ACO pilot programs modeled after the Medicare ACOs.

Comment: *The following groups of providers and suppliers would be eligible for participation: practitioners in group practice arrangements; networks of practices; partnerships or joint-venture arrangements between hospitals and practitioners; hospitals employing practitioners. Practitioners would be defined as physicians, regardless of specialty, nurse practitioners, physician assistants, and clinical nurse specialists.*

Center for Medicare and Medicaid Innovation.

CMS would add a new center – the Center for Medicare and Medicaid Innovation – to research, develop, test, and expand innovative payment and delivery arrangements to improve quality and reduce the cost of patient care.

Studies. The House legislation calls for the following reports and studies to be conducted relating to Medicare and Medicaid:

- An HHS Secretary report to Congress by January 1, 2016 on the effect of health care reform on Medicare disproportionate share hospital payments.
- Recommendations on the most appropriate way for Medicare to cover and pay for home infusion services.
- Adequacy of Medicare payment for bone mass measurement services under the physician fee schedule.
- Establishment of a competitive bidding program for manufacturers of durable medical equipment and supplies.
- Variations in Medicare margins among home health agencies.
- Validity and effects of the geographic adjusters used for Medicare physician and hospital payments.
- Geographic variation in health care spending among all payers; further HHS and congressional action necessary to implement recommendations of report.
- Effectiveness of the Medicare Advantage risk adjustment system for low-income and chronically ill populations.
- Effects of paying Medicare Advantage plans on a more aggregated basis than at the county level.
- Extent to which Medicare providers utilize, offer, or make available language services for beneficiaries with limited English proficiency.
- Impact on the quality and access to care, and reduction in medical errors and costs or savings associated with the provision of language access services to limited English proficient populations.
- Study of the content of training requirements for certified nurse aides and supervisory staff at nursing facilities.
- GAO report on the federal Medicaid matching rate formula and the use of federal Medicaid funds on administrative expenditures and the process for determining those rates.
- Whether existing cancer hospitals that are exempt from the inpatient prospective payment system (PPS) have costs under the outpatient PPS that exceed costs of other hospitals.
- Demonstration programs. The legislation calls for the following demonstration programs:
 - Program to provide Medicare reimbursement for culturally and linguistically appropriate services, to help expand Medicare to beneficiaries with limited English proficiency.

- Using decision aids and other technologies to help patients and consumers improve their understanding of the risks and benefits of various treatment options.
- Expanding the medical home pilot program to assess the feasibility of reimbursing for qualified patient-centered medical homes.
- Payment incentive and delivery system that uses physician- and nurse practitioner-directed home-based primary care teams to provide services for chronically ill beneficiaries.
- A national, independent monitor pilot program to oversee interstate and large intrastate chains of nursing homes.
- A medical home pilot program to test the concept with Medicare beneficiaries including medically fragile children and high-risk pregnant women.
- Stabilization of emergency medical conditions by institutions for mental diseases.

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