

## The Patient Protection and Affordable Care Act

By: Members of the Drinker Biddle Health Government Relations Group

On March 23, 2010, President Obama signed H.R. 3590, the Patient Protection and Affordable Care Act, also known as the Affordable Care Act (ACA), into law (Public Law 111-148).

The House and Senate both approved a package of fixes, H.R. 4872, the Health Care and Education Reconciliation Act of 2010. President Obama signed this bill into law on Tuesday, March 30, 2010. *(Please note that in the remainder of this document all changes made through the Reconciliation Act are included in italics).*

The final health reform law is more than 2,400 pages in length and this alert is meant to serve as a top-line overview of the major provisions that were part of the final bill. At the end of the alert there is a list of additional resources including links to key governmental agencies and nonpartisan policy organizations that provide a greater level of detail on various specific elements of the new law. If you would like more information on any provisions mentioned in this summary please feel free to contact any of the Drinker Biddle Health Government Relations professionals listed at the end of this document.

### Public Health and Health Workforce Provisions

- > **Modernizing Disease Prevention and Public Health Systems.** ACA creates a new interagency council to promote healthy policies and establish a national prevention and health promotion strategy. The Act also establishes a Prevention and Public Health Investment Fund to provide expanded and sustained national investment in prevention and public health.
- > **Increasing Access to Clinical Preventive Health Services.** Establishes new programs and benefits relating to prevention, including School-Based Health Clinics and an oral health care prevention education campaign. The Act also provides Medicare coverage with no payments or deductibles for annual wellness visits or the development of personalized prevention plans; waives coinsurance requirements and deductibles for most preventive services, so that Medicare covers 100 percent of the costs; requires Medicaid coverage for pregnant women for

cessation of tobacco use counseling and pharmacotherapy; and makes grants to states to provide incentives for Medicaid beneficiaries to participate in programs providing incentives for healthy lifestyles.

- > Creating Healthier Communities. The Secretary of Health and Human Services (HHS) is authorized to award grants to eligible entities to promote individual and community health and to prevent chronic disease. The Centers for Disease Control and Prevention (CDC) is also authorized to provide grants to states and large local health departments to conduct pilot programs to evaluate chronic disease risk factors among the 55-to-64 year-old population, conduct evidence-based public health interventions, and ensure that individuals with chronic disease or at risk for chronic disease receive clinical treatment. Chain restaurants with 20 or more locations doing business under the same name are required to list calorie counts on the menu board and in written form.
- > Support for Prevention and Public Innovation. The HHS Secretary will provide funding for research in public health services and systems to examine best practices in the area of prevention. A new CDC program will help state, local, and tribal public health agencies improve surveillance for and responses to infectious diseases and other conditions. CDC also will evaluate best employer wellness practices, and develop an educational campaign and provide technical assistance to promote the benefits of worksite health promotion.
- > United States Preventive Services Task Force. ACA sets standards for preventive service coverage through the United States Preventive Services Task Force (USPSTF). All insurance companies and health plans must cover any service given a rating of 'A' or 'B' in the current recommendations of the USPSTF. This does not mean that services not recommended by the USPSTF can or should necessarily be denied by insurers. ACA also sets up a separate task force to deal specifically with community health care, to be called the Community Preventive Services Task Force. The community task force will be responsible for developing recommendations around the effectiveness of community preventive interventions at the population level for organizations including primary care professionals, health care systems, professional societies, employers, community organizations and others. The community task force will work closely with the USPSTF in delivering recommendations.
- > Expansion of Health Care Workforce. Beginning in fiscal year (FY) 2011, the Act provides expanded funding for scholarships and loan repayments for primary care providers working in underserved areas. In addition, by July 2011, primary care and nurse training programs, including the Medicare Graduate Medical Education Program, will be expanded to help address workforce shortages. Workforce needs will be determined by a national commission that reviews America's health care workforce. The commission will provide Congress and the Administration with information that can be used to align resources with needs.
- > Nursing. ACA addresses the nursing shortage by increasing educational opportunities such as providing loan repayment and retention grants and creating a career ladder to nursing.

- > **Pain Care.** The Act authorizes an Institute of Medicine conference on pain to focus on policy and medical issues related to the delivery of pain care, creates a training program for health care professionals to assess and treat pain, and expands the National Institute of Health's pain research program.
- > **Cancer.** ACA includes a number of provisions that make cancer treatment more affordable and accessible, such as insurance subsidies and the elimination of annual and lifetime caps on coverage and exclusion from coverage based on pre-existing conditions. ACA focuses on prevention and early detection of disease and requires all insurance plans to provide coverage for essential, evidence-based preventive measures with no additional co-payments or deductibles. ACA also expands Medicaid and tax subsidies, increasing access to cancer treatment and prevention services for low-income populations. Additionally, insurers are now required to provide coverage for participation in clinical trials. (See Health Plan and Insurer Provisions below for more information on these and other items.)
- > **Other Public Health Authorizations.** ACA includes the authorization of numerous new public health initiatives and programs including, but not limited to: a congenital heart disease patient registry; a public health workforce corps; maternal, infant, and early childhood home visiting programs; and efforts to improve cultural competency in the delivery of health care and enhance the aptitude of individuals working with people with disabilities.

---

## Health Provider and Industry Provisions

### General Changes

- > **Accountable Care Organizations (ACO)/Gainsharing.** Effective 2012, groups of providers organized as Accountable Care Organizations (ACO) that reduce the cost of patient care will share in the Medicare savings they achieve. To qualify as an ACO, an organization must agree to be accountable for the overall care of Medicare beneficiaries received from providers in the ACO, have adequate participation of primary care physicians, promote evidence-based medicine, report on quality and costs, and coordinate care.
- > **Bundled Payment Pilot Program.** By 2013, a national Medicare pilot program will offer one bundled payment to all providers participating in each single inpatient episode (acute inpatient hospital services, physician services, outpatient hospital services, and post-acute care services) covering all care delivered beginning three days before hospitalization and continuing for 30 days after discharge. Participation in the pilot program will be voluntary. A manager's amendment created a separate pilot program for a Medicare bundling payment pilot program specific to continuing care hospitals. For the purposes of this program, a continuing care hospital is defined as "an entity that has demonstrated the ability to meet patient care and patient safety standards and that provides under common management the medical and rehabilitation services provided in inpatient rehabilitation hospitals, long term care hospitals, and skilled nursing facilities that are located in a hospital." An episode of care is defined as "the full period

that a patient stays in the continuing care hospital plus the first 30 days following discharge from such hospital.”

- > Increased Fraud and Abuse Enforcement. ACA increases funding for fraud and abuse compliance by \$250 million over 10 years.
- > Reductions in Medicare Reimbursement. Applies a productivity adjustment to reduce the annual market basket updates to Medicare fee schedule for inpatient acute hospitals, skilled nursing facilities, long-term care hospitals, inpatient rehabilitation facilities, home health agencies, laboratory services, and other Medicare providers.
- > Independent Payment Advisory Board. An independent 15-member board will be established to recommend means to reduce the per capita rate of growth in Medicare spending if it exceeds a target growth rate.
- > Center for Medicare and Medicaid Innovation. ACA requires the creation of a Center for Medicare and Medicaid Innovation within the Centers for Medicare and Medicaid Services (CMS), which will be responsible for development, testing, and implementation of payment and delivery arrangements to improve quality and reduce costs for services provided to Medicare and Medicaid patients.
- > Stark Law Disclosure Protocol. ACA directs the HHS Secretary to develop and implement a disclosure protocol for actual and potential Stark Law violations within six months. The protocol may include a means for the Secretary to reduce or compromise amounts owed under the Stark Law.

### Hospitals

- > Avoidable Errors. ACA reduces diagnosis-related group (DRG) payments to hospitals by 1 percent for avoidable readmissions (effective 2012) and hospital-acquired infections (effective 2015).
- > Value-Based Payments for Hospital Services (DRG Withhold Program). ACA reduces hospital DRGs by 1 percent in 2013 and 2 percent by 2017 through a withholding in payment. The pool created through withheld funds will be allocated among the best performing hospitals, as evidenced by achievement of certain quality measures.
- > DSH Payments. *Effective 2014, the Reconciliation Act reduces disproportionate share hospital (DSH) payments by 75 percent and subsequently increases payments based on the percentage of uninsured patients and the amount of uncompensated care provided.*
- > RAC Expansion. ACA expands the Recovery Audit Contractor (RAC) program to include state Medicaid programs.
- > Additional Requirements for Nonprofit Hospitals. Beginning for tax years after March 23, 2012, a new Internal Revenue Code Section 501(r) will require tax-exempt hospitals to conduct a community needs assessment every three years and adopt strategies to meet identified needs. In addition, effective immediately, tax-exempt hospitals must adopt and publicize written financial assistance policies and limit charges to patients who qualify for financial assistance to the amounts generally billed to insured patients. Further, tax-exempt hospitals may

not use extraordinary collection actions before undertaking reasonable efforts to determine whether a patient is eligible for financial assistance.

### Physicians

- > Elimination of Physician-Owned Hospitals. ACA virtually eliminates the Stark Law “Whole Hospital” exception permitting physician-owned hospitals. Grandfathered hospitals (*i.e.*, those with provider agreements as of August 1, 2010) are permitted to remain operational, but the percentage of physician ownership cannot increase from that held on March 23, 2010 (the enactment of the ACA). Further, ACA increases disclosure requirements, expands requirements to ensure the physicians’ investments are *bona fide*, and places severe restrictions on the hospitals’ abilities to add operator procedure rooms and beds. *The Reconciliation Act changes the date after which physician ownership of hospitals to which they self-refer is prohibited to December 31, 2010, and provides a limited exception to growth restrictions on existing physician-owned hospitals that treat the highest percentage of Medicaid patients in their counties.*
- > Increased Medicaid Payments for Primary Care. ACA will increase Medicaid payments for primary care physicians (pediatricians, family physicians, and internists) starting in 2013, raising them to Medicare levels by 2014.
- > Value-Based Payments for Physician Services. ACA will implement a relative value unit (RVU) modifier system to enable differential payments to physicians based on their achievement of certain quality metrics.
- > Disclosure of Ownership of Imaging and Other DHS. Effective immediately, ACA amends the in-office ancillary services exception to the Stark Law by requiring a referring physician to inform patients in writing at the time of a referral that the patient may obtain specified imaging services (*i.e.*, MRI, CT and PET scans) and other designated health services (DHS) as designated by the HHS Secretary from a person or entity unrelated to the referring physician. In addition, the referring physician must provide patients with a list of alternative suppliers in the area where the patient resides.
- > Disclosure and Compliance. Long-term care providers will be required to disclose ownership information and to implement compliance and ethics plans.

### Clinical Laboratories

- > Productivity Adjustment to the Annual CPI Update. In ACA, along with several other providers, a productivity adjustment was applied to the annual Consumer Price Index (CPI) fee schedule update for clinical laboratory services. The productivity adjustment provision repeals the current 0.5 percent cut to the fee schedule and replaces it with a reduction equal to the 10-year moving average of annual multi-factor productivity, which is determined by the Bureau of Labor Statistics. The productivity adjustment alone cannot drive the Clinical Laboratory Fee Schedule (CLFS) update into the negative. For example, if the CPI update is 1.2 percent and productivity is determined to be 1.3 percent for any given year, there would not be a negative 0.1 percent update, rather the change would be zero. Beginning in 2011, the productivity adjustment does not have a sunset date.

- > Additional Reduction to Clinical Laboratory Fee Schedule (CLFS). In addition to the annual productivity adjustment, ACA will reduce the CLFS by an additional 1.75 percentage points in years 2011 through 2015. Unlike the productivity adjustment, this additional cut could result in a negative update to the CLFS. The 1.75 percent cut to the CLFS is an alternative revenue raising provision to the original proposal of an industry wide fee to be determined based on market share.
- > Treatment of Complex Diagnostic Laboratory Tests. ACA sets up a demonstration project in which separate payments would be made for complex diagnostic laboratory tests performed on specimens collected during hospitalization. In order to qualify, tests must be Food and Drug Administration (FDA) approved, billed using an HCPCS code other than “not otherwise classified,” must not have an alternative test with equivalent performance characteristics, and must be either an analysis of gene protein expression, a topographic genotyping or a cancer chemotherapy sensitivity assay. The term “separate payments” means that direct payments would be made to the laboratory—either hospital-based or independent—that performs a complex diagnostic test (must fit the above definition) after the period of hospitalization, on a specimen that was collected while a patient was in the hospital. The demonstration project will begin July 1, 2011, will last for two years, and must not exceed \$100 million. Within two years after the completion of the demonstration project, the Secretary is required to submit a report to Congress.
- > Extension of Medicare Payments for Rural Laboratory Services. ACA extends the Medicare reasonable cost payments for some clinical laboratory tests that are performed on patients in rural areas.
- > Extension of Payment for Technical Component of Pathology Services. ACA extends the payment for the technical component of pathology services through the end of 2010.

#### Pharma/Device Manufacturers

- > Excise Taxes. Effective immediately, ACA imposes annual excise taxes on sales by pharmaceutical manufacturers in the amount of \$2.3 billion annually, allocated among manufacturers based on market share. ACA similarly imposes taxes on device manufacturers in the amount of \$2.0 billion in 2011 through 2017, and \$3 billion thereafter. *The Reconciliation Act delays the excise tax on pharma until 2011 and raises the amount of the tax to \$2.5 billion (with annual increases thereafter). The Reconciliation Act imposes a 2.3 percent sales tax on devices effective 2013.*
- > Generic Biologics. Effective immediately, ACA authorizes the FDA to approve generic versions of biologics and to grant biologics manufacturers 12 years of data exclusivity before generics can be marketed.
- > Increased Transparency. Effective 2012, pharmaceutical and device manufacturers will be required to publicly disclose payments made to hospitals, physicians, and other providers.

## Employer Provisions

- > **Employer Mandate.** While ACA does not require employers to offer health coverage to employees, effective in 2014, the Act assesses a fee on employers with more than 50 full-time employees (generally employees working at least 30 hours/week) if they don't offer "minimum essential coverage" and at least one full-time employee qualifies for a federal premium credit or cost-sharing reduction. The annual penalty amount is generally \$750 per full-time employee. If the employer *offers* minimum essential coverage but at least one employee qualifies for a federal premium credit or cost-sharing reduction, the annual penalty is \$3,000 per qualifying employee receiving the credit/reduction, but is capped at the penalty amount that would have been assessed if no coverage were offered; employers that offer qualifying low income employees a voucher to purchase coverage on an exchange are not subject to this penalty. Under the Act, additional penalties apply if large employers offer coverage with a waiting period in excess of 60 days. *The Reconciliation Act increases the penalty for not offering coverage to \$2,000 per full-time employee (excluding the first 30). The Reconciliation Act eliminates the additional penalties for excessive waiting periods, but the maximum waiting period for coverage remains 90 days. The Reconciliation Act counts part-time employees on a full-time equivalent basis for the sole purpose of determining the 50 full-time employee threshold.*
- > **Automatic Enrollment.** Employers with more than 200 employees and who offer health benefits are required to automatically enroll employees into such plans. Employers must provide employees with notice of automatic enrollment and an opportunity for employees to opt out. The effective date of this requirement is unclear and guidance is needed.
- > **Small Businesses.** Effective for tax years beginning in 2010, ACA provides tax credits of up to 35 percent (increasing to 50 percent by 2014) to encourage qualified small businesses to provide health care coverage to employees. Tax-exempt employers receive a 25 percent (increasing to 35 percent by 2014) credit.
- > **Retiree Drug Subsidy Tax.** Effective for tax years beginning on or after January 1, 2011, employers will no longer be able to deduct the 28 percent subsidies received for maintaining retiree drug coverage for Medicare-eligible employees. *The Reconciliation Act delays implementation of the end of the deduction until 2013.*
- > **W-2 Changes.** Beginning in 2011, employers must report the aggregate costs of health coverage received by each employee under the employer's health plan.
- > **1099 Changes.** For payments made beginning in 2012, ACA expands 1099 information reporting to include compensation paid for goods as well as services and for payments made to corporations as well as to individuals and partnerships.

## Health Plan and Insurer Provisions

- > **Required Plan Coverage.** As set forth herein and in the Consumer Implications section below, ACA dramatically alters the way health insurers currently do business, through mandated coverage requirements, elimination of policy restrictions and limitations on premiums, among other things.
- > **Health Insurance Exchanges.** To create affordable insurance options for individuals not insured through work and for some small business, ACA will create state-based American Health Benefit Exchanges and Small Business Health Options Program Exchanges through which individuals and small businesses of up to 100 employees can purchase qualified coverage.
- > **CO-OP Plan.** ACA will create the Consumer Operated and Oriented Plan (CO-OP) program to create non-profit, member-run health insurance companies in all 50 states and the District of Columbia.
- > **Benefit Tiers.** Insurance offered to eligible individuals and small businesses through an exchange or CO-OP program must fall under one of four “levels” of benefit plans or as catastrophic coverage. Exchange plans, as well as other new, qualified plans offered by other insurers, must provide essential health benefits, cover at least 60 percent of the benefit costs of the plan and have an out-of-pocket limit equal to the health savings account (HSA) limit. Out-of-pocket limits are reduced for those with incomes up to 400 percent of the federal poverty level.
- > **No Out-of-Pocket Fees for Preventive Care.** Effective for plan years beginning on or after September 23, 2010 (January 1, 2011 for calendar year plans), health plans will no longer be able to charge co-pays and deductibles for recommended preventive care. This requirement does not apply to grandfathered plans.
- > **Grandfathering.** Existing individual and employer-sponsored plans are not required to meet many of the new benefit standards. *The Reconciliation Act similarly grandfathers existing plans, but not as broadly. For example, effective for plan years beginning on or after September 23, 2010, the Reconciliation Act requires existing plans to extend coverage to dependents up to age 26 (with certain exceptions for children who have access to other employer-sponsored coverage) and prohibits recessions of coverage; grandfathered plans also have to eliminate lifetime limits, as well as most annual limits, on coverage. Effective for plan years beginning on or after January 1, 2014, grandfathered plans must eliminate waiting periods for coverage longer than 90 days, all remaining annual limits on coverage, and exclusions based on pre-existing conditions.*
- > **Excise Taxes.** Effective 2013, the Affordable Care Act imposes annual excise taxes on health insurers. *The Reconciliation Act varies the timing and amount of the fees.*
- > **Changes in Payments to MA Plans.** Medicare Advantage (MA) plans located in high-cost areas will see payments of 5 percent less than FFS Medicare; plans in lower cost areas may see payments go up, to an amount equal to 15 percent more than FFS Medicare.

- > Laboratory Services and Health Benefits Package. ACA lists laboratory services among several other services including ambulatory patient, emergency, and rehabilitative as part of the minimum required benefits available in the health insurance exchange.
- > Clinical Trials. Section 2709 of ACA requires health insurance plans, including those offered through the Federal Employee Health Benefit Program, to provide coverage for routine costs associated with participation in clinical trials.

---

## Consumer Provisions

- > Individual Coverage Mandate. ACA requires all individuals to obtain health insurance coverage or pay penalties. Coverage provided by employers generally will cover this individual obligation. Penalties will begin in 2014 at \$95 per uninsured and will increase to \$750 by 2016 (amounts thereafter will be indexed for inflation). Lower income individuals (within 100-400 percent of the federal poverty level) will receive tax credits or employer-provided vouchers to help pay for coverage. *The Reconciliation Act modifies the assessment formulas for individuals who choose to remain uninsured and provides higher tax credits and other support to make insurance more affordable for those with incomes under 250 percent of the federal poverty level.*
- > Taxes. Effective for tax years beginning in 2013, individual income tax filers with adjusted gross income (AGI) over \$200,000 and joint filers with AGI over \$250,000 will pay an additional 0.9 percent in Medicare payroll taxes. Self-employed individuals will also pay the new taxes. Taxes on HSA distributions made after December 31, 2010, that are not used for qualified medical expenses will double to 20 percent. *The Reconciliation Act expands the Medicare tax (effective for tax years beginning in 2013) to include a 3.8 percent tax on net investment income (i.e., income from dividends, interest, annuities, royalties, rents and disposition of properties) for the same high income filers.*
- > Temporary High-Risk Pool Coverage for Pre-Existing Conditions. Effective later this year, a temporary national high-risk pool will be created to permit adults with pre-existing conditions to obtain subsidized coverage, with maximum cost sharing capped at the current HSA limit (\$5,950 for individuals and \$11,900 for families). The high-risk pool will be eliminated after 2014, when insurers will be prohibited from excluding persons with pre-existing conditions.
- > Expanded Medicaid Coverage. Medicaid coverage will be available to those with incomes up to 133% of the federal poverty level (i.e., \$29,000 for a family of four in 2010). For 2014 through 2016, rather than sharing Medicaid costs with the states, the federal government will pay 100 percent of the cost of covering newly insured individuals. In addition, states are required to maintain income eligibility under the Children's Health Insurance Program through 2019.
- > Cadillac Tax Plan. Effective in 2013, ACA will impose a 40 percent excise tax on the excess benefit provided under high value health insurance plans (i.e., those with aggregate value over \$8,500 for individuals and \$23,000 for families, annually). The excise tax will be owed by insurers of insured plans and the

employer/administrator in the case of self-insured plans, but such costs are expected to be passed on to consumers. *Implementation of the excise tax is delayed until 2018 under the Reconciliation Act, and the thresholds increase to \$10,200 and \$27,500, respectively.*

- > **Elimination of Medicare Part D Donut Hole.** ACA does not close the Medicare “donut hole,” which requires seniors to pay 20 percent of drug costs up to \$2,850, 100 percent of drug costs up to \$6,350 and 5 percent thereafter. *The Reconciliation Act provides for a \$250 rebate to seniors who cross the Part D coverage gap in 2010. In 2011, seniors will get a 50 percent discount on branded prescription drugs (funded by the pharmaceutical companies) when they enter the donut hole. Thereafter, discounts will increase to 75 percent and also apply to generics until the donut hole is eliminated in 2020.*
- > **Flexible Spending Accounts.** Effective 2011, contributions to flexible spending accounts are capped at \$2,500 (to be indexed for inflation), and the use of such funds for non-prescription medications will no longer be allowed. *The Reconciliation Act delays implementation of flexible spending account limitations until 2013.*
- > **Immediate Insurance Policy Changes.** Effective for plan years beginning six months after enactment (September 23, 2010), insurers will not be permitted to impose lifetime limits on insurance coverage or to cancel policies due to serious illness; annual limits will be permitted as determined by the HHS Secretary. In addition, insurers are prohibited from excluding children under age 19 from coverage based on pre-existing conditions. Parents also will be able to cover their dependents on their own policies up to age 26. Insurers will be required to cover preventive health care services.
- > **Long-Term Insurance Policy Changes.** For plan years starting in 2014, insurers may not impose excessively long waiting periods, and no one may be denied coverage on the basis of pre-existing conditions. In addition, insurers may no longer place any annual limits on coverage.
- > **Exception for Existing Insurance Plans (Grandfathering).** Under the Affordable Care Act, existing individual and group plans are exempt from most of the reforms detailed above. *The Reconciliation Act requires grandfathered plans to comply with many of the above requirements, generally at the time the provisions would apply without regard to grandfathering status. This includes the prohibitions on lifetime and annual limits (the latter for group plans only), rescissions, excessive waiting periods and the denial of coverage for pre-existing conditions, as well as the extension of dependent coverage.*

---

## Implementation of the Health Reform Law

The following are links to federal government resources with respect to: copies of the Patient Protection and Affordable Care Act and Reconciliation Act, documents outlining the timeline for implementation and agencies expected to be involved in the implementation of the health care reform law.

**Centers for Medicare and Medicaid**

<http://www.cms.hhs.gov/>

**Congressional Budget Office**

<http://www.cbo.gov/publications/collections/health.cfm>

**Department of Health and Human Services**

<http://www.hhs.gov/> and <http://www.healthreform.gov/>

**Department of Labor**

<http://www.dol.gov/>

**H.R. 3590 Patient Protection and Affordable Care Act (Library of Congress)**

<http://www.thomas.gov/cgi-bin/bdquery/D?d111:1:./temp/~bdCIca:@@L&summ2=m&|/bss/111search.html>

**H.R. 4872 Health Care and Education Reconciliation Act of 2010 (Library of Congress)**

<http://www.thomas.gov/cgi-bin/bdquery/D?d111:1:./temp/~bd1uaq:@@L&summ2=m&|/bss/111search.html>

**H.R. 4872, the Health Care & Education Affordability Reconciliation Act of 2010 Implementation Timeline (House Committee on Energy and Commerce)**

<http://docs.house.gov/energycommerce/TIMELINE.pdf>

**Indian Health Reauthorization Act (U.S. Indian Health Service)**

<http://www.ihs.gov/AdminMngrResources/reauthor/files/IHS-6TitlebyTitleSummary.doc>

**Internal Revenue Service**

<http://www.irs.gov/>

**The White House**

<http://www.whitehouse.gov/healthreform>

---

## Additional Resources on Health Reform Law

The following are links to other organizations' summaries and articles regarding the new law.

**Community Health Centers (National Association of Community Health Centers)**

<http://www.nachc.org/client/Summary%20of%20Final%20Health%20Reform%20Package.pdf>

**Consumers Guide to Health Reform (Kaiser Health News, 26 March 2010)**

<http://www.kaiserhealthnews.org/Stories/2010/March/22/consumers-guide-health-reform.aspx>

**"Health care reform bill 101: rules for preexisting conditions" (Christian Science Monitor, 24 March 2010)**

<http://www.csmonitor.com/USA/Politics/2010/0324/Health-care-reform-bill-101-rules-for-preexisting-conditions>

**Health Disparity Provisions in the Health Reform Statute (PREMIER)**

<http://healthyamericans.org/assets/files/HealthDisparities.pdf>

**Health Reform (Kaiser Family Foundation)**

<http://healthreform.kff.org/>

**Health Reform Implementation Timeline (Kaiser Family Foundation)**

<http://www.kff.org/healthreform/8060.cfm>

**Health Reform Tool Kit: Getting Specific about Health Reform (Families USA)**

<http://www.familiesusa.org/health-reform-tool-kit/getting-specific/>

**Health System Reform Resources (American Medical Association)**

<http://www.ama-assn.org/ama/pub/health-system-reform/resources.shtml>

**Implementation Timeline Under H.R. 3590 The Patient Protection and Affordable Care Act (American Medical Association)**

<http://www.ama-assn.org/ama1/pub/upload/mm/399/hsr-implementation-timeline.pdf>

**Key Provisions Related to Nursing (American Nurses Association)**

[http://www.rnaction.org/site/DocServer/Key\\_Provisions\\_Related\\_to\\_Nursing-HR\\_3962.pdf?docID=761](http://www.rnaction.org/site/DocServer/Key_Provisions_Related_to_Nursing-HR_3962.pdf?docID=761)

**Maternal and Child Health Related Highlights (Association of Maternal and Child Health Programs)**

<http://healthyamericans.org/assets/files/HealthDisparities.pdf>

**Prevention, Public Health & Workforce Provision (Trust for America's Health)**

<http://healthyamericans.org/assets/files/Summary.pdf>

**Side-by-Side Comparison of Major Health Care Reform Proposals (Kaiser Family Foundation)**

<http://www.kff.org/healthreform/sidebyside.cfm>

**The Immediate Effects of the Health Reform Bill (Kaiser Health News, 22 March 2010)**

<http://www.kaiserhealthnews.org/Stories/2010/March/22/immediate-effects-health-reform.aspx>

**The Patient Protection and Affordable Care Act – Full Text (George Washington University School of Public Health and Health Services)**

[http://www.gwumc.edu/sphhs/departments/healthpolicy/healthReform/propSummaries/Combined\\_Senate\\_Summary.pdf](http://www.gwumc.edu/sphhs/departments/healthpolicy/healthReform/propSummaries/Combined_Senate_Summary.pdf)

---

## Health Government Relations Team

**Brian Altman, JD**  
Senior Government Relations Manager  
(202) 230-5185  
Brian.Altman@dbr.com

**Greg T. Billings**  
Senior Government Relations Director  
(202) 230-5104  
Greg.Billings@dbr.com

**Jodie A. Curtis**  
Senior Government Relations Director  
(202) 230-5147  
Jodie.Curtis@dbr.com

**Rebecca Freedman McGrath, JD**  
Senior Government Relations Manager  
(202) 230-5679  
Rebecca.McGrath@dbr.com

**Ilisa Halpern Paul, MPP**  
Managing Government Relations Director  
(202) 230-5145  
Ilisa.Paul@dbr.com

**R. Edwin Redfern**  
Government Relations Director  
(202) 230-5151  
Edwin.Redfern@dbr.com

**Jeremy R. Scott**  
Government Relations Director  
(202) 230-5197  
Jeremy.Scott@dbr.com

**James W. Twaddell, IV, MA**  
Government Relations Director  
(202) 230-5130  
James.Twaddell@dbr.com

**Elaine H. Vining**  
Government Relations Director  
(202) 230-5676  
Elaine.Vining@dbr.com

**Robert J. Waters, JD**  
Partner  
(202) 230-5152  
Robert.Waters@dbr.com

**Erin Will Morton**  
Government Relations Manager  
(202) 230-5634  
Erin.WillMorton@dbr.com

**Courtney Yohe, MPP**  
Government Relations Manager  
(202) 230-5649  
Courtney.Yohe@dbr.com