

# Federal Legislation Quick Guide

August 6, 2008

## Pending Legislation—Health and Welfare Plans

**Note:** The following charts summarize federal legislation that is currently under active consideration by Congress or has recently been enacted into law. In most cases, other bills have also been introduced on the same issue, but are not being actively considered by Congress at this time. For more information on the summarized bills, or to find other bills on the same issue, go to the Library of Congress Web site at <http://thomas.loc.gov>.

### Mental Health Parity

<b>Current Legislation</b>	Jobs, Energy, Families and Disaster Relief Act of 2008 (S. 3335).
<b>Status</b>	S. 3335 was introduced by Senator Baucus (D-MT) on July 24, 2008. A bipartisan, bicameral compromise on mental health parity was included in the bill. Because of opposition to other parts of the bill, on July 30 the Senate by a vote of 51 to 43 was unable to get the 60 votes needed to vote on S. 3335. The bill will be held until September.
<b>Outlook</b>	Debate on S. 3335 will resume when Congress returns the second week of September. Since a bipartisan agreement has been reached, mental health parity has a good chance of enactment this year, either as a part of S. 3335 or through another legislative vehicle.
<b>Details</b>	S. 3335 would amend ERISA, the Public Health Service Act and the Internal Revenue Code to prohibit group health plans from imposing different treatment or financial limits on mental health and substance abuse disorder benefits compared with the most common medical/surgical benefits. Medical necessity criteria would have to be made available to current and prospective plan participants and contracting providers and reasons for denial of coverage would have to be made available to the participant or beneficiary on request. Plans would have to provide out-of-network coverage for mental health benefits if out-of-network coverage is provided for medical/surgical benefits. Coverage of mental health benefits would be defined by the plan and any applicable federal and state laws for fully insured plans. A cost exemption would be available if, after six months an actuary certifies that the plan's actual total costs of coverage increased by more than 2% in the first plan year (and 1% in any subsequent year). ERISA's current enforcement and remedy provisions would apply.
<b>Effective Date</b>	S. 3335 would be effective for plan years beginning after the date that is one year after the date of enactment, regardless of whether regulations have been issued (i.e. January 1, 2010 for calendar year plans). The financial parity requirements for substance abuse disorder benefits under current law would become effective January 1, 2009.

## Trade Adjustment Assistance Act (Health Care Tax Credit and COBRA)

<b>Current Legislation</b>	<ul style="list-style-type: none"> <li>■ Trade and Globalization Adjustment Assistance Act of 2007 (S. 1848).</li> <li>■ Trade and Globalization Assistance Act of 2007 (H.R. 3920).</li> </ul>
<b>Status</b>	<ul style="list-style-type: none"> <li>■ S. 1848 was introduced by Sens. Baucus (D-MT) and Snowe (R-ME) on July 23, 2007 and is awaiting action in the Senate Finance Committee.</li> <li>■ The House approved H.R. 3920 on October 31, 2007 by a vote of 264 to 157.</li> </ul>
<b>Outlook</b>	<p>The TAA bill will not be addressed until Congress returns in September.</p> <p>The White House issued a Statement of Administration Policy in October 2007 stating that while the president generally supports a reauthorization of TAA, he would veto H.R. 3920 because it converts the trade-related program into a “universal income-support and training program” and because he opposes the increase in the HCTC premium subsidy. However, the president has since softened his stance.</p>
<b>Details</b>	<p>S. 1848 would increase the refundable, advanceable health care tax credit (HCTC) from 65% to 85% of monthly health insurance premiums for eligible workers under the Trade Adjustment Assistance Act (TAA). The bill would allow TAA recipients who are not enrolled in training programs to be eligible for the HCTC, and would amend the creditable coverage calculation period to exclude the time between the loss of coverage and the time when the individual receives notice of eligibility for the HCTC. In addition, spouses and dependents would continue to be eligible for the HCTC if the worker becomes eligible for Medicare, in the case of divorce, or death of the worker. The bill would require COBRA coverage to continue during the time that the worker is TAA-eligible. In addition, VEBAs would be added to the list of qualifying coverage for the HCTC.</p> <p>H.R. 3920 would increase the refundable, advanceable HCTC for qualified insurance premiums from 65% to 85% and allow the end-of-year credit to be applied to premiums for qualified insurance that are paid prior to a TAA-eligibility determination (provided the person is ultimately determined eligible for assistance) or December 31, 2007, whichever is later. The bill would allow workers not enrolled in a training program and who are receiving unemployment insurance to be eligible for the HCTC, and would amend the creditable coverage calculation period to exclude the time between the loss of coverage and five days after the individual receives notice of eligibility for the HCTC. The bill would allow spouses and dependents to continue to receive the HCTC when the worker becomes eligible for Medicare, dies, or is divorced. The GAO would be required to conduct a study on the HCTC to help Congress develop an alternative health benefit for trade-displaced workers. The bill would provide extended COBRA eligibility for: (1) PBGC pension recipients until the recipient’s date of death, and for a surviving spouse or dependents for 36 months after the date of death; (2) TAA-eligible individuals until TAA-eligibility ends; and (3) TAA-eligible individuals who are age 55 or have ten years of service with the employer until they obtain other group health coverage or become eligible for Medicare.</p>

## Trade Adjustment Assistance Act (Health Care Tax Credit and COBRA) (continued)

<b>Effective Date</b>	<p>S. 1848 would apply to taxable years after December 31, 2007.</p> <p>Under H.R. 3920, the COBRA amendments would apply to periods of coverage that would end on or after January 1, 2008. The HCTC increase would apply to months beginning after December 31, 2007 in taxable years ending after that date, and the HCTC would sunset after December 31, 2009.</p>
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## Medicare Reforms

<b>Current Legislation</b>	Resolution suspending Section 803 of the Medicare Modernization Act of 2003 (H. Res. 1368).
<b>Status</b>	The House approved H. Res. 1368 on July 24 by a vote of 231-184.
<b>Details</b>	H. Res 1368 provides that section 803 of the Medicare Modernization Act (MMA) will not apply for the remainder of the 110 <sup>th</sup> Congress. Section 803 of the MMA requires the president to propose a savings measure if the Medicare trustees for two consecutive years project that general revenue spending on Medicare will rise above 45%. In April 2007, the trustees issued a second consecutive warning prompting the administration to propose legislation. The resolution circumvents a requirement that action be taken on the president's legislation by July 30. If no action had been taken on the measure by the deadline, any member of the House could have forced a debate and a vote on it. The resolution does not require Senate action.
<b>Effective Date</b>	The resolution became effective upon passage.

## Health Information Technology (IT)

<b>Current Legislation</b>	<ul style="list-style-type: none"> <li>■ Protecting Records, Optimizing Treatment, and Easing Communication through Healthcare Technology Act of 2008 (PRO(TECH)T) Act of 2008) (H.R. 6357).</li> <li>■ Wired for Health Care Quality Act of 2007 (S. 1693).</li> <li>■ Healthcare Information Technology Enterprise Integration Act (H.R. 2406).</li> </ul>
<b>Status</b>	<ul style="list-style-type: none"> <li>■ The House Energy and Commerce Committee approved H.R. 6357 July 23 by a voice vote.</li> <li>■ The Senate Health, Education, Labor, and Pensions (HELP) Committee approved S. 1693 by a voice vote on June 27, 2007. Senate sponsors tried to "hotline" the bill July 31 to bring the bill to a vote on the floor but were unable to reach a unanimous consent agreement.</li> <li>■ H.R. 2406 was approved by the House Committee on Science and Technology on October 24, 2007 by voice vote. The bill now heads to the House floor for a vote but the timing is uncertain.</li> </ul>
<b>Outlook</b>	<p>H.R. 6357 is a bipartisan bill that has support of some business groups, although they do not support all the privacy protection requirements.</p> <p>S. 1693 will be held over until September, but with only about three weeks until target adjournment and a packed agenda, prospects remain uncertain.</p> <p>The House Ways and Means Health Subcommittee held a hearing on promoting health IT on July 24, and is considering developing its own bill.</p>

## Health Information Technology (IT) (continued)

<b>Details</b>	<p>H.R. 6357 would codify the HHS Office of the National Coordinator for Health Information Technology (ONCHIT) and would require ONCHIT to lead efforts to develop policies and recognition of standards to allow for the secure electronic exchange of health information, including developing and updating a strategic plan to achieve these goals. The strategic plan would have to include steps to encourage utilization of electronic health records (EHRs) for each person in the U.S. by 2014, and ensure the incorporation of adequate privacy and security protections into EHRs. ONCHIT would also be required to develop a program of voluntary certification of products meeting standards for secure electronic exchange of health information. Federal government agencies implementing, acquiring or upgrading HIT systems would be required to adopt the HIT standards after review and rulemaking by the Secretary of HHS, and use products that are certified as meeting standards. The HIT standards would be voluntary with respect to private entities, but mandatory for private entities that contract with federal agencies to carry out HIT-related activities. The bill would establish a HIT Policy Committee and HIT Standards Committee (which would succeed the current AHIC) comprised of public and private stakeholders to advise the ONCHIT. ONCHIT would establish a HIT Resource Center to provide technical assistance, develop best practices and service as a forum for exchange of knowledge and experience concerning HIT adoption.</p> <p>H.R. 6357 contains incentives to encourage and facilitate adoption of HIT with \$113 million (through 2013) via three separate competitive grant programs: one offering matching funds to eligible healthcare providers for the purchase of qualified HIT; a second program offering funds to States and Indian Tribes to develop loan programs to healthcare providers, and a third program to provide support for local and regional organizations to develop HIT plans. Preferences for awarding the grants would be given to small and rural providers. There would also be a demonstration program to integrate HIT into clinical education. The privacy and security provisions of H.R. 6357 would make the HIPAA privacy and security safeguards and penalties for their violations apply to “business associates” of “covered entities” (as both of these terms are defined under HIPAA) in the same manner as they do for covered entities themselves. The Secretary of HHS would also be required to issue annual security safeguard updates. The bill would require covered entities to provide notification of a breach of unencrypted protected health information (PHI) to each individual whose information has been or is reasonably believed to have been breached, no later than 60 days from discovery of the breach (with limited exceptions). The Secretary of HHS is required to issue guidance on encryption technology or methodology that meets the safe harbor standard within 60 days and annual thereafter. Patients would be able to request, and providers are required to honor such requests, that their PHI not be disclosed by a covered entity to a health plan if the patient pays for a health care item or service out of pocket. The HIPAA PHI disclosure and consent provisions are clarified and strengthened, including provisions that consent may be revoked only prospectively, and may be a one-time aggregated consent. Covered entities would be required to make reasonable effort to request, use or disclose only the minimum necessary PHI to accomplish the intended purpose and this “limited data set” as well as other consent and disclosure provisions would be defined and clarified in new regulations to be issued by HHS.</p>
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## Health Information Technology (IT) (continued)

<b>Details (continued)</b>	<p>Patients could request a free copy of their electronic medical records (EMR) if a provider maintains that record in electronic format and an accounting of disclosures of their electronic PHI going back to up to three years. (The accounting requirements would take effect either when an entity acquires or upgrades its EMR or six months after technical standards for accounting of disclosures are adopted by the federal government, whichever is sooner.) The provider would have to obtain the patient's consent to use or disclose the patient's PHI for health care operations if the provider uses an electronic medical record. The bill would prohibit the sale of EMRs or protected PHI obtained from EMRs without authorization unless it is necessary for treatment or reimbursement for treatment of that patient. H.R. 6357 would also clarify the definition of marketing under HIPAA and would preclude direct and indirect payments to covered entities for the use of PHI to make certain communications without authorization from the patient. The bill would clarify that the criminal penalties for violations of HIPAA can be applied directly to individuals.</p> <p>Personal Health Record (PHR) vendors would be required to notify individuals and the FTC if there is a breach of unencrypted identifiable PHI and the FTC would have authority to enforce this provision, which sunsets after two years. The Secretary of HHS, in consultation with the FTC, would have to make recommendations to Congress on the application of privacy and security requirements to PHR vendors. Finally, the bill strengthens HIPAA privacy enforcement by the HHS Office of Civil Rights by requiring formal investigation of complaints and imposition of civil monetary penalties for violations that rise to the level of "willful neglect," and by permitting OCR to investigate and impose civil monetary penalties for alleged criminal violations of federal health privacy laws if the Department of Justice declines to prosecute.</p> <p>S. 1693 would streamline the process for adoption of HIT interoperability standards; codify (and extend until 9/30/2014) the position of National Coordinator for HIT in the Department of HHS to facilitate interoperable HIT exchanges and coordinate the federal government's HIT activities and procurements; authorize funding to promote nationwide health care IT adoption, create a Partnership for Health Care Improvement (a public-private advisory body to recommend or endorse HIT interoperability standards and adoption time frames); authorize federal grants to assist states and local governments to adopt and promote HIT in their states; provide incentives for using broadband to deliver HIT to underserved areas; and provide patient privacy protections by establishing a system to certify electronic health record (EHR) products and granting patients rights to obtain, inspect, and correct inaccurate or fraudulent information in their EHRs. Additional privacy and security provisions would limit the ability of operators of personal health information databases to disclose sensitive health records under Health Insurance Portability and Accountability Act (HIPAA), prohibit certain health care providers from using or disclosing health records for marketing purposes, direct the Secretary of HHS to submit a report to Congress recommending privacy and security protections for personal health records, give patients the right to inspect their e-health records and receive electronic copies of their records, and strengthen congressional oversight over federal health privacy compliance and enforcement of the HIPAA Privacy Rule.</p>
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## Health Information Technology (IT) (continued)

<b>Details (continued)</b>	H.R. 2406 would require the National Institutes of Standards and Technology (NIST) (part of the U.S. Department of Commerce) to develop or adopt interoperable standards for health care information technology for federal agencies within one year of enactment. It would also require NIST to establish a program on health care information enterprise integration to build upon existing efforts at NIST, other federal agencies, and the private sector. Technical activities to be included in the NIST program may include: standards and interoperability analysis, software conformance and certification, security and privacy technical issues, information management, and medical device communication.
<b>Effective Date</b>	H.R. 6357 would generally become effective one year after the date of enactment. S. 1693 would become effective on date of enactment. H.R. 2406 would become effective on date of enactment.

## Continuation Coverage for Dependent Students

<b>Current Legislation</b>	Michelle's Law (H.R. 2851/S. 400).
<b>Status</b>	The House approved H.R. 2851 by voice vote on July 30.
<b>Outlook</b>	Senate action remains uncertain given the short legislative timeframe. Some employer lobbying groups are urging caution because potentially faulty drafting could lead to unintended consequences.
<b>Details</b>	H.R. 2851/S. 400 would amend ERISA, the Internal Revenue Code and the Public Health Service Act to require group health plans to allow "seriously ill or injured" (as certified by a physician) college students to take up to one year of medically necessary leave without losing their eligibility as a covered dependent under a parent's health insurance because they do not have the status of a "full-time student" at an institution of higher education.
<b>Effective Date</b>	H.R. 2851/S. 400 would be effective for plan years beginning on or after one year after the date of enactment and to medically necessary leaves of absence beginning during such plan years.

## Comparative Effectiveness

<b>Current Legislation</b>	Comparative Effectiveness Research Act of 2008 (S. 3408)
<b>Status</b>	S. 3408 was introduced by Sens. Baucus (D-MT) and Conrad (D-ND) on July 31, 2008.
<b>Outlook</b>	It is unlikely that S. 3408 can be passed in Congress this year with only about three weeks left in the legislative session and a packed agenda. This concept will likely reemerge as a component of health reform in the next Congress.
<b>Details</b>	S. 3408 would establish a private, non-profit Health Care Comparative Effectiveness Research Institute (Institute) to contract with public and private entities to conduct research comparing the effectiveness of various medical technologies and treatments. The Institute would be charged with: identifying national priorities for comparative effectiveness research; establishing a research agenda; establishing a methodology committee to develop and update scientifically-based standards for conducting comparative effectiveness research; ensuring a process for peer review; disseminating research findings to clinicians, patients and the public; creating a process for public feedback and awareness through public forums and comment periods; coordinating its activities and resources with other public and private agencies to avoid unnecessary duplication; issuing an annual report of completing activities, research agenda and budget and other criteria; and, conducting a study on feasibility of conducting in-house research. S. 3408 directs the Secretary of HHS to permit the Institute to have access, with appropriate privacy safeguards, to Medicare, Medicaid and SCHIP data to carry out its activities. The Institute would be funded for the first three years (beginning with \$5 million in 2009) by general federal appropriations, and thereafter (beginning in 2012) the Institute would be funded at \$300 million annually with the federal appropriation supplemented by an annual assessment of \$0.50 per beneficiary/enrollee per year (indexed for health inflation) in insured and self-insured private plans and Medicare. This amount would increase to \$1 per beneficiary in 2013.
<b>Effective Date</b>	S. 3408 would generally be effective upon enactment. The funding assessment provisions would sunset on September 30, 2018.