



MEMORANDUM

December 21, 2009

Subject: Comparison of Prevention and Wellness Provisions in House and Senate Health Reform Legislation

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This memorandum was prepared to enable distribution to more than one congressional office.

Per your request, this memorandum compares prevention and wellness provisions in H.R. 3962, the Affordable Health Care for America Act, as passed by the House, with provisions on this topic in S.Amdt. 2786, the Patient Protection and Affordable Care Act, an amendment introduced in the nature of a substitute to H.R. 3590. Generally, H.R. 3962 is used as the referent, meaning that within a subject matter table, provisions in H.R. 3962 are presented first (along with comparable sections of the Senate bill, if applicable), followed by provisions in the Senate amendment that have not already been presented as comparable to a House provision.

In general, provisions presented in this memorandum would address coverage of clinical preventive services by adding to or amending the authority for Medicare or Medicaid in the Social Security Act (SSA), or would address public health or community-based prevention activities by adding to or amending provisions in the Public Health Service Act (PHSA). House provisions are those dealing with preventive services coverage in Division B of H.R. 3962 (regarding Medicare or Medicaid), or in Division C of the bill (regarding community prevention activities). For more information about these provisions, see "Prevention and Wellness" in CRS Report R40892, *Public Health, Workforce, Quality, and Related Provisions in H.R. 3962*. Senate provisions presented in this memorandum are those in Title IV ("Prevention of Chronic Disease and Improving Public Health") of S.Amdt. 2786. For more information, see "Prevention and Wellness" in CRS Report R40943, *Public Health, Workforce, Quality, and Related Provisions in the Senate Amendment in the Nature of a Substitute to H.R. 3590*. Comparisons of these House and Senate prevention and wellness provisions are presented in the following tables:

- **Table 1**, Medicare Coverage of Preventive Services, and Related Provisions;
- **Table 2**, Medicaid Coverage of Preventive Services;
- **Table 3**, Funding and Strategic Planning for Community-Based Prevention Activities;
- **Table 4**, Task Forces to Review Effectiveness of Prevention Services and Programs;
- **Table 5**, Community Preventive Services Grants and Demonstrations;
- **Table 6**, Wellness Programs Offered by Employers/Private Insurers;
- **Table 7**, Research, Information Management, Education, and Outreach;
- **Table 8**, Immunization Provisions;

- **Table 9**, Oral Health Care Prevention Activities;
- **Table 10**, Pain Care and Management; and
- **Table 11**, Miscellaneous Prevention Provisions.

In each table, each row outlines relevant provisions in current law, if any. Then each House and Senate bill section summary begins with a reference to the section number in the House or Senate measure, respectively. Provisions are summarized so as to highlight key differences between current law, House, and Senate provisions. (In some cases, italics are used to emphasize these differences). Summaries do not necessarily present all of the details of a provision. Unless otherwise specified, “the Secretary” refers to the Secretary of Health and Human Services (HHS). Acronyms used in this memorandum are as follows:

AAA	Abdominal aortic aneurysm
ACIP	Advisory Committee on Immunization Practices
ADA	Americans with Disabilities Act
AHRQ	Agency for Healthcare Research and Quality, in HHS
ATBC Board	Architectural and Transportation Barriers Compliance Board
CBO	Congressional Budget Office
CDC	Centers for Disease Control and Prevention, in HHS
CHIP	Children’s Health Insurance Program
CHIPRA	Children’s Health Insurance Program Reauthorization Act (P.L. 111-3)
DRA	Deficit Reduction Act of 2005 (P.L. 109-171)
DSMT	Diabetes self-management training
EPSDT	Medicaid’s Early and Periodic Screening, Diagnostic, and Treatment Services program
ERISA	Employee Retirement Income Security Act of 1974
FACA	Federal Advisory Committee Act
FDA	Food and Drug Administration, in HHS
FEHBP	Federal Employee Health Benefits Program
FFDCA	Federal Food, Drug, and Cosmetic Act
FMAP	Medicaid Federal Medical Assistance Percentage
FQHC	Federally Qualified Health Center
GAO	Government Accountability Office
HHS	Department of Health and Human Services
HIPAA	Health Insurance Portability and Accountability Act
HRSA	Health Resources and Services Administration, in HHS
IOM	Institute of Medicine
IPPE	Medicare’s Initial Preventive Physical Examination
IRC	Internal Revenue Code
MIPPA	Medicare Improvements for Patients and Providers Act of 2008 (P.L. 110-275)
MMA	Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (P.L. 108-173)
NIH	National Institutes of Health, in HHS
OMB	White House Office of Management and Budget
PHIF	Public Health Investment Fund
PHSA	Public Health Service Act
SBHC	School-Based Health Center
SSA	Social Security Act
SSAN	Such sums as may be necessary
TFCPS	Task Force on Community Preventive Services
USPSTF	U.S. Preventive Services Task Force

VFC Vaccines for Children program

WISEWOMAN CDC's Well-Integrated Screening and Evaluation for Women Across the Nation program

Table I. Medicare Coverage of Preventive Services, and Related Provisions

Table prepared by Sarah A. Lister, 7-7320.

Topic	Current Law	H.R. 3962 (as passed)	S.Amdt. 2786 to H.R. 3590
Coverage and cost sharing	<p>Under several subsections of SSA Sec. 1861, Medicare Part B covers a number of clinical preventive services, including a one-time comprehensive examination (the Initial Preventive Physical Examination or IPPE, also called the “Welcome to Medicare” exam), certain periodic cancer screenings, certain vaccines, and other services. Congress has waived cost-sharing for some but not all of these services under SSA Sec. 1833(a) re: coinsurance, and/or SSA Sec. 1833(b) re: application of the deductible. Sec. 101 of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA, P.L. 110-275, SSA Sec. 1861(ddd)) provided administrative authority for the Secretary to add Part B coverage of additional preventive services under specified conditions. Among other conditions, a preventive service that may be covered under this authority must be recommended (i.e., with a grade of A or B) by the U.S. Preventive Services Task Force (USPSTF).^a Medicare Advantage (Part C) is an alternative way for Medicare beneficiaries to receive covered benefits through private health plans. Medicare Advantage plans must cover benefits covered under Part B, but have considerable flexibility in how they apply or waive cost-sharing. Many of these plans waive cost-sharing for preventive services.</p>	<p>Sec. 1305 would amend SSA Sec. 1861 to define “Medicare covered preventive services” as a specified list of currently covered services, and any services subsequently covered under the Secretary’s administrative authority. Coverage would be subject to conditions and limitations that currently apply to each listed service, except that SSA subsections 1833(a) and 1833(b) would be amended to waive any cost-sharing (coinsurance and/or deductible) that currently applies.</p> <p>Sec. 1306 would amend SSA Sec. 1833 to clarify that cost sharing would be waived for colorectal cancer screening services regardless of the code applied, of the establishment of a diagnosis, or of the removal of tissue or other matter or other procedure that is performed in connection with and as a result of the screening, in the same clinical encounter.</p> <p>Amendments made by Secs. 1305 and 1306 would apply to services furnished on or after January 1, 2011.</p>	<p>Sec. 4104 would amend SSA Sec. 1861 to define preventive services covered by Medicare as a specified list of currently covered services. Coverage would be subject to conditions and limitations that currently apply to each listed service, except that SSA subsections 1833(a) and 1833(b) would be amended to waive, for most services, any cost-sharing (coinsurance and/or deductible) that currently applies. Services for which no coinsurance would be required are the IPPE, personalized prevention plan services (as under Sec. 4103 of this bill), additional preventive services covered under the Secretary’s administrative authority, and any currently covered preventive service (including medical nutrition therapy and excluding electrocardiograms) if it is recommended (i.e., with a grade of A or B) by the USPSTF. Sec. 4104 would generally waive the deductible for the same preventive services noted above for which coinsurance would be waived. It would not, however, waive the deductible for additional preventive service covered under the Secretary’s administrative authority.</p> <p>Sec. 4104 would also amend SSA Sec. 1833 to clarify that cost sharing would be waived for colorectal cancer screening services regardless of the code applied, of the establishment of a diagnosis, or of the removal of tissue or other matter or other procedure that is performed in connection with and as a result of the screening, in the same clinical encounter.</p> <p>Amendments made by Sec. 4104 would apply to services furnished on or after January 1, 2011.</p>
Reports	No provision.	<p>Sec. 1305 would require the Secretary, within 12 months of enactment, to report to Congress on barriers, if any, facing Medicare beneficiaries in accessing the benefit for abdominal aortic aneurysm screening (see below) and other preventive services through the IPPE.</p>	<p>Sec. 4204(e) would require GAO to study, and report by June 1, 2011, regarding the impact of vaccine coverage under Medicare Part D on access to those vaccines by beneficiaries who are 65 years of age or older. It would appropriate \$1 million for FY2010 for this study.</p>

Topic	Current Law	H.R. 3962 (as passed)	S.Amdt. 2786 to H.R. 3590
Abdominal aortic aneurysm (AAA) screening	Under SSA Sec. 1861(s)(AA) , Medicare Part B covers AAA screening for certain beneficiaries based on risk and/or physician referral.	Sec. 1305 would require the Secretary, to the extent practical, to identify and implement policies promoting proper use of AAA screening among Medicare beneficiaries at risk for such aneurysms.	No provision.
Coverage of vaccines	Under SSA Sec. 1861 , Medicare Part B covers three vaccines and the cost of their administration. Covered vaccines are those against influenza, pneumococcus, and, for individuals at increased risk, hepatitis B. Under SSA Sec. 1860D-2(e) , Medicare Part D covers any FDA-licensed vaccine, and the cost of its administration, when prescribed by a recognized provider.	Sec. 1310 would provide Medicare Part B coverage for all federally recommended vaccines, defined as any FDA-approved vaccine that is recommended for use by the CDC. Generally, provisions in this section would apply to services furnished on or after January 1, 2011.	As noted above, Sec. 4204(e) would require GAO to study, and report by June 1, 2011, regarding the impact of vaccine coverage under Medicare Part D on access to those vaccines by beneficiaries who are 65 years of age or older. It would appropriate \$1 million for FY2010 for this study.
Preventive services furnished at FQHCs	Under SSA Sec. 1861(aa)(3)(A) , FQHCs may receive Medicare reimbursement for services furnished to covered beneficiaries by physicians and other specified providers, and for the three vaccines currently covered under Medicare Part B, as noted above.	Sec. 1311 would amend SSA Sec. 1861(aa)(3)(A) to provide that FQHCs may receive reimbursement for Medicare covered preventive services, as defined in Sec. 1305 of this bill. This amendment would be effective not later than January 1, 2011.	Sec. 5502(a) would amend SSA Sec. 1861(aa)(3)(A) to provide that FQHCs may receive reimbursement for Medicare covered preventive services, as defined in Sec. 4104 of this bill, furnished on or after January 1, 2011.
Certified diabetes educators	SSA Sec. 1861(qq) provides Medicare coverage of diabetes outpatient self-management training (DSMT) services provided by a certified provider, defined as a physician or other provider who provides other items or services, in addition to DSMT services, that are reimbursed under Medicare.	Sec. 1313 would amend SSA Sec. 1861(qq) to designate certain certified diabetes educators as Medicare-certified providers of covered DSMT services. A "certified diabetes educator" would be defined as an individual who meets specified criteria including certification by a "recognized certifying body," which also would be defined. This section would be effective for services furnished on or after the first day of the first calendar year that is at least 6 months after the date of enactment.	No provision.
Annual wellness visit	Medicare does not cover routine visits to assess beneficiaries who do not have symptoms of an illness, or to develop prevention plans. In 2003, in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA, P.L. 108-173), Congress required Medicare to cover a one-time Initial Preventive Physical Examination (IPPE) and health risk appraisal (the "Welcome to Medicare" exam) for new Part B enrollees.	No provision.	Sec. 4103 would amend SSA Sec. 1861 to require that Medicare Part B cover, without cost sharing, beginning on January 1, 2011, "personalized prevention plan services," including a comprehensive health risk assessment. The personalized plan could include several specified elements, including medical and family history; identification of health risk factors; and a plan for preventive screenings. All enrolled beneficiaries would be eligible for personalized prevention plan services once every year without any cost sharing. During the first year of Part B enrollment, beneficiaries could choose to receive either the

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			<p>IPPE or personalized prevention plan services, but not both. The Secretary would be required to develop appropriate guidance and conduct outreach and related activities with respect to personalized prevention plan services and health risk assessments. These services would be included in the list of Medicare covered preventive services under Sec. 4104 of this bill.</p>
<p>Authority to modify coverage of currently covered preventive services</p>	<p>In general, Medicare law authorizes the Secretary to cover services for the diagnosis and treatment of illness, while coverage of preventive services (i.e., services provided in the absence of symptoms) has required legislation. As noted earlier, authority provided in MIPPA allows the Secretary to cover additional preventive services if specified conditions are met. However, the Secretary is not authorized to modify the coverage of those preventive services currently covered through statute.</p>	<p>No provision.</p>	<p>Sec. 4105 would authorize the Secretary, effective January 1, 2010, to modify the coverage of any currently covered preventive service (including services included in the IPPE, but not the IPPE itself) to the extent that the modification is consistent with USPSTF recommendations. This section also would allow the Secretary to withhold payment for any currently covered preventive service graded D (i.e., recommended against) by the USPSTF. The enhanced authority would not apply to services furnished for the purposes of diagnosis or treatment (rather than as preventive services furnished to asymptomatic patients).</p>
<p>Demonstration Program</p>	<p>No provision.</p>	<p>No provision.</p>	<p>Sec. 4202(b) would require the Secretary to conduct an evaluation of community-based prevention and wellness programs and develop a plan for promoting healthy lifestyles and chronic disease self-management for Medicare beneficiaries, and report to Congress by September 30, 2013. \$50 million in total from the Medicare Part A and Part B Trust Funds would be used to pay for this activity.</p>

Source: Table prepared by the Congressional Research Service based on the text of H.R. 3962 and S. Amdt. 2786 to H.R. 3590. See also CRS Report R40978, *Medicare Coverage of Clinical Preventive Services*, by Sarah A. Lister and Kirsten J. Colello; and CRS Report R40374, *Medicare Advantage*, by Paulette C. Morgan.

- a. See Table 4 for more information about the USPSTF.

Table 2. Medicaid Coverage of Preventive Services

Table prepared by Sarah A. Lister, 7-7320.

Topic	Current Law	H.R. 3962 (as passed)	S.Amdt. 2786 to H.R. 3590
Coverage of preventive services for adult beneficiaries	State Medicaid plans must cover a package of preventive services under the Early and Periodic Screening, Diagnostic, and Treatment Services program (EPSDT), for beneficiaries under 21 years of age. Current law does not explicitly require that Medicaid state plans cover preventive services for adults, although coverage may be required if a service meets another applicable requirement, such as a physician's service.	Sec. 1711 would require Medicaid state plans to cover without cost sharing, for all beneficiaries, preventive services that the Secretary determines are (1) services recommended by the Task Force on Clinical Preventive Services (established by this bill), ^a or vaccines recommended by the CDC; and (2) appropriate for Medicaid beneficiaries. Coverage would be required for services furnished on or after July 1, 2010, whether or not relevant regulations had been promulgated by then.	Sec. 4106 would, among other things, also require Medicaid state plans to cover without cost sharing, for all beneficiaries, (1) any clinical preventive services recommended (i.e., with a grade of A or B) by the USPSTF, and (2) with respect to adults, immunizations recommended by the ACIP, and the cost of their administration. States that elect to cover these additional services and vaccines and prohibit cost-sharing for them would receive the increased federal medical assistance percentage (FMAP) for medical assistance for newly eligible mandatory individuals (as under Sec. 2001(a)(3)(A) of this bill, excluding the 95% cap on such FMAP), for which an additional one percentage point increase in that FMAP would apply for these services, and for counseling and drug therapy for tobacco cessation use by pregnant women (as under Sec. 4107 of this bill, described below). Provisions would take effect on January 1, 2013.
Coverage of tobacco cessation services	Federal Medicaid law requires states that cover outpatient drugs (which all states do) to cover all drugs for which manufacturers have rebate agreements in place with the federal Medicaid program. SSA Sec. 1927 lists 11 drug categories, including prescription smoking cessation products and all nonprescription drugs, that states are permitted to exclude from their coverage of outpatient drugs.	Sec. 1712 would amend SSA Sec. 1927(d)(2) by removing prescription smoking cessation products from the list of excluded drugs and specifying that nonprescription drugs do not include FDA-approved smoking cessation products (e.g., nicotine patches). Thus, state Medicaid plans would be required to cover, for all beneficiaries, prescription and FDA-approved nonprescription smoking cessation products for which rebate agreements are in effect. ^b Coverage would be effective for drugs and services furnished on or after January 1, 2010.	Sec. 4107 would require states to provide Medicaid coverage to pregnant women for counseling and drug therapy for tobacco cessation. Such services would include diagnostic, therapeutic, and counseling services and drug therapy (including FDA-approved prescription and non-prescription tobacco cessation products), as recommended by the U.S. Surgeon General, and other services that the Secretary recognizes to be effective for cessation of tobacco use by pregnant women. These services would exclude coverage for drugs or biologicals that are not otherwise covered under Medicaid. States would continue to be allowed to exclude coverage of products used for smoking cessation except for pregnant women. This section would prohibit cost-sharing, under either traditional Medicaid or the DRA option ^c for counseling and drug therapy, as well as for covered outpatient prescription and non-prescription drugs, provided to or used by pregnant women for tobacco cessation. Coverage would be effective on October 1, 2010.

Topic	Current Law	H.R. 3962 (as passed)	S.Amdt. 2786 to H.R. 3590
Vaccines for Children (VFC) program	SSA Sec. 1928 authorizes the VFC program, under which Medicaid assumes the costs for providing certain low-income children with recommended vaccinations. Current law defines VFC-eligible children as those who are eligible for Medicaid; who are uninsured; who do not have health insurance coverage for vaccines and receive vaccines purchased through VFC and administered at a FQHC or rural health clinic; or who are Indians.	Sec. 1725 would amend SSA Sec. 1928 to add public health clinics to the list of providers that may administer vaccines to eligible children under the VFC program.	No provision.
Grants to study incentives for health promotion for Medicaid beneficiaries	No provision.	No provision.	Sec. 4108 would require the Secretary to award grants to states to provide incentives for Medicaid beneficiaries to participate in programs to promote healthy lifestyles. Programs would have to be comprehensive and targeted to the needs of Medicaid beneficiaries; address criteria developed by the Secretary according to evidence-based guidelines from the USPSTF, TFCPS, and the National Registry of Evidence-based Programs and Practices ^d and have demonstrated effectiveness for managing cholesterol and/or blood pressure, losing weight, quitting smoking, and/or preventing or managing diabetes. Programs could address co-morbidities, such as depression, associated with these conditions. This section would appropriate \$100 million for the program for a 5-year period beginning January 1, 2011. The Secretary could waive Medicaid requirements relating to statewideness, and would be required to ensure that a participating state makes the program widely available. A number of outreach, evaluation, and reporting requirements would apply. Any incentives received by a beneficiary could not be taken into account for the purpose of determining eligibility for, or the amount of, benefits under any federally funded program.

Source: Table prepared by the Congressional Research Service based on the text of H.R. 3962 and S. Amdt. 2786 to H.R. 3590.

- a. See Table 4 for more information on this task force.
- b. The Medicare Part D prescription drug benefit also excludes coverage of the drug categories listed in SSA Sec. 1927(d)(2) that state Medicaid plans are permitted to exclude, with the exception of prescription smoking cessation products. [SSA Sec. 1860D-2(e)(2)]
- c. See CRS Report RS22578, *Medicaid Cost-Sharing Under the Deficit Reduction Act of 2005 (DRA)*, by Elicia J. Herz.
- d. The National Registry of Evidence-based Programs and Practices is a database of interventions for the prevention and treatment of mental and substance use disorders, administered by SAMHSA. See <http://www.nrepp.samhsa.gov/>.

Table 3. Funding and Strategic Planning for Community-Based Prevention Activities

Table prepared by Sarah A. Lister, 7-7320.

Topic	Current Law	H.R. 3962 (as passed)	S.Amdt. 2786 to H.R. 3590
Funding	No comparable provision. Most federal public health activities are funded through annual discretionary appropriations.	Sec. 2301 would create a new PHSA Title XXXI —Prevention and Wellness, consisting of several new subtitles and sections. New Subtitle A, Sec. 3111 would establish a Prevention and Wellness Trust and authorize the appropriation to it of funds from the Public Health Investment Fund (PHIF) established in Sec. 2002 of this bill, as follows: \$2.400 billion for FY2011; \$2.845 billion for FY2012; \$3.100 billion for FY2013; \$3.455 billion for FY2014; and \$3.600 billion for FY2015. Amounts in the Trust would be available for carrying out this title as provided in advance in appropriation acts. The provision would authorize the appropriation from the Trust of specified amounts for specified subtitles or sections in this title for each of FY2011 through FY2015.	Sec. 4002 would establish a Prevention and Public Health Fund for prevention and public health programs, and would authorize the appropriation of, and appropriate to the Fund from the Treasury: \$500 million for FY2010; \$750 million for FY2011; \$1.00 billion for FY2012; \$1.25 billion for FY2013; \$1.50 billion for FY2014; and \$2.00 billion for each fiscal year thereafter. The Secretary would be required to transfer amounts from the Fund to HHS accounts to increase funding, over the FY2008 level, for programs authorized by the PHSA for prevention, wellness, and public health activities, including prevention research and health screenings. The House and Senate Appropriations Committees would have authority to transfer monies in the Fund to eligible activities.
Federal prevention planning and oversight	No comparable provisions. Federal prevention activities may be led or coordinated by the HHS Office of Public Health and Science, the CDC, or other HHS agencies.	Sec. 2301 would create a new PHSA Title XXXI —Prevention and Wellness, consisting of several new subtitles and sections. New Subtitle B, Sec. 3121 would require the Secretary to submit to Congress within one year of enactment, and update biennially, a National Prevention and Wellness Strategy to improve the nation's health through evidence-based clinical and community-based prevention and wellness activities, including public health infrastructure improvements. The strategy would include goals and priorities, and identify health disparities in prevention, among other things.	Sec. 4001 would require the President to establish a National Prevention, Health Promotion and Public Health Council, composed of secretaries, chairmen, and directors of federal departments, boards and agencies (as specified), and appoint a chairperson. The Council would be required to provide federal coordination and leadership with respect to prevention, wellness, and health promotion practices; develop a national prevention, health promotion, and public health strategy; report to the President and Congress on activities under the strategy and progress toward identified goals; and other activities as specified.

Source: Table prepared by the Congressional Research Service based on the text of H.R. 3962 and S. Amdt. 2786 to H.R. 3590.

Table 4. Task Forces to Review Effectiveness of Prevention Services and Programs

Table prepared by Sarah A. Lister, 7-7320.

Current Law	H.R. 3962 (as passed)	S.Amdt. 2786 to H.R. 3590
<p>The U.S. Preventive Services Task Force (USPSTF), administered by the Agency for Healthcare Research and Quality (AHRQ), is established in PHSa Sec. 915(a), which requires it to “review the scientific evidence related to the effectiveness, appropriateness, and cost-effectiveness of clinical preventive services for the purpose of developing recommendations for the health care community, and updating previous clinical preventive recommendations.” The USPSTF appears to be exempt from requirements of the Federal Advisory Committee Act (FACA).^a</p> <p>The Task Force on Community Preventive Services (TFCPS), administered by CDC, is not explicitly authorized but is conducted under general authorities of the Secretary in Title III of the PHSa. The TFCPS does not appear to function according to FACA requirements.</p>	<p>Sec. 2301(a) would create a new PHSa Title XXXI, Subtitle C, Secs. 3131 and 3132, “Prevention Task Forces,” which would require the Secretary to establish, respectively, a Task Force on Clinical Preventive Services (similar to the USPSTF), to be administered by AHRQ, and a Task Force on Community Preventive Services (essentially codifying the existing TFCPS), to be administered by CDC. Each task force would be required to, among other things, “review the scientific evidence related to the benefits, effectiveness, appropriateness, and costs” of clinical or community preventive services, respectively, and to develop and disseminate recommendations for the use of such services. Each task force would also be required to convene an advisory stakeholders board and would, in general, be subject to FACA. For carrying out this section, Sec. 3111 of the bill would authorize the appropriation from the Prevention and Wellness Trust of \$30 million for each of FY2011 through FY2015. Sec. 2301(b) would transition functions from the existing task forces to the task forces established under this section.</p>	<p>Subsection 4003(a) would strike and replace PHSA Sec. 915(a), the current authority for the USPSTF, with language requiring the AHRQ Director to convene a Preventive Services Task Force, with specified duties, to “review the scientific evidence related to the effectiveness, appropriateness, and cost-effectiveness of clinical preventive services” for the purpose of developing recommendations for the health care community, and updating previous clinical preventive recommendations. Members of the Task Force convened under this subsection, and any recommendations made by such members, would be “independent and, to the extent practicable, not subject to political pressure.”</p> <p>Subsection 4003(b) would create a new PHSA Sec. 399U requiring the CDC Director to convene a Community Preventive Services Task Force (essentially codifying the existing TFCPS) to “review the scientific evidence related to the effectiveness, appropriateness, and cost-effectiveness of community preventive interventions” for the purpose of developing recommendations. The Community Task Force would have specified duties similar to those of the Preventive Services Task Force, except applied to policies, programs, processes, or activities designed to affect or otherwise affecting health at the population level. Each task force would be required to coordinate its activities with the other and with the Advisory Committee on Immunization Practices (ACIP). The task forces would not be required to convene advisory boards, and neither would be subject to FACA. There would be authorized to be appropriated SSAN for each fiscal year to carry out the activities of each task force.</p>

Source: Table prepared by the Congressional Research Service based on the text of H.R. 3962 and S. Amdt. 2786 to H.R. 3590.

- a. The Federal Advisory Committee Act (FACA) establishes certain requirements of committee membership, public access to proceedings, and other protections to assure that committees properly represent the public interest. See CRS Report R40520, *Federal Advisory Committees: An Overview*, by Wendy R. Ginsberg.

Table 5. Community Preventive Services Grants and Demonstrations

Table prepared by Sarah A. Lister, 7-7320 and Elayne Heisler, 7-4453.

Topic	Current Law	H.R. 3962 (as passed)	S.Amdt. 2786 to H.R. 3590
Community prevention and wellness services grants	No comparable provision. Comparable activities could be carried out under general authorities of the Secretary.	Sec. 2301 would create a new PHSA Title XXXI —Prevention and Wellness, consisting of several new subtitles and sections. New Subtitle E, Sec. 3151 would require the Secretary, through the CDC Director, to award grants for programs to deliver prevention and wellness services that address priority areas identified in the National Prevention and Wellness Strategy (required under this bill). Program requirements would emphasize services intended to reduce health disparities. Funds could not be used for construction, or to fund services that would otherwise be covered by public or private health care programs. For carrying out this section, new PHSA Sec. 3111 would authorize the appropriation from the Prevention and Wellness Trust of the following amounts: \$1.065 billion for FY2011; \$1.260 billion for FY2012; \$1.365 billion for FY2013; \$1.570 billion for FY2014; and \$1.600 billion for FY2015.	Sec. 4201 would require the Secretary, through the CDC Director, to award competitive grants for the implementation, evaluation, and dissemination of evidence-based community preventive health activities, in order to reduce chronic disease rates, address health disparities, and develop a stronger evidence base of effective prevention programming. Grantees would be required to: develop community transformation plans that include the policy, environmental, programmatic, and infrastructure changes needed to promote healthy living and reduce health disparities; and conduct health promotion activities and evaluations and disseminate findings. There would be authorized to be appropriated SSAN for FY2010 through FY2014. Sec. 4202(a) also would require the Secretary, through the CDC Director, to award grants to state or local health departments or Indian tribes for pilot programs to provide community prevention interventions, screenings, and clinical referrals for individuals between 55 and 64 years of age. Grantees would be required to determine whether individuals found to have chronic health conditions have a source of health insurance coverage, and make referrals for care as appropriate. There would be authorized to be appropriated SSAN for FY2010 through FY2014. See also Sec. 4202(b) , a demonstration program for Medicare beneficiaries, in Table I.
State, local, and tribal public health capacity	No strictly comparable provisions. However, the PHSA authorizes funding for state, local, or tribal health departments for a number of specific public health purposes. For example, Sec. 319C-1 requires the Secretary to enter into cooperative agreements with health departments in all states and territories to address a number of capacity needs for the response to public health emergencies. PHSA Title XXVIII establishes certain HHS programs and activities for public health emergency preparedness in the Office of the	Sec. 2301 would create a new PHSA Title XXXI —Prevention and Wellness, with several new sections. New Subtitle F, Sec. 3161 would require the Secretary to award grants to each state health department, and authorize the Secretary to award competitive grants to state, local, and tribal health departments, to address core public health infrastructure needs. A specified funding formula would apply to the mandatory grant program; specified maintenance of effort requirements would apply to both grant programs. This new section would also require the Secretary, through the CDC Director, to implement a program of voluntary	Sec. 4304 would amend PHSA Title XXVIII, National All-Hazards Preparedness for Public Health Emergencies, adding a new Subtitle C, new PHSA Sec. 2821 , regarding Epidemiology-Laboratory Capacity Grants. The purpose would be to establish a grant program to strengthen national epidemiology, laboratory, and information management capacity for the response to infectious diseases and other conditions of public health importance. Eligible entities would be state, local, or tribal health departments, tribal jurisdictions, or academic centers that meet CDC-specified criteria. Grants would be subject to the availability of

Topic	Current Law	H.R. 3962 (as passed)	S.Amdt. 2786 to H.R. 3590
	<p>Secretary.</p> <p>The Epidemiology and Laboratory Capacity cooperative agreement funds provided to states and some localities by CDC are not explicitly authorized, but are based in general authorities of the Secretary in several sections in Title III of the PHSa.</p>	<p>accreditation of state or local health departments and public health laboratories. For these activities, new PHSA Sec. 3111 would authorize the appropriation from the Prevention and Wellness Trust of: \$800 million for FY2011; \$1.000 billion for FY2012; \$1.100 billion for FY2013; \$1.200 billion for FY2014; and \$1.265 billion for FY2015.</p>	<p>appropriations. There would be authorized to be appropriated for this program \$190 million for each of FY2011 through FY2013, of which at least \$95 million per fiscal year must be used to award grants for epidemiology and disease control capacity, at least \$60 million per fiscal year for grants for information management capacity, and at least \$32 million per fiscal year for laboratory capacity.</p>
CDC capacity	<p>PHSA Sec. 319D(a) authorizes or requires certain activities by the CDC Director, and provides certain contracting authorities, in order to enhance the agency's capacity to address public health threats domestically and abroad. Appropriations authority for these activities expired at the end of FY2006, although, in general, such activities could be undertaken under permanent general authorities of the Secretary in several other sections of PHSa Title III.</p>	<p>Sec. 2301 would create a new PHSA Title XXXI—Prevention and Wellness, with several new sections. New PHSA Sec. 3162 would require the Secretary to expand and improve the core public health infrastructure and activities of the CDC to address unmet and emerging public health needs. For these activities, proposed PHSa Sec. 3111 would authorize the appropriation from the Trust of \$350 million for each of FY2011 through FY2015.</p>	<p>No provision.</p>
School-based health clinics/centers (SBHCs)^a	<p>No provision.</p>	<p>Sec. 2511 would create a new PHSA Sec. 399Z-1, School-Based Health Clinics, requiring the Secretary to establish an SBHC grant program. To receive a grant, an SBHC would have to meet certain specified criteria, match 20% of the grant amount from nonfederal sources, agree to use grant funds to supplement and not supplant funds received from other sources, and demonstrate that grant funds will not be used until funds from all payers, including private insurance, Medicaid, and CHIP, are used. SBHCs would not be permitted to use funds to provide abortions. Priority would be given to qualified applicants based on their record of providing care to medically underserved children and adolescents, and of providing care in communities where a high percentage of children and adolescents are uninsured, underinsured, or eligible for Medicaid or CHIP. There would be authorized to be appropriated \$50 million for FY2011, and SSAN for each of FY2012 through FY2015. The section would strike language in the Health Care Safety Net Act of 2008 requiring GAO to conduct a study of SBHCs.</p>	<p>Sec. 4101(a) would create a grant program for the establishment of SBHCs. Grant funds would be used for facility construction, expansion, and equipment. SBHCs would be prohibited from using funds for personnel or to provide health services. The Secretary would be required to give funding preference to facilities that serve a large population of children eligible for the Medicaid and CHIP programs. The section would appropriate, out of Treasury funds not otherwise appropriated, \$50 million for each of FY2010 through FY2013, to remain available until expended.</p> <p>Sec. 4101(b) would create a new PHSA Sec. 399Z-1, School-Based Health Centers, requiring the Secretary to award grants for the operating costs of SBHCs. To receive a grant, an SBHC would have to meet similar criteria to those specified in H.R. 3962. SBHCs would be required to provide only age-appropriate services and would be prohibited from providing abortion services and from providing services to minors without parental or guardian consent. Entities in violation of state reporting and parental notification laws, and entities receiving Sec. 330 funding that would overlap with the SBHC grant period would be prohibited from receiving funds under this section. The Secretary would be</p>

Topic	Current Law	H.R. 3962 (as passed)	S.Amdt. 2786 to H.R. 3590
WISEWOMAN program (Well-integrated Screening and Evaluation for Women Across the Nation)	PHSA Sec. 1509 authorizes the CDC WISEWOMAN grant program, which funds demonstrations to provide preventive services and appropriate follow-up to low-income women. Only states that receive funding to provide breast and cervical cancer screening services to low-income women (under PHSA Sec. 1501) are eligible for WISEWOMAN grants. The program's appropriations authority expired at the end of FY2003, but it has continued to receive funding. Although PHSA Sec. 1509 authorizes grants to no more than 3 states, currently 19 states and 2 tribal organizations receive funding under the Secretary's general authority to award grants for public health and disease prevention programs.	Sec. 2525 would amend PHSA Sec. 1509 to reauthorize the WISEWOMAN program. It would remove the 3-state limit and authorize the appropriation of \$70.0 million for FY2011, \$73.5 million for FY2012, \$77.0 million for FY2013, \$81.0 million for FY2014, and \$85.0 million for FY2015.	authorized to give preference to applicants who demonstrate ability to serve communities with specified barriers to access. In addition, the Secretary would be authorized to consider whether an applicant received a grant under this section to establish an SBHC. There would be authorized to be appropriated SSAN for each of FY2010 through FY2014. No provision.
Community-based Overweight and Obesity Prevention Programs	CDC's Nutrition, Physical Activity, and Obesity program was established to prevent and control obesity and other chronic diseases by supporting state health departments in developing and implementing nutrition and physical activity interventions. The program received \$44 million for FY2009.	Sec. 2535 would amend PHSA Title III, Part Q by adding a new Sec. 399W-1 , requiring the Secretary to award grants and contracts for an evidence-based, community-based overweight and obesity prevention program. Funds would be awarded for five-year periods (renewable for demonstrated performance) to community partnerships that demonstrate broad stakeholder involvement. Awardees would be required to match \$1 for every \$9 of federal funds, and meet specified maintenance of effort requirements. Funds could not be used to provide health care services that could be covered through existing public or private programs. Preference would be given to entities that serve communities with high levels of overweight and obesity and related chronic diseases, or that plan to implement programs in school or workplace settings. There would be authorized to be appropriated \$10 million for FY2011 and SSAN for each of FY2012 through FY2015.	No provision.

Topic	Current Law	H.R. 3962 (as passed)	S.Amdt. 2786 to H.R. 3590
CHIPRA childhood obesity demonstration	The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA; P.L. 111-3) instructed the Secretary to conduct a demonstration project to develop a comprehensive and systematic model for reducing child obesity, and authorized the appropriation of \$25 million for the period FY2009 through FY2013 for this demonstration.	No provision.	Sec. 4306 would amend SSA Sec. 1139A(e) by replacing the authorization of appropriations for the CHIPRA child obesity demonstration with an appropriation of \$25 million for the period FY2010 through FY2014.
Pilot program for individualized wellness plans	No provision.	No provision.	Sec. 4206 would create a new PHSA Section 330(s) requiring the Secretary to establish a pilot program in community health centers to test the impact of providing at-risk individuals with individualized wellness plans (to reduce risk factors for preventable conditions), and would authorize to be appropriated SSAN for this program.

Source: Table prepared by the Congressional Research Service based on the text of H.R. 3962 and S. Amdt. 2786 to H.R. 3590.

- a. Additional health centers provisions are compared in the CRS memorandum for general distribution, *Workforce Provisions in the House and Senate Health Reform Legislation: A Side-by-Side Comparison of H.R. 3962 and S.Amdt. 2786 to H.R. 3590*, available from C. Stephen Redhead, 7-2261.

Table 6. Wellness Programs Offered by Employers/Private Insurers

Table prepared by Jennifer Staman, 7-2610 and Sarah A. Lister, 7-7320

Topic	Current Law	H.R. 3962 (as passed)	S.Amdt. 2786 to H.R. 3590
Incentives in employer-provided wellness programs	<p>Among the federal laws that apply to wellness programs, HIPAA clarifies that group health plans and health insurance issuers offering group health coverage may establish premium discounts or rebates or modify otherwise applicable copayments or deductibles (i.e., rewards) in return for adherence to these programs. HIPAA regulations provide a framework for structuring these wellness programs and divide wellness programs into two categories. First, if a wellness program provides a reward based solely on participation in a wellness program, or if it does not provide a reward, the program complies with HIPAA without having to satisfy any additional standards, as long as the program is made available to all similarly situated individuals. Second, if a reward is based on an individual meeting a certain standard relating to a health factor, then the program must meet additional requirements. Among these additional requirements, a reward offered by this type of wellness program must not exceed 20% of the cost of employee coverage under the plan (i.e., the amount paid by the employer and the employee for that employee for coverage).^a</p>	No provision.	<p>Sec. 1201 (creating sec. 2705 of the PHSA) would amend sec. 2702 of the PHSA to largely codify an amended version of the HIPAA wellness program regulations. Wellness programs that do not require an individual to satisfy a standard related to a health factor as a condition for obtaining a reward (or do not offer a reward) would not violate HIPAA, so long as participation in the programs is made available to all similarly situated individuals. Wellness programs with conditions for obtaining a reward that are based on an individual meeting a certain standard relating to a health factor, would have to meet additional requirements. Among these requirements, the reward must be capped at 30% of the cost of the employee-only coverage under the plan (instead of 20% under the current regulations), but the Secretaries of HHS, Labor, and the Treasury would have the discretion to increase the reward up to 50%. The HHS Secretary, in consultation with the Secretaries of the Treasury and Labor, would establish a 10-state pilot program in which participating states would be required to apply the wellness program provisions to health insurers in the individual market.</p> <p>Also, while Sec. 1201 of the Senate amendment only modifies the PHSA, Sec. 1562 of the amendment would make these provisions applicable to group health plans and health insurance issuers under ERISA and the IRC.</p>
Reporting requirements/promulgation of regulations regarding coverage of prevention and wellness activities	No provision.	No provision.	<p>Sec. 1201 (creating Sec. 2717 of the PHSA) would require the Secretary to develop reporting requirements for group health plans and health insurance issuers with respect to plan or coverage benefits and health care provider reimbursement structures that, among other things, implement “wellness and health promotion activities.” Health plans and insurance issuers would be required to annually submit to the Secretary and enrollees a report on whether the benefits under the plan or coverage satisfy these and other elements. This section also would require the Secretary to</p>

Topic	Current Law	H.R. 3962 (as passed)	S.Amdt. 2786 to H.R. 3590
			<p>promulgate regulations providing criteria for determining whether a reimbursement structure meets these elements. Under this section, wellness and health promotion activities could include personalized wellness and prevention services “that are coordinated, maintained or delivered by a health care provider, a wellness and prevention plan manager, or a health, wellness or prevention services organization that conducts health risk assessments or offers ongoing face-to-face, telephonic or web-based intervention efforts for each of the program’s participants....” These activities could include wellness and prevention efforts such as smoking cessation, weight management, nutrition, and healthy lifestyle support.</p>
<p>Wellness program grants, evaluations, technical assistance, and related provisions</p>	<p>No provision.</p>	<p>Sec. 112 would require the Secretaries of HHS and Labor jointly to establish a grant program to help small employers (to be defined) cover 50% of the costs of providing employee wellness programs. Allowable costs would be those attributable to the wellness program (excluding the cost of food), and not to the health plan or health insurance coverage offered in connection with such a plan. Grants for a given plan year would be capped at \$150 per employee. Grants could be provided for up to three years and would be capped at \$50,000, in total, for an employer.</p> <p>A qualified wellness program would be jointly certified by the Secretaries of HHS and Labor as meeting several criteria, including (1) being consistent with current evidence-based research and best practices; (2) being culturally appropriate, and accessible for individuals with disabilities and with limited English proficiency, among others; (3) having a number of required components, including health awareness, health education, periodic screenings, employee engagement, and listed behavioral change activities (including smoking cessation and weight reduction); and (4) having supportive work policies regarding tobacco use, food choices, stress management, and physical activity. A program could not be certified unless each required program component were available to all employees. Employee participation could not be mandated. Qualified programs could provide</p>	<p>Sec. 4303 would add a new Part U in PHS Title III, Employer-Based Wellness Program, including several new sections. A new PHS Sec. 399MM would require the CDC Director to provide employers with technical assistance and other resources to evaluate workplace wellness programs, including measuring employee participation; developing standardized measures of factors that have a positive effect on health behaviors, outcomes, and expenditures; and evaluating the effect of programs on health outcomes, absenteeism, productivity, workplace injury rates, and medical costs. The Director also would be required to build evaluation capacity among workplace staff by providing resources, technical assistance, and consultation. A new PHS Sec. 399MM-1 would require the CDC Director to conduct a national survey of employer-based health policies and programs, and to report to Congress on findings and recommendations for the implementation of effective policies and programs. In addition, a new PHS Sec. 399MM-2 would require the Secretary to evaluate all programs funded through the CDC before conducting such an evaluation of privately funded programs, unless an entity with a privately funded wellness program requests such an evaluation. Finally, a new PHS Sec. 399MM-3 would, notwithstanding any other provision of this Part, prohibit the use of any</p>

Topic	Current Law	H.R. 3962 (as passed)	S.Amdt. 2786 to H.R. 3590
		<p>incentives for participation provided such incentives are not tied to the premium or cost-sharing of the individual under the health benefits plan. Any employee health information collected through the wellness program would be confidential and could not be used for purposes other than administration of the program.</p> <p>There would be authorized to be appropriated SSAN to carry out this section.</p>	<p>recommendations, data, or assessments carried out under this Part to mandate requirements for workplace wellness programs.</p>

Source: Table prepared by the Congressional Research Service based on the text of H.R. 3962 and S. Amdt. 2786 to H.R. 3590.

- a. For a discussion of other federal laws that apply to wellness programs, see CRS Report R40661, *Wellness Programs: Selected Legal Issues*, coordinated by Nancy Lee Jones.

Table 7. Research, Information Management, Education, and Outreach

Table prepared by Sarah A. Lister, 7-7320.

Topic	Current Law	H.R. 3962 (as passed)	S.Amdt. 2786 to H.R. 3590
Prevention and Wellness Research	No comparable provision. Comparable activities could be carried out under general authorities of the Secretary.	Sec. 2301 would create a new PHS Title XXXI —Prevention and Wellness, consisting of several new subtitles and sections. New Sec. 3141 would require the Directors of the CDC and NIH, in conducting or supporting research on prevention and wellness, to take into consideration the Strategy and the recommendations of the Task Forces on Clinical and Community Preventive Services. New PHS Sec. 3142 would require the Secretary, through the CDC Director, to conduct, or award grants for, research in prevention and wellness priority areas identified in the Strategy, or by the Task Forces. New Sec. 3143 would require the Secretary to fund research and demonstration projects on the use of incentives to encourage individuals and communities to promote wellness, adopt healthy behaviors, and use evidence-based preventive services. For carrying out this subtitle, new Sec. 3111 would authorize the appropriation from the Prevention and Wellness Trust of the following amounts: \$155 million for FY2011; \$205 million for FY2012; \$255 million for FY2013; \$305 million for FY2014; and \$355 million for FY2015.	Sec. 4301 would require the Secretary, through the CDC Director, to fund research on public health services and systems, to include (1) examining evidence-based prevention practices relating to prevention, including comparing community-based public health interventions in terms of effectiveness and cost; (2) analyzing the translation of interventions from academic settings to real world settings; and (3) identifying effective strategies for organizing, financing, or delivering public health services in community settings, including comparing state and local health department structures and systems in terms of effectiveness and cost. Such research would have to be coordinated with the TFCPS.
Diabetes Screening Collaboration and Outreach Program	Medicare Part B covers a number of preventive services, including a one-time initial preventive physical examination and diabetes screening. Part B also covers certain diagnostic and treatment items and services for diabetics, including blood glucose self-testing equipment and supplies, therapeutic shoes and inserts, insulin pumps, and the insulin for the pumps. Medicare Part D drug plans cover diabetes supplies used for injecting insulin (e.g., syringes, needles, alcohol swabs, gauze, and inhaled insulin devices), insulin, and anti-diabetic drugs.	Sec. 2594 would require the Secretary, in consultation with specified government agencies and private groups, to review and report to Congress regarding the utilization of benefits for recommended diabetes screening and any problems with utilization or associated data collection, and to establish an outreach program to increase awareness among seniors and providers of diabetes screening benefits.	No provision.

Topic	Current Law	H.R. 3962 (as passed)	S.Amdt. 2786 to H.R. 3590
Health promotion and disease prevention communication and outreach	No comparable provision. Comparable activities could be carried out under general authorities of the Secretary.	No provision.	Sec. 4004 would require the Secretary to carry out seven specified communications activities regarding health promotion and disease prevention, oriented toward the most common and serious chronic problems, including poor nutrition, tobacco use, and obesity. Funding for these activities would take priority over funding provided through CDC grants for similar purposes, and no more than \$500 million could be spent on the required activities. There would be authorized to be appropriated SSAN for each fiscal year to carry out these activities.

Source: Table prepared by the Congressional Research Service based on the text of H.R. 3962 and S. Amdt. 2786 to H.R. 3590.

Table 8. Immunization Provisions

Table prepared by Sarah A. Lister, 7-7320.

Topic	Current Law	H.R. 3962 (as passed)	S.Amdt. 2786 to H.R. 3590
Influenza vaccination centers	No provision.	Sec. 2524 would require the Secretary to award grants for demonstration programs to study the feasibility of using elementary and secondary schools as influenza vaccination centers. The participation of any school or individual would be voluntary. There would be authorized to be appropriated SSAN to carry out the program for each of FY2011 through FY2015.	No provision.
“Section 317” immunization program grants	PHSA Sec. 317 authorizes grants to states to support immunization programs. Funds may be used for program administration and to purchase vaccines.	No provision.	Sec. 4204 would amend PHSA Sec. 317 to provide explicit authority to the Secretary to negotiate and enter into contracts with manufacturers for the purchase of vaccines for adults, and for states to purchase such vaccines at the prices negotiated by the Secretary. The section also would amend PHSA subsection 317(j) to permanently reauthorize the program of immunization grants to states. The section would also add a new PHSA Section 317(m) requiring the Secretary, through the CDC Director, to conduct a demonstration program of grants to states to improve immunization coverage of children, adolescents, and adults. There would be authorized to be appropriated SSAN for FY2010 through FY2014 to carry out this subsection.

Source: Table prepared by the Congressional Research Service based on the text of H.R. 3962 and S. Amdt. 2786 to H.R. 3590.

Notes: See also Table I regarding Medicare coverage of vaccines.

Table 9. Oral Health Care Prevention Activities

Table prepared by Sarah A. Lister, 7-7320.

Topic	Current Law	S.Amdt. 2786 to H.R. 3590
Oral health education campaign and demonstration grants	No provision.	Sec. 4102 would create a new PHSA Title II,I Part T , Oral Healthcare Prevention Activities, with three new sections. A new PHSA Sec. 399LL would require the Secretary to establish a national public education campaign on oral health. A new PHSA Sec. 399LL-I would require the Secretary to award grants to demonstrate the effectiveness of dental caries management activities. A new PHSA Sec. 399LL-2 would authorize the appropriation of SSAN to carry out this new Part.
School-based dental sealant program	PHSA Sec. 317M authorizes grants for community water fluoridation and school-based dental sealant programs.	Sec. 4102 also would amend PHSA Sec. 317M to mandate a school-based dental sealant program that is currently discretionary, and require the Secretary to award program grants to each state and territory, and to Indians, Indian tribes, tribal organizations, and urban Indian organizations.
Oral health leadership cooperative agreements	PHSA Sec. 317M authorizes grants for community water fluoridation and school-based dental sealant programs.	Sec. 4102 also would require the Secretary to enter into cooperative agreements with states, territories, and tribal entities to establish oral health leadership and program guidance for data collection and interpretation, delivery systems, and implementation of programs, and would authorize to be appropriated SSAN for FY2010 through FY2014.
Oral health surveys and surveillance systems	No provision.	Sec. 4102 would require the Secretary to update, improve, and implement oral health components in specified health surveys and surveillance systems, and would authorize to be appropriated SSAN for each of FY2010 through FY2014 to increase participation from the current 16 states to all 50 states, the territories, and DC.

Source: Table prepared by the Congressional Research Service based on the text of S. Amdt. 2786 to H.R. 3590.

Notes: Applicable provisions found only in S.Amdt. 2786 to H.R. 3590. No comparable provisions in H.R. 3962.

Table 10. Pain Care and Management

Table prepared by Kirsten J. Colello, 7-7839.

Topic	Current Law	H.R. 3962 (as passed)	S.Amdt. 2786 to H.R. 3590
IOM Conference on Pain	No provision.	Sec. 2561 would require the Secretary to seek an agreement with the IOM, or another appropriate entity if the IOM declines, to convene a Conference on Pain for the purposes of increasing the recognition of pain as a significant public health problem in the United States, among other purposes. It would authorize to be appropriated \$500,000 for each of FY2011 and FY2012.	Sec. 4305(a) is identical, except it would authorize to be appropriated SSAN for each of FY2010 and FY2011.
Pain research at NIH	Under general authorities in PHSA Title III and Title IV , NIH established the Pain Consortium to enhance pain research and promote collaboration among researchers across various NIH Institutes and Centers. PHSA Sec. 403 requires the NIH Director to submit to the President and Congress a biennial report that includes, among other things, a summary of the research activities throughout the agency organized by category; the chronic disease category includes pain and palliative care.	Sec. 2562 would amend PHSA Title IV, Part B to add a new Sec. 409J , which would encourage the NIH Director to continue and expand research on the causes of and potential treatment for pain through the Pain Consortium. The Pain Consortium, no less than annually, would develop and submit to the NIH Director recommendations on appropriate pain research initiatives that could be undertaken with funds reserved under the PHSA Common Fund or otherwise available. The Secretary also would be required to establish, and as necessary maintain, the Interagency Pain Research Coordinating Committee to coordinate all efforts within HHS and other federal agencies that relate to pain research.	Same provision. [Sec. 4305(b)]
Public awareness campaign on pain management	No provision.	Sec. 2563 would amend PHSA Title II, Part B to add a new Sec. 249 requiring the Secretary to establish and implement a national pain care education outreach and awareness campaign. The Secretary would be authorized to make awards to entities to assist with the public awareness campaign. It would authorize to be appropriated \$2 million for FY2011 and \$4 million for each of FY2012 and FY2015.	No provision.
Education and Training in Pain Care	PHSA Title VII, Part D, comprising Secs. 750-758 , authorizes several grant programs to support interdisciplinary, community-based health workforce training.	No provision.	Sec. 4305(c) would add a new PHSA Sec. 759 to Title VII, Part D, authorizing the Secretary to establish a program to train health professionals in pain care. It would authorize to be appropriated SSAN for each of FY2010 through FY2012 with amounts remaining available until expended.

Source: Table prepared by the Congressional Research Service based on the text of H.R. 3962 and S. Amdt. 2786 to H.R. 3590.

Table I I. Miscellaneous Prevention Provisions

Table prepared by Sarah A. Lister, 7-7320; Erin D. Williams, 7-4897; and C. Stephen Redhead, 7-2261.

Topic	Current Law	H.R. 3962 (as passed)	S.Amdt. 2786 to H.R. 3590
<p>Nutrition Labeling in Chain Restaurants and Vending Machines</p>	<p>No comparable provision. FFDCA Sec. 403 lists the circumstances that would cause a food to be deemed misbranded, which include the failure to adhere to FFDCA’s nutrition labeling requirements. Sec. 403A prohibits states and localities from establishing their own nutrition labeling that is not identical to the Act’s requirements. States and localities may petition the Secretary of HHS for an exemption from the preemption clause in Sec. 403A.</p>	<p>Sec. 2572 would insert a new paragraph H into FFDCA Sec. 403(q)(5), requiring nutrition labeling for standard menu items offered for sale in chain restaurants or similar retail food establishments with 20 or more locations. These establishments would be required, for standard menu items, to disclose as specified: (1) the number of calories contained in the item; and (2) the suggested daily caloric intake, as specified by the Secretary by regulation. Such establishments would also be required to make available, at the premises upon request, certain detailed written nutritional information.</p> <p>The establishments would be required to have a reasonable basis for their nutrient content disclosures. The Secretary would be required to establish by regulation standards for determining and disclosing the nutrient content for standard menu items that come in different flavors, varieties, or combinations, but which are listed as a single menu item.</p> <p>Certain vending machine operators that own or operate 20 or more machines would be required to provide specified signs disclosing the number of calories contained in each article of food, so that the information is accessible to consumers before they make their purchases.</p> <p>The Secretary would be required to promulgate proposed regulations as specified to carry out the requirements of the section, and to provide quarterly reports to Congress describing progress toward promulgating final regulations.</p>	<p>Sec. 4205 contains substantively equivalent provisions. There are the following technical differences: (1) shortened provision title; (2) different phrasing of FFDCA references in paragraphs (a)(1)-(2), and (d)(1); (3) different phrasing of FFDCA references in proposed paragraph H (vii)(II); (4) addition of the term “in general” and different numbering of provisions in proposed paragraph H (viii).</p>
<p>Access for individuals with disabilities</p>	<p>Section 502 of the Rehabilitation Act establishes the Architectural and Transportation Barriers Compliance Board (ATBC Board) to develop design standards for, and to assure compliance by, facilities designed, built, altered, or leased with federal funds, in order to improve access for people with disabilities.</p>	<p>Sec. 2592 would add a new Sec. 510 to the Rehabilitation Act, requiring the ATBC Board to issue <i>guidelines</i> for minimal technical criteria for new medical diagnostic equipment (as specified) used in medical settings. The guidelines must ensure that individuals with disabilities can use, enter, and exit such equipment independently, to the maximum extent possible. The Board would be required periodically to review the guidelines</p>	<p>Sec. 4203 would add a new Sec. 510 to the Rehabilitation Act requiring the ATBC Board, in consultation with FDA, to issue <i>regulatory standards</i> for minimal technical criteria for medical diagnostic equipment (as specified) used in medical settings. The standards must ensure that individuals with disabilities can use, enter, and exit such equipment independently, to the maximum extent possible. The Board would be required</p>

Topic	Current Law	H.R. 3962 (as passed)	S.Amdt. 2786 to H.R. 3590
		<p>and amend them as necessary.</p> <p>Within six months of the issuance of the guidelines, each federal agency authorized to promulgate regulations under the Rehabilitation Act or the Americans with Disabilities Act (ADA) would be required to prescribe regulations to carry out the provisions of each Act with respect to accessibility standards that are consistent with the guidelines, and to ensure that health care providers and health care plans covered under this bill meet the requirements of Section 504 of the Rehabilitation Act and the ADA, including ensuring that individuals with disabilities receive equal access to all aspects of the health care delivery system.</p>	<p>periodically to review the standards and amend them as necessary.</p>
<p>Reasonable break time for nursing mothers</p>	<p>Sec. 7 of the Fair Labor Standards Act of 1938 sets forth certain requirements for employers regarding maximum work hours.</p>	<p>No provision.</p>	<p>Sec. 4207 would amend Sec. 7 of the Fair Labor Standards Act to require employers of 50 or more employees to provide reasonable break time for an employee to express breast milk for her nursing child for one year after the child's birth. This provision would not preempt a state law that provides greater protections to employees.</p>
<p>Health disparities data collection and analysis</p>	<p>The federal government does not require collection and aggregation of race and ethnicity data. However, OMB issues statistical policy guidance for when such data are collected from federally sponsored surveys, administrative forms and other records. OMB standards do not apply to state and municipal public health departments or to Medicaid. While the standards do apply to CHIP, they are not binding on states that opt to use CHIP funding to finance a Medicaid expansion or that employ a combined approach. The OMB standards do not address primary language.</p>	<p>No provision. (Secs. 1221-1224 relate to health disparities, but address Medicare beneficiaries with limited English proficiency.)</p>	<p>Sec. 4302 would add a new PHSA Title XXXI, Data Collection and Analysis and a new Sec. 3101 which would require the Secretary to establish procedures to ensure that all data collected on race, ethnicity, sex, and primary language by any federally conducted or supported health care or public health program does so in compliance with OMB directives and guidance. New Sec. 3101 would require that federally funded population surveys collect sufficient data to generate statistically reliable estimates in studies comparing health disparities among populations. It would ensure that quality reporting requirements under federal health care programs would include the collection of data on individuals receiving health care items or services under these programs by race, ethnicity, sex, primary language, and type of disability. The Secretary, working through the National Coordinator for Health Information Technology, would be required to develop national interoperability and security standards for the management of the</p>

Topic	Current Law	H.R. 3962 (as passed)	S.Amdt. 2786 to H.R. 3590
Sense of the Senate Concerning CBO Scoring	Not applicable.	No provision.	<p>aforementioned data. Sec. 4302 also would require the Secretary to establish procedures for sharing health disparities data collected under a federal health care or insurance program and relevant analyses of such data, with other federal and state agencies. Finally, Sec. 4302 would authorize the appropriation of SSAN for FY2010 through FY2014 to carry out this section.</p> <p>Sec. 4401 states that the Senate finds that the costs of prevention programs are difficult to estimate, in part because prevention initiatives are hard to measure, and because results may occur outside the 5- and 10-year budget windows currently considered by the CBO. The section further states that it is the sense of the Senate that Congress should work with CBO to develop better methodologies for scoring progress to be made in prevention and wellness programs.</p>
Effectiveness of Federal Health and Wellness Initiatives	<p>U.S. Code Title 5, Chapter 89, Sec. 8910 requires the Office of Personnel Management, which oversees the Federal Employee Health Benefits Program (FEHBP), to study certain aspects of program operation and administration, including aspects of health benefits plans available to employees. Specific aspects of FEHBP prevention and wellness activities are not mentioned in law, but are discussed in administrative documents.</p>	No provision.	<p>Sec. 4402 would require the Secretary, in order to determine whether existing federal health and wellness initiatives are effective in achieving their stated goals, to conduct an evaluation and report to Congress regarding changes in the health status of the American public, and specifically the federal workforce, including absenteeism, productivity, the rate of workplace injury, and the medical costs incurred by employees; and health conditions, including workplace fitness, healthy food and beverages, and incentives in the FEHBP.</p>

Source: Table prepared by the Congressional Research Service based on the text of H.R. 3962 and S. Amdt. 2786 to H.R. 3590.

