

Understanding National Health Reform:

Prepared by
North Carolina Institute of Medicine

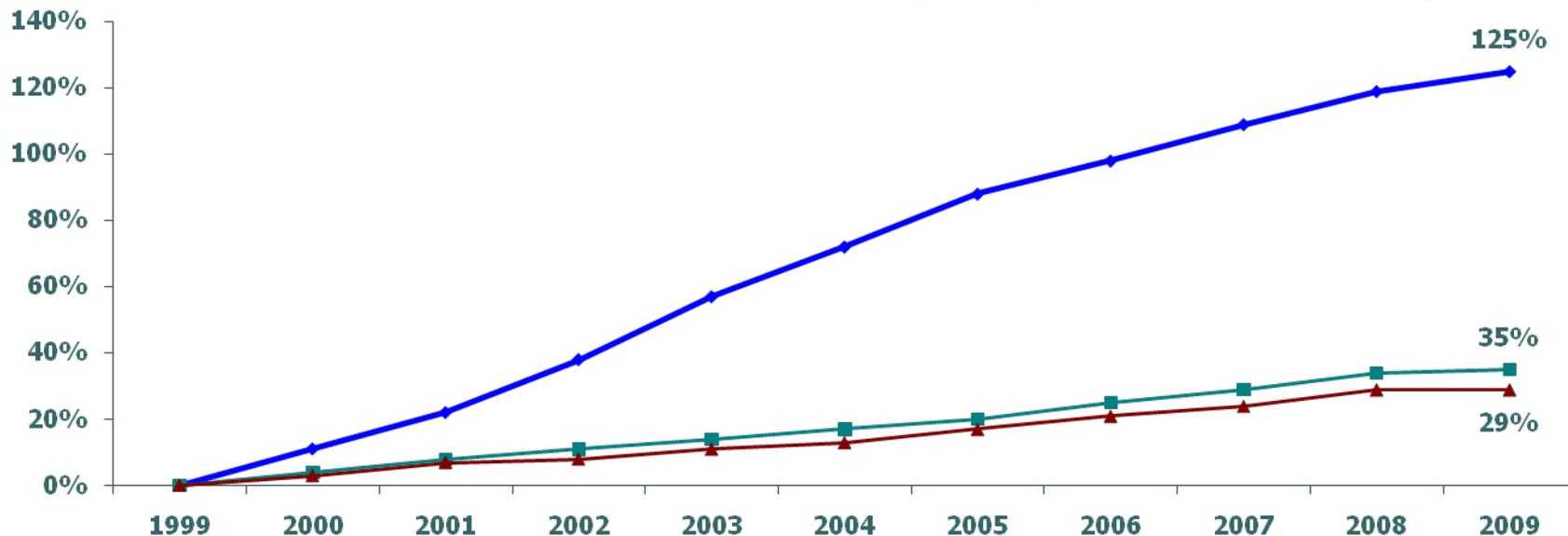
Background

- Estimates of the uninsured (2009):
 - 200 US Census estimates: 1.7 million non-elderly uninsured in North Carolina (20.4%)
 - 2009 NCIOM estimate after downturn in the economy: 1.75 million non-elderly uninsured (21%)
- Average annual per capita personal health care spending (1998-2004):
 - Rising rapidly nationally and in North Carolina
 - North Carolina: 7.2% average annual increase



Source: NCIOM. Health Care Costs and Insurance Coverage in Five Southern States. Data Snapshot. 2009-3. North Carolina's Increase in the Uninsured: 2007-2009; US Census, Historical Health Insurance Tables. HI6.

US Health Insurance Premiums Increasing More Rapidly Than Inflation or Earnings (1999-2009)



Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2000-2008. Bureau of Labor Statistics, Consumer Price Index, U.S. City Average of Annual Inflation (April to April), 2000-2008; Bureau of Labor Statistics, Seasonally Adjusted Data from the Current Employment Statistics Survey, 2000-2008 (April to April). Claxton G. et. al. Job-Based Health Insurance: Costs Climb at a Moderate Rate. Health Affairs. Sept. 15, 2009.



Health Care: Three Legs of a Stool

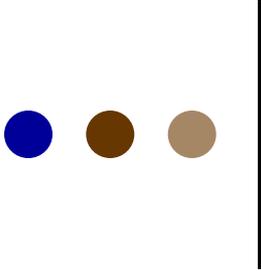
Health reform must address the three critical components of our health care system—costs, quality, and access

Costs

Access

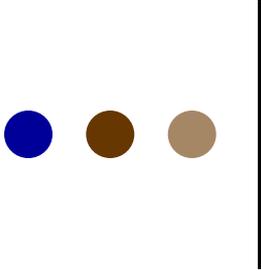


Quality



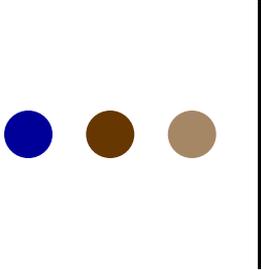
Legislation

- Patient Protection and Affordable Care Act (HR 3590) (signed into law March 23, 2010), and Health Care and Education Affordability Act of 2010 (HR 4872)
 - The following slides reference HR 3590, unless noted as part of Reconciliation.
- Appropriation vs. Authorization:
 - Important to note the differences between direct *appropriations* (i.e., funding available immediately as part of the enacted legislation), and *authorizations* for future funding (i.e., some or all of the funding may be included in a future appropriations bill).



Basics of National Health Reform--Overview

- Overview of health reform legislation
- Immediate implementation
- Changes in public coverage
- Private coverage
- Other provisions
- Cost containment and financing
- Congressional Budget Office (CBO) estimates

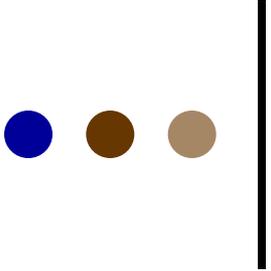


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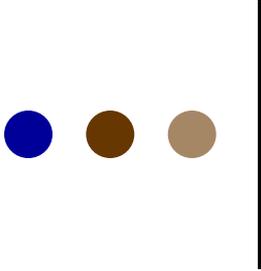
Overview of Health Reform

- By 2014, the bill requires most people to have health insurance and most employers to provide health insurance--or pay a penalty.
 - Most low-income people under 138% Federal Poverty Level (FPL) eligible for Medicaid
 - Most individuals/families with incomes below 400% FPL are eligible for premium subsidies, unless they have employer or governmental insurance
 - Large employers (50+) required to offer affordable insurance coverage or pay penalty
 - Small employers exempt from mandates, but some eligible for tax credits if they offer insurance



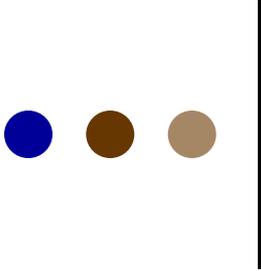
Overview of Health Reform

- Insurance reform to:
 - Cover more people and make it more affordable to many
 - Cover preventive services and essential health benefits
- New funding for:
 - Health promotion and wellness initiatives
 - Expansion of the safety net
 - Health professions education
- Increased emphasis on quality and testing new delivery models
- Efforts to reduce unnecessary health care costs



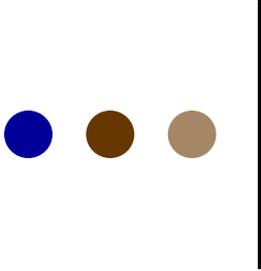
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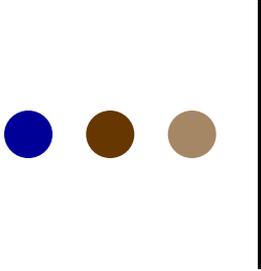
Immediate Implementation: Coverage

- HHS Secretary will have a website to help consumers identify affordable insurance
(Sec. 1103)
- Sliding scale tax credits for small businesses (up to 25 employees) with average annual wage of up to \$50,000
(Sec. 1421, 10105)
- Appropriates \$5B to help support a high-risk pool for people with preexisting conditions
(Effective 90 days after enactment for FY 2010-2014; Sec. 1101)
 - States can qualify for funding but must maintain existing funding for high-risk pool.
 - Can't charge higher for pre-existing conditions, but individuals must have been uninsured for 6 months to qualify under new provisions..



Immediate Implementation: Coverage

- Appropriates \$5B to create a temporary reinsurance program for employers providing health insurance coverage to early retirees ages 55-64
(Effective 90 days after enactment for FY 2010-2014; Sec. 1102, 10102)
 - Program will reimburse employers or insurers for 80% of retiree claims between \$15,000 and \$90,000.
 - Reinsurance can be used to lower premium costs, or reduce cost sharing.

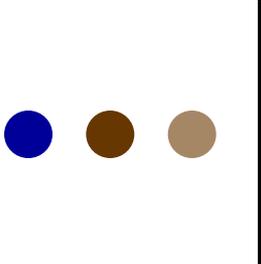


Immediate Insurance-Related Provisions

- Effective for plan years that begin after September 23, 2010:
 - Prohibits insurers from dropping coverage to people when they get sick (Sec. 1001, as amended Sec. 2301 of Reconciliation)
 - Prohibits insurers from denying coverage to children under age 19 with pre-existing conditions or imposing pre-existing condition exclusions (Sec. 1001, 1201, 10103(e))
 - Prohibits plans from imposing lifetime caps; and restricts use of annual caps (annual caps prohibited 2014) (Sec. 1001, as amended Sec. 2301 of Reconciliation)
 - Extends coverage for young people up to 26th birthday through parents coverage (Sec. 1001, as amended Sec. 2301 of Reconciliation)
 - *New private plans must cover preventive services with no cost sharing* (Sec. 1001)*



* These provisions only apply to new group or non-group plans issued after the effective date. These provisions do not apply to grandfathered plans or ERISA plans.

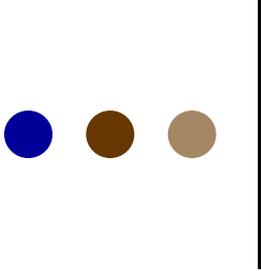


Immediate Insurance-Related Provisions

- Effective for plan years that begin after September 23, 2010:
 - Enrollees can select any PCP from participating providers, can't be charged more for out-of-network emergency services, and can self-refer to an OB-GYN. (Sec. 10101)
- Appropriate to the states (effective immediately):
 - Authorizes funds as necessary to states to support state health insurance consumer assistance offices to help individuals file complaints and appeals (Sec. 1002)
 - \$250M (FY 2010-2014) to assist states in reviewing, and if appropriate under state law, approving premium increases for health insurance coverage and to make recommendations about whether insurers should be excluded from participation in Health Benefit Exchange based on unjustified rate increases (Sec. 1003)

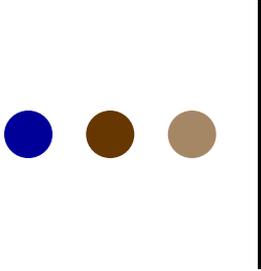
Immediate Provisions: Implementation Activities

- Requires insurers to spend at least 80% (individual and small group) or 85% (large group market) of premium dollars on medical services or provide rebate to enrollees (Rebate effective 2011; Sec. 1001, 10101)
- Appropriates \$1B to the HHS Secretary to establish a Health Insurance Reform Implementation Fund (to carry out the provisions of the Patient Protection and Affordable Care Act) (Sec. 1005 of Reconciliation)
 - States will be eligible for grants to begin planning Health Benefit Exchanges. (Sec. 1311)



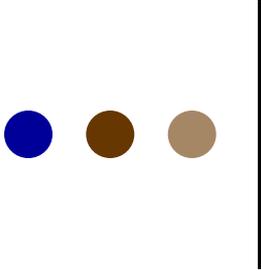
Immediate Medicare Provisions

- Medicare beneficiaries will receive a 50% discount on brand-name drugs and biologics in donut hole (2011) (Sec. 3301, Sec. 1101 of Reconciliation)
- Expands Medicare to cover more preventive services with no cost-sharing (2011) (Sec. 4104)
- Provides a 10% bonus payment for primary care physicians and general surgeons practicing in underserved areas (2011-2015) (Sec. 5501)



Other Immediate Provisions

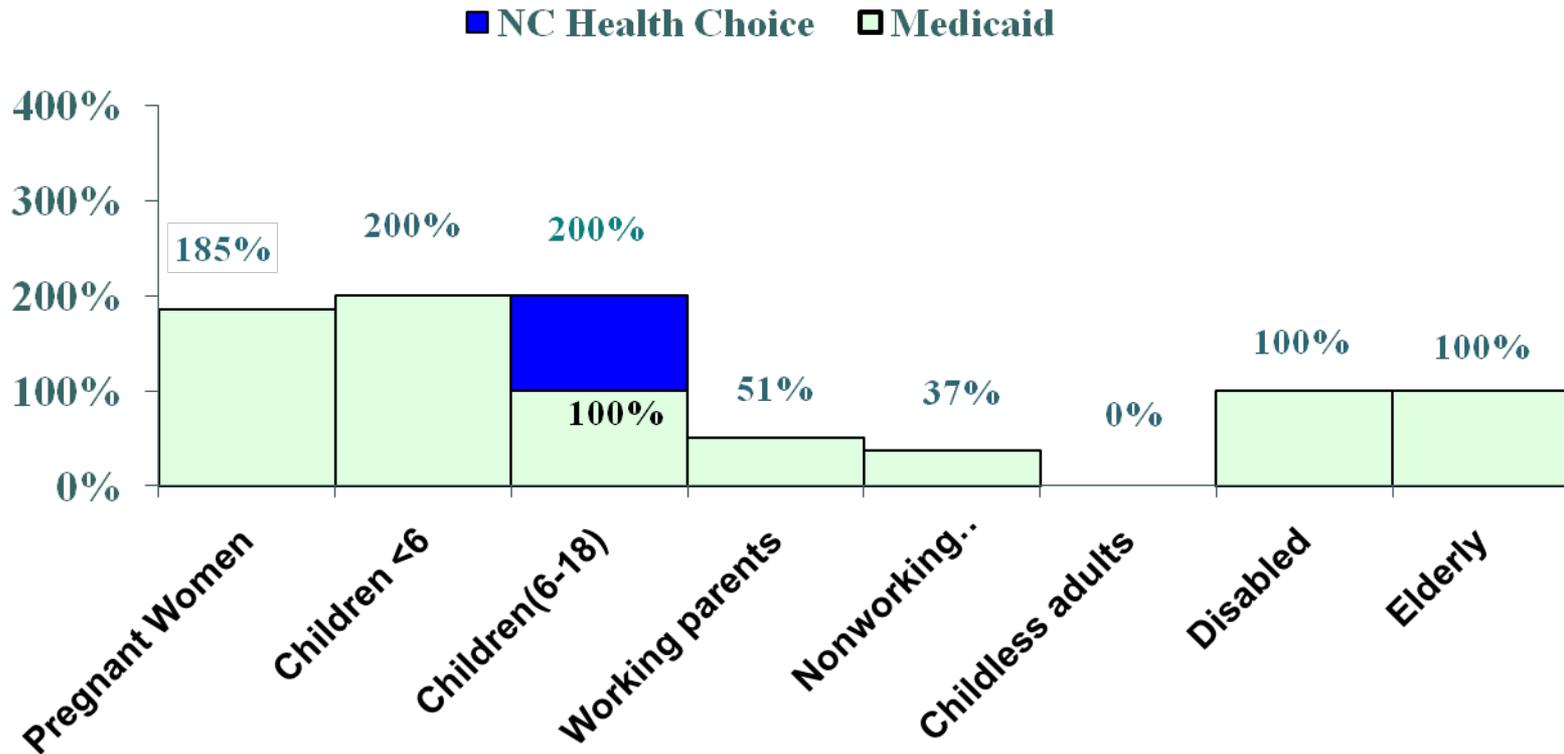
- Additional funding for safety net organizations (Sec. 4101, 5207-5208, 3504-3505, 10503; Sec. 2303 Reconciliation)
- Additional funding for prevention (Sec. 4001-4402)
- Creates new voluntary, public, long-term care insurance program (Sec. 8001-8002)
- New health information technology (HIT) standards to facilitate enrollment of individuals into federal and state health and human services programs (Sec. 1561)

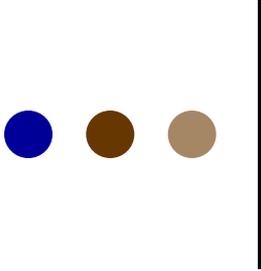


Basics of National Health Reform--Overview

- Overview of health reform legislation
- Immediate implementation
- **Changes in public coverage**
 - **Medicaid, CHIP and Medicare**
- Private coverage
- Other provisions
- Cost containment and financing
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Existing NC Medicaid Income Eligibility (2010)



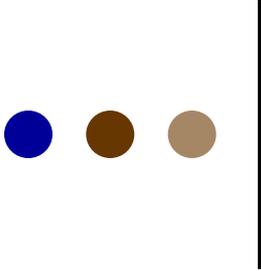


Expansion of Public Programs

- Expands Medicaid to cover all low-income people under age 65 (including childless adults) with incomes up to 138% FPL, based on modified gross income (begins FY 2014) (Secs. 2001, 2002)

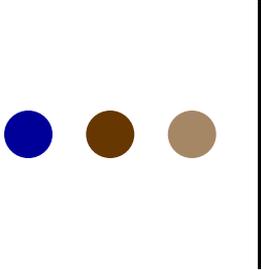
Family Size	138% FPL/yr. (2011)
1	\$15,028
2	\$20,300
3	\$25,571
4	\$30,843

- No asset tests for children and most adults (Sec. 2002)
- Undocumented immigrants not eligible for Medicaid



Enrollment Simplification and Coordination

- States can expand Medicaid coverage to non-elderly individuals above 138% FPL. (Sec. 2001)
- States will be required to simplify enrollment and coordinate between Medicaid, CHIP, and the new Health Benefit Exchange (Sec. 2201; 1413)
 - Must conduct outreach to vulnerable populations (Sec. 2201)
 - Common application, electronic data exchange between programs, administrative data matches (Sec. 1413, 1414)
 - At state option, hospitals can determine presumptive eligibility for all Medicaid populations. (Sec. 2202)

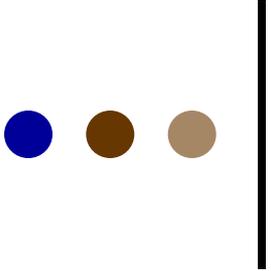


Enhanced Federal Match for Medicaid Expansion

- Federal government will pay 100% of costs of *new eligibles* in first three fiscal years (2014-2016).

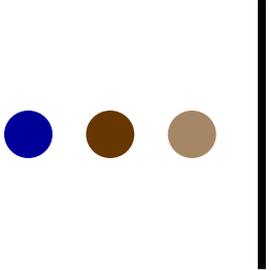
(Sec. 2001(3), amended Sec. 1201 Reconciliation)

- After first three years, federal government will pay 95% (2017), 94% (2018) , 93% (2019) and 90% (2020 and thereafter).
 - ***However, states will have to cover costs of people who are currently eligible but who had not enrolled in the past***
 - States must increase reimbursement for primary care procedures to 100% of Medicare payment rates.
- (Sec. 1202 Reconciliation)
- Federal government will pay 100% of the costs of the enhanced provider rates (2013-2014).



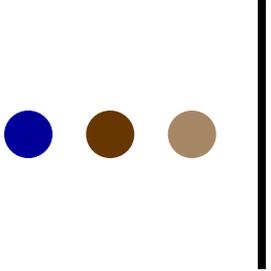
Other Medicaid Provisions

- All newly eligible adults will be guaranteed a benchmark benefit package that includes essential health benefits. (Sec. 2001(a)(2))
- States may cover adult preventive services.
(Effective Jan. 1, 2013; Sec. 4106)
 - Increased Federal Medical Assistance Percentage (FMAP) by one percentage point if state covers all recommended immunizations and preventive services for adults
- Appropriates \$100M (FY 2011-2015) for demonstration grants to provide incentives to participate in healthy lifestyle initiatives (Sec. 4108)



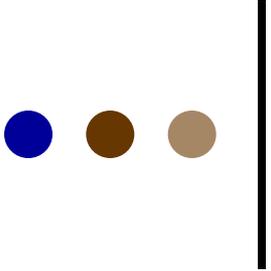
Other Medicaid Provisions

- States must cover:
 - Tobacco cessation services for pregnant women
(Sec. 4107)
 - Former foster children up to age 25
(Effective 2014; Sec. 2004, 10201)
 - Services provided by free-standing birth centers
(Sec. 2301)
- States may cover family planning services to non-pregnant individuals through a state plan amendment rather than a waiver. (Sec. 2303)



CHIP (NC Health Choice)

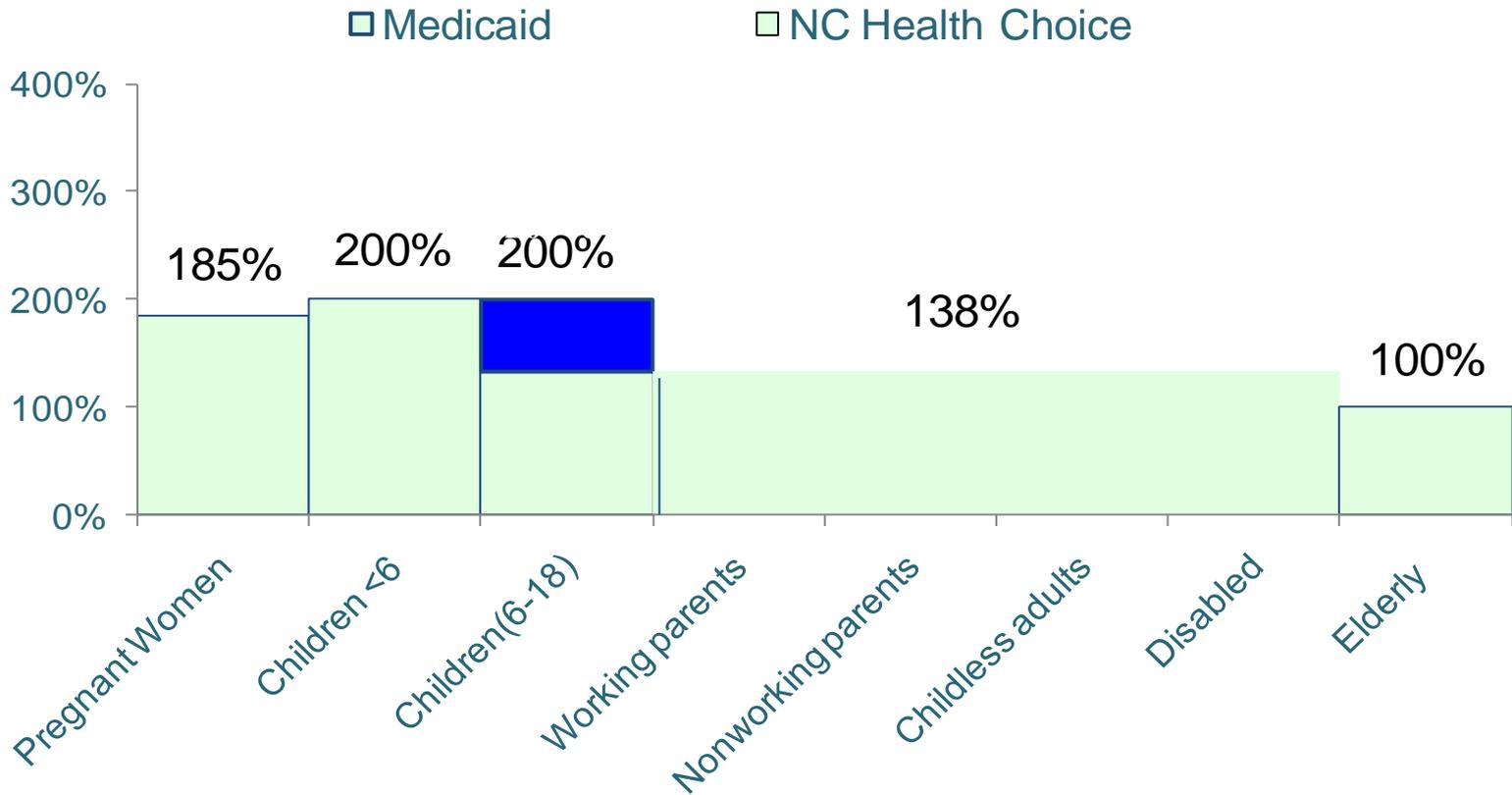
- States must maintain current income eligibility for children in Medicaid and CHIP until 2019 (Sec. 2101(b), 10203).
 - Beginning in 2015, states will receive a 23 percentage point increase in the CHIP match rate (up to cap of 100%) (Sec. 2101(a))
 - Children ineligible to enroll in CHIP because of enrollment caps will be eligible for tax credits in the state exchanges. (Sec. 2101(b)(1)(B))
 - Increases outreach and enrollment grants by \$40M (2009-2015) (Sec. 10203)

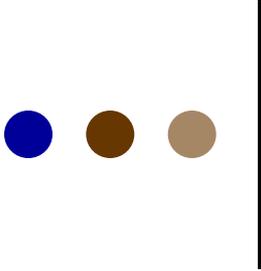


Medicaid & CHIP

- Medicaid and CHIP Payment and Access Commission (MACPAC) will study policies affecting all Medicaid beneficiaries (Sec. 2801)

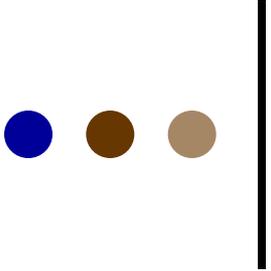
After Health Reform Fully Implemented (Beginning 2014)





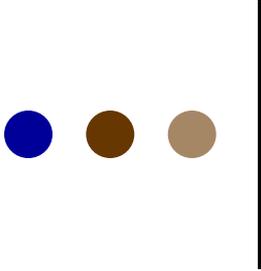
Medicare

- Enhances preventive services (Sec. 4103-4105, 10402, 10406)
 - Covers preventive services with no cost-sharing (Sec. 4104)
 - Covers annual wellness visit as part of personalized prevention plan (Sec. 4103)
- Phases out the gap in the Part D “donut hole” by 2020 (Sec. 3315, as amended by 1101 Reconciliation)
 - Pharmaceutical companies required to provide 50% discount on brand-name prescription drugs beginning in 2011 (Sec. 3301)
- Appropriates \$45M in additional funds (FY 2010-2012) to expand outreach and assistance to enroll low-income Medicare beneficiaries in Part D (Sec. 3306)



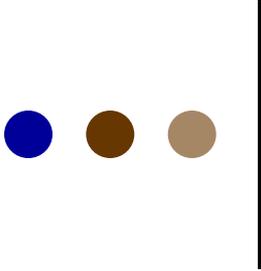
Medicare

- Increases Medicare payments:
 - 10% bonus payment to primary care physicians and general surgeons practicing in health professional shortage areas (2011-2015) (Sec. 5501, 10501)
- Medicare Advantage plans cannot charge more cost-sharing for covered services than traditional Medicare (Sec. 3202)



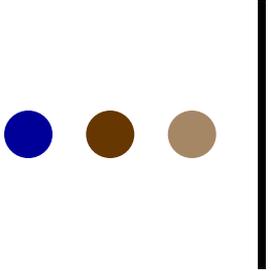
Medicare

- Legislation protects existing Medicare benefits (Sec. 3601, 3602)
 - All savings from the legislation must be used to extend the solvency of Medicare trust funds, reduce Medicare premiums and other cost-sharing, improve or expand guaranteed benefits, and protect access to Medicare providers
- Appropriates \$15 million increased by the Consumer Price Index (CPI) in subsequent years to support the Independent Payment Advisory Board (Effective FY 2012; Sec. 3403, 10320):
 - Must present Congress with proposal to reduce excess cost growth and improve quality (recommendations beginning Jan. 2014)
 - In years when cost escalation unsustainable, Board's proposals will take effect unless Congress passes alternative proposal
 - Can't enact proposals to ration care, raise taxes or Part B premiums, change benefits, eligibility or cost-sharing, reduce premium supports



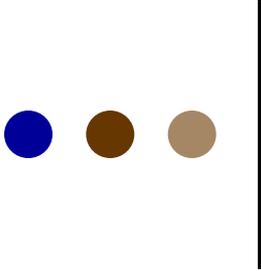
Basics of National Health Reform--Overview

- Overview of health reform legislation
- Immediate implementation
- Changes in public coverage
- **Private coverage**
 - **Standardized benefit package**
 - **Individual mandate and subsidies**
 - **Employer responsibilities**
 - **Health benefit “exchanges” and insurance reform**
- Other provisions
- Cost containment and financing
- CBO estimates



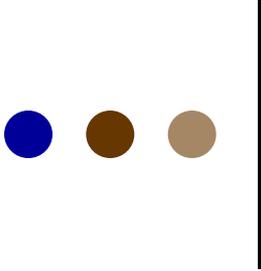
Essential Benefit Package

- HHS Secretary will recommend an essential health care benefits package that includes a comprehensive set of services: (Sec. 1302)
 - Essential benefit package must cover at least 60% actuarial costs and be similar to (not more extensive than) benefits covered through typical employer plan
 - All qualified health plans offered through Health Benefit Exchange (HBE), small group or individual market must provide at least essential benefits
 - With exception of “grandfathered plans”, insured plans offered outside the HBE must cover the essential benefits but can offer additional benefits*



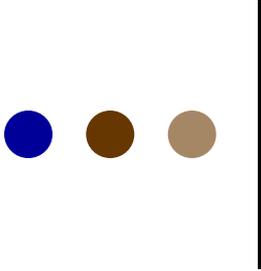
Essential Benefits Package

- Essential benefits must cover:
 - Hospital services; professional services; prescription drugs; rehabilitation and habilitative services; mental health and substance use disorders; and maternity care
 - In addition, plans must cover well-baby, well-child care, oral health, and vision services for children under age 21 (Sec. 1001, 1302)
 - Plans must cover preventive services recommended by US Preventive Services Task Force (USPSTF) and Advisory Committee on Immunization Practices (ACIP) with no cost-sharing and all recommended immunizations (Sec. 1001, 10406)
 - Cannot include annual or lifetime limits for essential benefits (Sec. 1001, 10101)
 - Mental health parity law applies to qualified health plans (Sec. 1311(j))



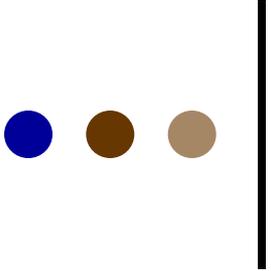
Essential Benefits Package

- Four levels of plans, all must cover essential benefits package: (Sec. 1302(d))
 - Bronze (minimum creditable coverage): must cover, on average, 60% of the costs of covered services
 - **Silver: 70% of the benefits costs***
 - Gold: 80% of the benefit costs
 - Platinum: 90% of the benefit costs
 - Catastrophic plan (only available to people up to age 30 or if exempt from coverage mandate) (Sec. 1302(e))
- With some exceptions, existing grandfathered plans not required to meet new benefit standards (Sec. 1251, 10103 as amended Sec. 2301 of Reconciliation)



Essential Benefits Package

- States can mandate additional benefits:
 - Must pay for the cost of additional mandates for people in health benefit exchange. (Sec. 1311(d), 1401(b)(3)(D))
 - Can still require mandates for insurance outside exchange. (Sec. 1312(d)(2))
- Abortion coverage (Secs. 1303, 10104)
 - Plans may elect whether to cover abortion.
 - Must have segregation of funds for subsidy-eligible individuals if the plan covers abortions.
 - States may enact laws to prohibit abortion coverage in qualified health plans in the HBE.

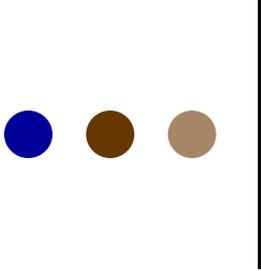


Individual Mandate

- Citizens and legal immigrants will be required to pay penalty if they do not have qualified health insurance.

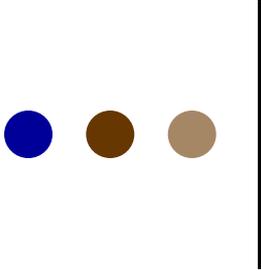
(Sec. 1312(d), 1501, amended Sec. 1002 in Reconciliation)

- Hardship waiver if health insurance is unaffordable.
- If they don't enroll, they must pay tax penalties.
 - Must pay the greater of: \$95/person or 1% taxable income (2014); \$325 or 2.0% (2015); or \$695 or 2.5% (2016), increased by cost-of living adjustment.*
 - The maximum penalty is equal to the amount the individual or family would have paid for the lowest cost bronze plan (minus any allowable subsidy).
- Required to report health insurance coverage to the IRS. (Sec. 1502)



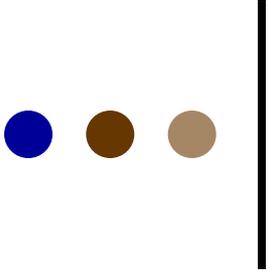
Individual Mandate

- Exemption/Affordability defined: (Sec. 1501(d)(2)-(4),(e))
 - Some of the exemptions include individuals who are not required to file taxes; without coverage for less than three months; and those for whom the lowest cost plan exceeds 8% of an individual's income.
- Individuals not required to change coverage under group plan or individual policy that person enrolled in on or before March 23, 2010. (Sec. 1251, amended by Sec. 2301 of Reconciliation)
 - Existing plans are called “grandfathered” plans
- Individuals can enroll in qualified health plans in or outside the HBE. (Sec. 1312(a), 1312(d))



Subsidies to Individuals

- Refundable and advanceable premium credits will be available to individuals with incomes up to 400% FPL on a sliding scale basis (\$43,560/yr. for one person, \$89,400 for a family of four in 2011).* (Sec. 1401, as amended Sec. 1001 of Reconciliation)
 - Subsidies based on the second lowest cost silver plan.
 - Limited to citizens and legal immigrants (including those who are barred from enrolling in Medicaid during the first 5 years in the country). (Sec. 1401(c))



Subsidies to Individuals

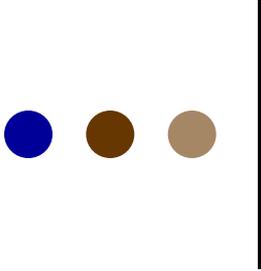
- Individuals are generally not eligible for subsidies if they have employer-based coverage, TRICARE, VA, Medicaid, or Medicare. (Sec. 1401(c)(2)(B)(C), 1501)
 - Employees are eligible for the premium credit if offered coverage by an employer that does not meet requirements for minimum essential benefits (60% actuarial value) or if the premium for employee-only coverage exceeds 9.5% of the employee's annual income.
(Sec. 1401(c)(2)(C) as amended by Sec. 1001 of Reconciliation; Sec. 1501 creating 5000A of Internal Revenue Code of 1986)

Sliding Scale Subsidies

Individual or family income	Maximum premiums (Percent of family income)	Out-of-pocket cost sharing:* Gov't. subsidies (Individual responsibility)	Out-of-pocket cost sharing limits**
<138% FPL	2% of income	94% (6%)	\$1,983 (ind)/\$3,967 (fam) (1/3 rd HSA limits)
138-150% FPL	3-4%	94% (6%)	\$1,983 / \$3,967
150-200% FPL	4-6.3%	87% (13%)	\$1,983/ \$3,967
200-250% FPL	6.3-8.05%	73% (27%)	\$2,975/ \$5,950 (1/2 HSA limit)
250-300% FPL	8.05-9.5%	70% (30%)	\$2,975/ \$5,950
300-400% FPL	9.5%	70% (30%)	\$3,967/ \$7,934 (2/3 rd s HSA limit)

*Out-of-pocket cost sharing includes deductibles, coinsurance, copays.

**Out of pocket limits do not include premium costs. Annual cost sharing limited to: \$5,950 per individual and \$11,900 family in 2011 (HSA limits) (Sec. 1302(c), 1401, 1402, as amended by Sec. 1001 of Reconciliation)

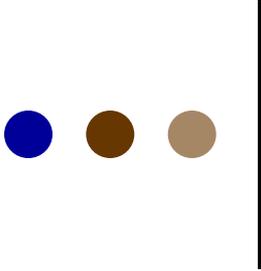


Employer Responsibilities

- Employers with 50 or more full-time employees required to offer insurance or pay penalty (Sec. 1201, 1513, amended Sec. 1003 Reconciliation)
 - Must offer affordable coverage to employee *and* dependents
 - May not have waiting period of more than 90 days
 - Not required to pay for any part of the premium
 - However, subject to a penalty if:
 - Employer does not offer coverage that meets essential coverage requirements (premium covers 60% of the actuarial costs of the plan)
 - Employees qualify for and receive a subsidy in the health benefit exchange
 - Employer penalty only for full-time employees, not dependents

Employer Responsibilities

- Potential penalties for employers with more than 50 employees (Sec. 1513, amended by Sec. 1003 Reconciliation)
 - If employer *does not offer* coverage, the employer must pay \$2,000 per full-time employee, excluding first 30 employees.
 - If an employer *does offer* coverage, but at least one full-time employee qualifies for and receives a subsidy, then the employer must pay \$3,000 for any full-time employee who receives a subsidy (but in no event more than \$2,000 per full-time employee, excluding the first 30 employees).
 - Penalty determined on monthly basis.
- Employers with 50 or fewer employees exempt from penalties. (Sec. 1513(d)(2))

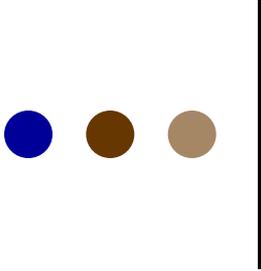


Counting “Full-Time” Employees

- Full-time employee includes anyone working 30 or more hours/week
 - Excludes full-time seasonal employees who work less than 120 days/year
- Hours of part-time employees counted in determining number of full-time employees
 - Determined by taking number of monthly hours worked by part-time employees and dividing by 120
 - Example: Employer has 3 part-time employees that work 20 hours/week (80 hours/month). $3 \text{ employees} \times 80 \text{ hours} = 240 / 120 = 2 \text{ full-time employees}$
- While number of full-time employees counted in determining whether employer must offer coverage, *penalty only applies to employees who DO work full-time*

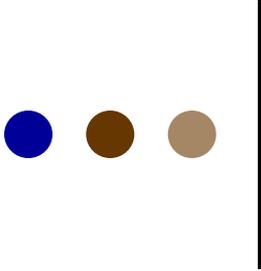
Potential Annual Penalties for Employers

<p>Small employer:</p> <p>Less than 50 FT employees</p>	<p>Large employer: Does <i>not</i> offer coverage</p> <p>No FT employees receive credits in HBE</p>	<p>Large employer: Does <i>not</i> offer coverage</p> <p>1 or more FT employees receive credit in HBE</p>	<p>Large employer: Does offer coverage</p> <p>No FT employees receive credit for exchange coverage</p>	<p>Large employer: Does offer coverage</p> <p>1 or more FT employees receive credit in HBE</p>
<p>No penalty</p>	<p>No penalty</p>	<p>Number of FT employees minus 30 multiplied by \$2,000</p>	<p>No penalty</p>	<p><i>Lesser of:</i></p> <ul style="list-style-type: none"> ○ Number of FT employees minus 30, multiplied by \$2,000 ○ Number of FT employees who receive credits for exchange coverage, multiplied by \$3,000



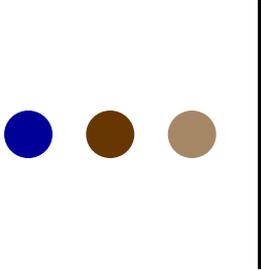
Free Choice Voucher

- Employers that offer essential coverage and pay a portion of the costs must provide a “free choice voucher” to certain employees (Sec. 10108)
 - If premium is between 8-9.8% of the employee’s annual household income
 - Employee does not participate in the employer-sponsored insurance (ESI)
 - Amount of free choice voucher equal to amount employer would have paid if the individual participated in ESI
 - Employee can use the free choice voucher to purchase insurance through the Health Benefit Exchange



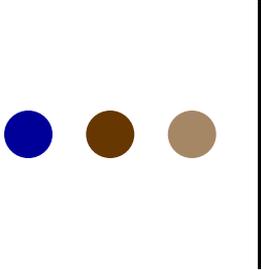
Additional Employer Responsibilities

- Employers may not discriminate against lower-paid employees in providing health insurance (Sec. 1001)
- Reporting requirements (Secs. 1502, 1512, 1514, 9002)
 - Employers must report full value of employer-sponsored health insurance (including employee and employer share and contributions to FSAs) on W-2 forms
 - Employers must provide information to employees about the availability of coverage through the HBE, but if employees seek coverage through the HBE they do not receive employer subsidies (March 1, 2013)
 - Employers will be required to report on whether they offer essential minimum coverage to full-time employees and dependents, length of the waiting period, information about each full-time employee who was covered (2014)



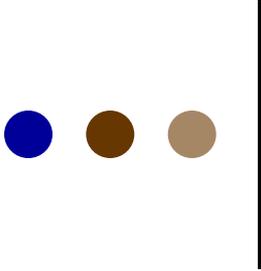
Special Rules for Small Business Plans

- Deductibles: Cannot exceed \$2,000 (individual) or \$4,000 (family) in small group market. (Sec. 1302(c)(2), 1304)
 - Small employer defined as less than 100 employees (but state can limit small employers to less than 50 employees until 2016)



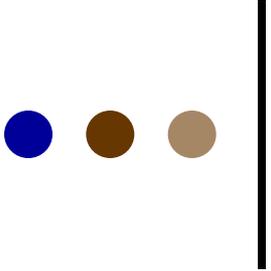
Separate Rules for Large Employers

- Employers with more than 200 employees are required to automatically enroll employees into health insurance plans if offered by the employers. (Sec. 1511)
 - Employees can opt out of coverage.



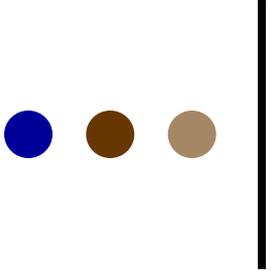
Subsidies for Small Employers

- Employers with 25 or fewer employees and average annual wages of less than \$50,000 can receive a tax credit. (Sec. 1421, Sec. 10105)
 - *Phase I (2010-2013):* 35% tax credit if for-profit employer provides coverage and pays at least 50% of total premium cost. (Full credit limited to employers with 10 or fewer employees and average annual wages of less than \$25,000. Credit phases out for larger employers or higher average wages. Non-profit organization only eligible for 25%.)
 - *Phase II (2014-on):* Maximum of 50% tax credit for up to 2 years (with similar targeting and phase-out, non-profits eligible for up to 35% tax credit). Subsidies only available for coverage purchased through the Health Benefit Exchange.



Health Benefit Exchange

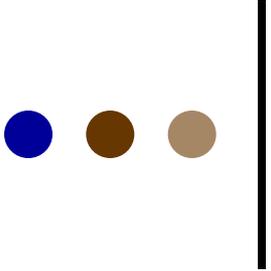
- States will create a Health Benefit Exchange and Small Business Health Options (SHOP) Exchange for individuals and small businesses. (Sec. 1311, 1321)
 - To facilitate the purchase of qualified health plans
 - Limited to citizens and lawful residents who do not have access to employer-sponsored or governmental-supported health insurance and to small businesses with 100 or fewer employees (states can allow larger employers to enroll beginning 2017) (Sec. 1312(f))
 - States will get initial grants to help establish HBEs, but must be self-sufficient beginning 2015 (Sec. 1311(a),(d)(5))
 - States can merge small group and individual markets (Effective Jan. 1, 2014; Sec. 1311(b)(2))



Health Benefit Exchange

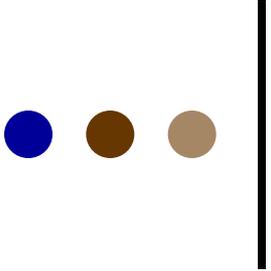
- Exchanges will:

- Offer standardized information to help consumers choose between plans and develop rating system based on quality and cost. (Sec. 1311(d)(4), 1311(c))
- Offer navigators to provide information to the public about health plan choices and help them enroll. (Sec. 1311(i))
- Determine eligibility for subsidy. If people are eligible for Medicaid or CHIP, they must enroll. (Sec. 1311(d)(4)(F), 1411, 1413)
- Certify people who are exempt from insurance mandate and provide information to IRS. (Sec. 1311(d)(4))



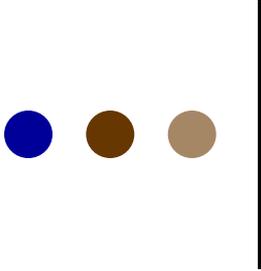
Health Benefit Exchange

- States may:
 - Contract with state Medicaid agencies to determine eligibility for subsidy (Sec. 1311(f), 1413(d))
 - Allow agents or brokers to enroll people into plans and assist people in qualifying for subsidy (Sec. 1312(e))
- If states do not create qualifying HBE, then federal government will assume these responsibilities (Sec. 1321)



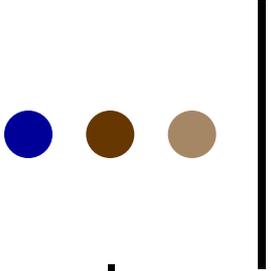
Qualified Health Plans

- Qualified health plans must: (Sec. 1301, 1311, 10104)
 - Provide essential benefits package
 - Be licensed under state law
 - Offer at least one qualified health plan in silver and gold levels in the HBE
 - Agree to charge the same premium rate for each qualified health plan whether or not offered through the HBE
 - Be accredited, report on clinical quality measures, and implement activities to reduce health disparities (including language services)
 - Provide specific plan-related information to enrollees, in plain language



New Insurance Plans Offered through HBE

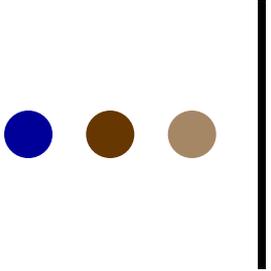
- Secretary shall establish Consumer Operated and Oriented Plan (CO-OP) (Sec. 1322; 10104)
 - Loans and grants to foster creation of non-profit health insurance issuers to offer qualified health plans in individual and small group markets (loans must be paid back within 15 years)
 - Profits must be used to lower premiums, improve benefits or quality
 - Appropriates \$6 billion to support this effort
- Basic Health Plan: States may establish basic health programs for individuals not eligible for Medicaid with incomes <200% FPL (Sec. 1331)
- Multi-state or nationwide qualified health plan, at least one of which is non-profit (Sec. 10104, amending 1334)
 - Through contract with US Office of Personnel Management



Insurance Reform

○ Insurers are required to:

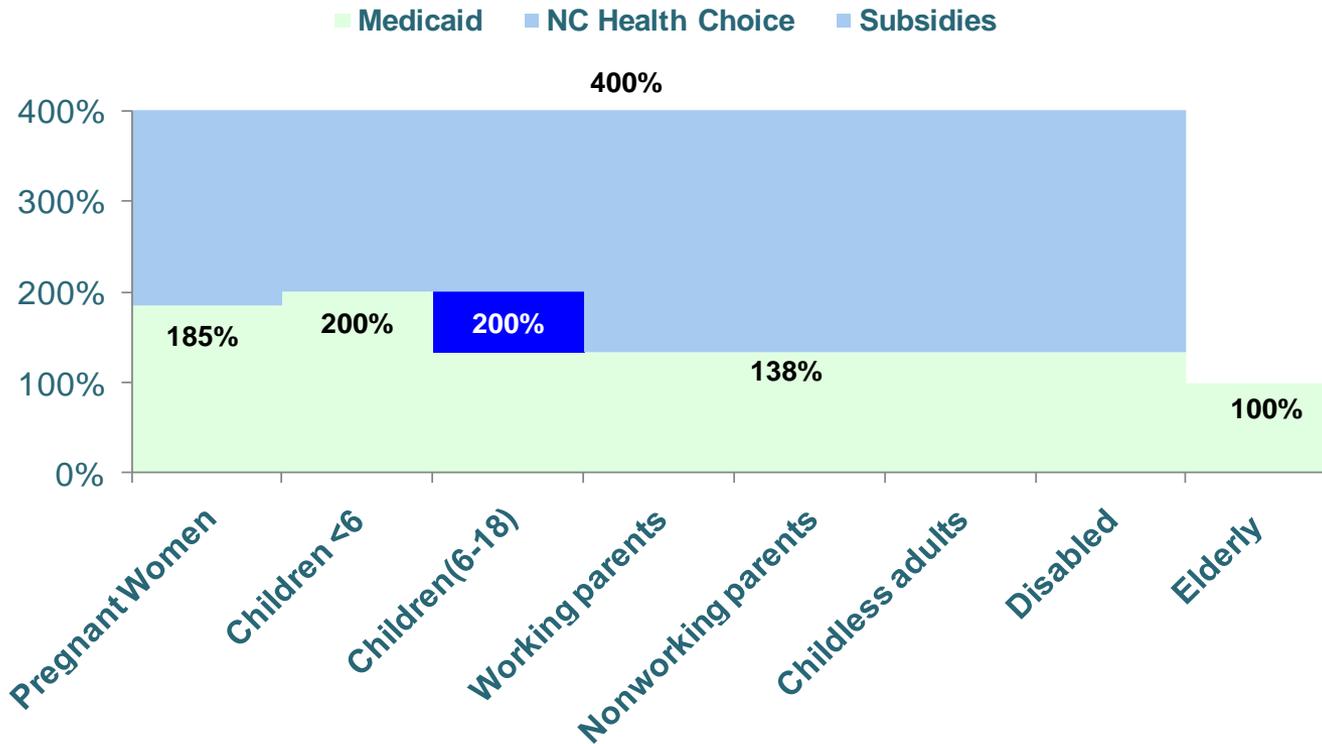
- Enroll any individual or group, and cannot exclude, charge people more, or rescind policies because of preexisting conditions or use of health services (guarantee issue) (Effective 2014; Sec. 1201)
- Limit age adjustment to 3:1, geographic rating area, family composition, and tobacco use (limited to 1.5:1 ratio) in individual and small group market and exchange (Effective 2014; Sec. 1201)
- Have medical loss ratio of no less than 80% for individual plans or 85% for small group plans (Sec. 10101)
- Submit premium rate increases to regulators for review and/or approval if allowed under state law (Sec. 1003)
- Participate in reinsurance program (CY 2014-2016), risk corridors (CY 2014-2016), and risk adjustment for individual and small group markets (Sec. 1341-1343)



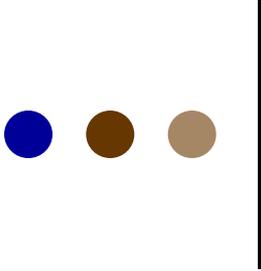
Insurance Reform

- Insurers are prohibited from:
 - Including annual or lifetime limits for essential benefits.
(Sec. 1001, 10101)
 - Imposing a waiting period of more than 90 days.
(Effective Jan, 1, 2014; Sec. 1201)

After Health Reform Fully Implemented (Beginning 2014)

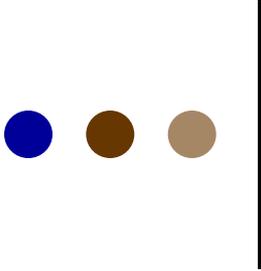


Beginning 2014, most people with incomes $\leq 400\%$ FPL who do not have Medicaid, Medicare, Health Choice, TRICARE, or access to employer-based coverage can qualify for subsidies to purchase insurance in the Exchange



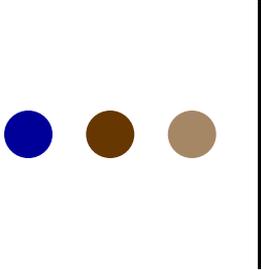
Basics of National Health Reform--Overview

- Overview of health reform legislation
- Immediate implementation
- Changes in public coverage
- Private coverage
- **Other provisions**
 - **Prevention and Wellness; Workforce; Quality and New Models of Care; Safety Net; Long-Term Care; Other Provisions; States' Roles**
- Cost containment and financing
- CBO estimates



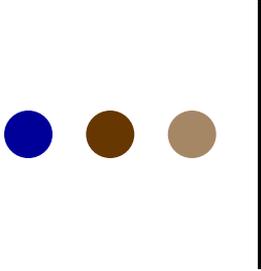
Prevention and Wellness: Overview

- Federal government providing more funding to support prevention efforts at national, state and local levels
 - Grant funds will be made available for prevention, wellness, and public health activities
 - Some of the focus areas include: healthy lifestyle changes, reduction and control of chronic diseases, health disparities, public health infrastructure, obesity and tobacco reduction, improved oral health, immunizations, maternal and child health, worksite wellness



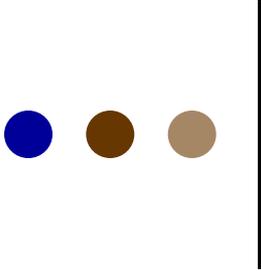
Prevention

- Creates National Prevention, Health Promotion and Public Health Council and task forces on clinical preventive services and community preventive services (Sec. 4001, 4003)
- Appropriated funds for a Prevention and Public Health Fund (\$500M FY 2010-\$2B FY 2015) to invest in prevention, wellness, and public health activities (Sec. 4002)
- Outreach and Education Efforts
 - Public private partnership to support health promotion outreach and education campaign (Authorizes funds not to exceed \$500M, Sec. 4004)
 - 5-year education campaign for oral health (Authorizes sums as necessary, Sec. 4102)



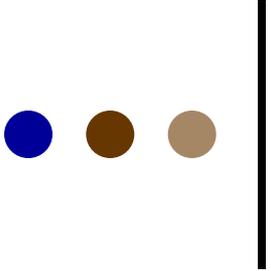
Prevention

- CDC authorized to award competitive grants:
 - Community transformation grants to state and local government agencies and community-based organizations.
 - Activities may focus on healthier school environments, active living communities, access to nutritious foods, chronic disease, worksite wellness, healthy food options, reducing disparities.
(Authorizes funds as necessary, Sec. 4201, 10403)
 - Transfers \$50M to Centers for Medicare and Medicaid Services (CMS) for Healthy Aging grants to states/local health departments to test interventions with Medicare population.
(Authorizes funds as necessary for pre-Medicare, Sec. 4202)
 - Diabetes grants for community-based diabetes prevention model sites.
(Authorizes funds as necessary, Sec. 10501)



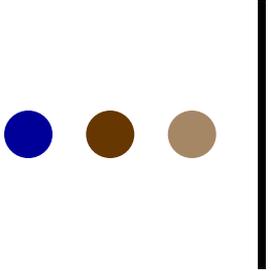
Prevention

- CDC authorized to award demonstration grants
 - Dental caries disease management
(Authorizes funds necessary, Sec. 4102)
 - Authorizes funds as necessary to increase immunization rates for children, adolescents, adults
(Sec. 4204)
- Epidemiology laboratory capacity grants
(Authorizes \$190M in each fiscal year 2010-2013, Sec. 4304)
 - Funding to strengthen epidemiological capacity and implement prevention and control
(Of funds appropriated, not less than \$95M)
 - Funding to not less than \$32M to enhance laboratory practice and report tests electronically
(Of funds appropriated, not less than \$32M)
 - Funds to improve information system
(Of funds appropriated, not less than \$60M)



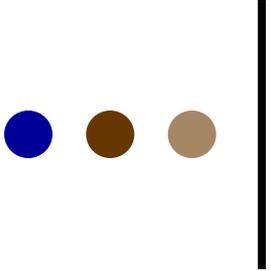
Prevention

- Continuation of Children's Health Insurance Reauthorization Act (CHIPRA) Childhood Obesity Demonstration project: Appropriates \$25M (FY 2010-2014) (Sec. 4306)
- Personal Responsibility Education: Appropriates \$75M in each fiscal year (2010-2014) (Sec. 2953)
 - Each state is eligible for grants of at least \$250,000 for personal responsibility education that includes both abstinence and contraception education and adulthood preparation.
 - At least \$10M shall be allocated for innovative demonstration strategies.
- Restoration of Funding for Abstinence Education: Appropriates \$50M in each fiscal year (2010-2014) (Sec. 2954)



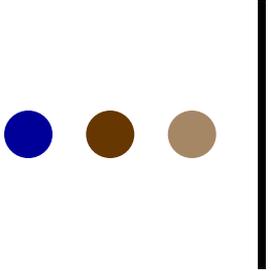
Prevention

- Maternal, infant and early childhood home visiting programs: Appropriated \$100M (2010)-\$400M (FY 2014) (Sec. 2951)
 - Intended to improve maternal and infant health, child development, parent skills, school readiness and academic achievement, family self-sufficiency; and reduce crime, delinquency or domestic violence
- Pregnancy assistance funds for states to assist pregnant and parenting teens and women: Appropriates \$25M for each FY (2010-2019) (Sec. 10211-10214)
 - Can be used to help pregnant and parenting high-school or college students, or improve services for pregnant women who are victims of violence



Prevention

- Research on postpartum depression, and grants to public or nonprofits to operate programs to address postpartum depression (Sec. 2952)
- Centers of Excellence for Depression: up to 30 centers for research, dissemination of evidence-based interventions, training, education of policymakers, employers and community leaders, and improving treatment standards
(Authorizes \$100M each FY 2011-2015, \$150M FY each FY 2016-2020, Sec. 10410)
- Congenital heart surveillance system
(Authorizes funds necessary, Sec. 10411, 10412)
- Young women's breast health awareness and support
(Authorizes \$9M for each FY 2010-2014, Sec. 10413)



Prevention and Wellness

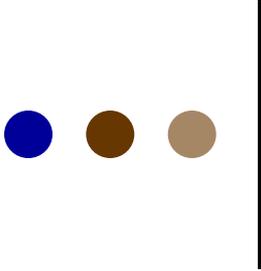
○ Worksite wellness initiatives

- CDC to provide technical assistance (Sec. 4303)
- Grants to encourage *small businesses* to offer wellness programs (Authorizes \$200M FY 2011-2015, Sec. 10408)
- Employers can have wellness programs that include requirements that enrollees satisfy health status factors (i.e., tobacco cessation or weight) if the financial consequences (reward or penalty) do not exceed 30% of the cost of employee-only coverage (or 30% of family coverage if dependents participate)* (Sec. 1201)

○ Employer requirements for breastfeeding employees:

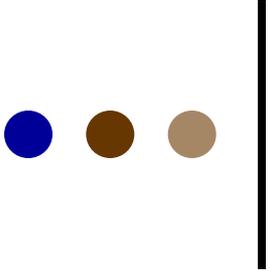
- Employers with 50+ employees must provide break time and a place for breastfeeding mothers to express milk. (Sec. 4207)

* HHS Secretary can authorize similar wellness programs in the individual market in up to 10 states; however, states must show the program will not result in a decrease in coverage.



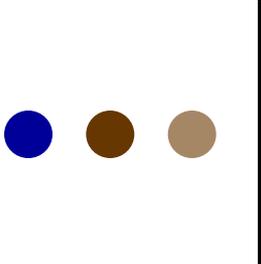
Prevention and Wellness

- Require chain restaurants and food sold from vending machines to provide nutritional content. (Sec. 4205)
 - Applies to chain restaurants with 20 or more locations and to vending machine companies that own/operate 20 or more vending machines
- Research and evaluation
 - Secretary must ensure that all publicly-funded health programs, surveys, and reports collect data on race, ethnicity, sex, primary language, and disability status and that data be collected at the smallest geographic level possible (Authorizes funds necessary Sec. 4302)
 - Funding for research to optimize the delivery of public health services (Sec. 4301)
 - Effectiveness of federal health and wellness initiatives (Sec. 4402)
- Better diabetes care (Sec. 10407)
 - HHS Secretary must prepare a biennial report card on diabetes and pre-diabetes and help collect better vital records on chronic diseases (Authorizes funds as necessary)



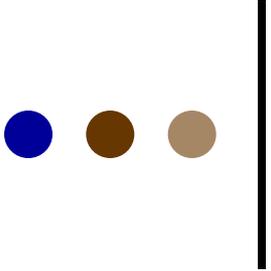
Workforce Overview

- Provisions aim to expand and promote better training for the health professional workforce
 - By enhancing training for quality, interdisciplinary and integrated care and encouraging diversity
 - By increasing the supply of health professionals in underserved areas
 - By offering loan forgiveness and scholarships to train primary care, nursing, long-term care, mental health/substance abuse, dental health, public health, allied health and direct care workforce
- Most of the workforce provisions include *authorizations*, not direct *appropriations*.



Health Care Workforce

- Establishes a National Workforce Advisory Commission and National Center for Health Workforce Development to develop national workforce strategy (Sec. 5101, 10501)
 - Priority study shall include primary care, integrated health care workforce training, impact of HIT on health care workforce, aligning Medicare and Medicaid Graduate Medical Education (GME) with national workforce goals, workforce demands, education, and integration of: nurses, oral health, mental and behavioral health, allied health, public health, emergency medical service workforce
- National Center for Health Care Workforce to provide information to the Commission and to state and regional workforce development centers (Authorizes \$7.5M for National Workforce Center and \$4.5M in each FY 2010-2014 for state and regional centers, Sec. 5103)

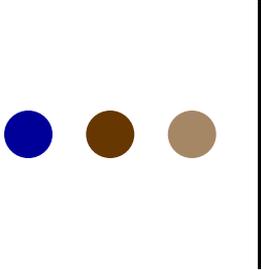


Health Care Workforce

○ State Health Workforce Development grants

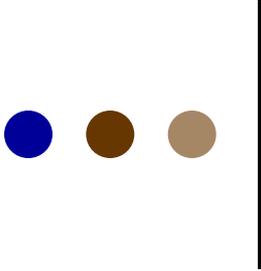
(Sec. 5102)

- States can qualify for \$150,000 in planning grants (for one year) to identify workforce and educational/training needs*
(Authorizes sums necessary)
- States can apply for competitive implementation grants (for 2 years), 60% to be spent on regional partnerships*
(Authorizes sums necessary)



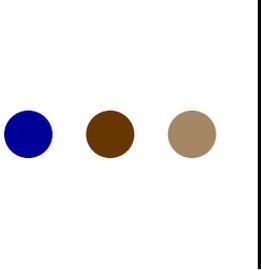
Health Care Workforce: Underserved Areas

- Expansion of National Health Service Corps: Appropriates a total of \$1.5B total over 5 years (FY 2011-2015) (Sec. 5207, 10503)
- Many grant programs offer priority to those applications that plan to work in medically underserved areas (Sec. 5315, 5203, 5205, 5301, 5303, 5306, 5307, 5309, 5403, 5507, 5508, 5606, 10501)
 - Rural physician training grants: Establishes grant program for medical schools to recruit and train students to practice in underserved rural areas (Authorizes \$4M each FY 2010-2013, Sec. 5606, 10501)



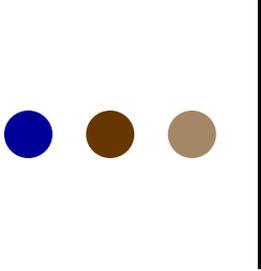
Health Care Workforce: Underserved Areas

- Health professionals serving in underserved areas: Funding to improve retention, enhance practice environment, increase representation of minority faculty (Authorizes \$5M each FY 2010-2014, Sec. 5403)



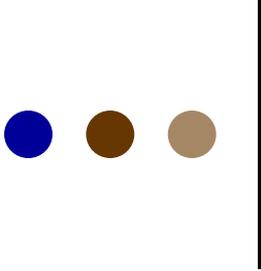
Health Care Workforce: Primary Care

- Federally-supported student loan funds (Sec. 5201, 10501)
 - Eases criteria for students and schools to qualify for loans, shorten payback period, and takes other steps to make loan program more attractive for primary care.
- Primary care: funding to provide grants to schools to develop and operate training in primary care. (Authorizes sums necessary in FY 2011-2014, Sec. 5301)
 - Priority given to programs that educate in team-based approaches, patient-centered medical home, provide training in the care of vulnerable populations, have a track record of training individuals from underrepresented minorities or rural/disadvantaged communities, have formal relationships with FQHCs, AHECs or RHCs; and/or train in cultural competency and health literacy.



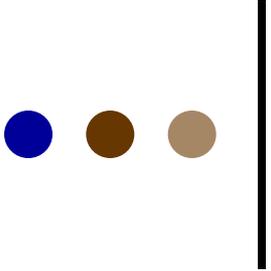
Health Care Workforce: Primary Care

- Primary care extension grants: Funds to educate PCPs about preventive medicine, health promotion, chronic disease management, mental health and substance abuse, evidence-based therapies, and working with community-based health extenders
(Authorizes \$120M in each FY 2011, 2012 and sums necessary in FY 2013-2014, Sec. 5405)
- Family nurse practitioner grants: Demonstration project that supports recent family nurse practitioner graduates in primary care in FQHCs and nurse-managed health clinics (2011-2014)
(Authorizes sums necessary FY 2011-2014, Sec. 10501)



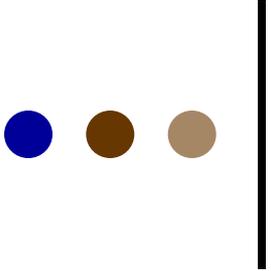
Health Care Workforce: Specialists

- Geriatric Education: Funding to increase training of a broad range of health professionals in geriatrics
(Authorizes \$10.8M for FY 2011-2014 for geriatric education centers, and \$10M for FY 2011-2013 for geriatric career incentive awards, Sec. 5305)
- Pediatric specialty loan repayment program: Funding for pediatric medical and surgical specialists willing to serve in underserved areas
(Authorizes \$30M in each FY 2010-2014, Sec. 5203)



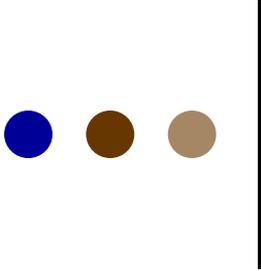
Health Care Workforce: Residencies

- Redistribution of unused GME residency positions
 - Allows hospitals to count the time that a resident is spending in a non-provider setting or at educational conferences as full-time equivalency for that resident
(Sec. 5504, 5505, 10501)
 - Priority to primary care and general surgery programs in states with lowest resident physician-to-population ratio or highest ratio of people living in health professional shortage areas
(Sec. 5503-5506)



Health Care Residencies

- Grants to support primary care residencies in teaching health centers: (Sec. 5508)
 - Provides funding to establish new accredited or expand primary care residency programs
(Authorizes \$50M for FY 2011-2012 and sums necessary thereafter, Sec. 5508)
 - Teaching health centers can include FQHCs, community mental health centers, rural health clinics, Indian health centers, or family planning organizations
 - Appropriates sums necessary up to a total of \$230 million over five years (FY 2011-2015) in graduate medical education to pay for the indirect and direct expenses of teaching health centers to provide the training



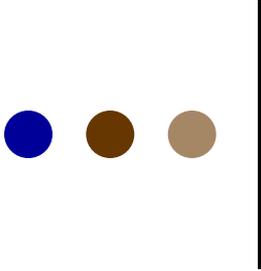
Health Care Workforce: Mental Health

- Child and adolescent mental and behavioral health education loan repayment for service in the fields of psychiatry, psychology, behavioral pediatrics, social work, and family therapy in underserved areas

(Authorizes \$30M in each FY 2010-2014, Sec. 5203)

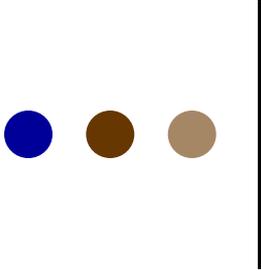
- Mental and behavioral health: Grants to schools to develop, expand, or enhance mental health and substance abuse training for children and adults

(Authorizes \$8M for social work, \$12M for psychology, \$10M for child and adolescent mental health, \$5M for paraprofessional child and adolescent health for FY 2010-2013, Sec. 5306)



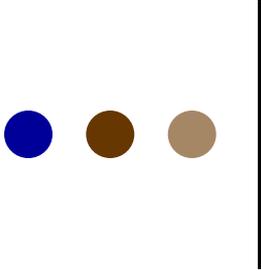
Health Care Workforce: Public Health and Allied Health

- Public health workforce loan repayment program
 - Loans to public health students with agreement to work for at least 3 years in public health agency (Authorizes such sums as are necessary in FY 2011-2015, Sec. 5204)
- Allied health loan repayment for service in professional shortage areas in underserved geographical areas (Sec. 5205)
 - Employment may be with federal, state or local health agencies or in understaffed provider areas (acute care, ambulatory care facilities, personal residences)
- Training for mid-career public and allied health professionals to receive additional training (Authorizes such sums as are necessary FY 2011-2015, Sec. 5206)



Health Care Workforce: Public Health

- Funding to expand public health fellowships
(Authorizes \$39.5M for each FY 2010-2013 for public health, of these funds: \$5M for epidemiology fellowship, \$5M for laboratory science fellowship, \$5M for informatics fellowship, and \$24.5M to expand epidemic intelligence service, Sec. 5314)
- Reauthorizes preventive medicine and public health residency programs
(Authorizes \$43M in FY 2011, and sums necessary thereafter, Sec. 10501)
- Eliminate cap on Commissioned Corps and establishes a Ready Reserve Corps
(Authorizes \$5M for each FY 2010-2014, \$12.5M for each FY 2010-2014; Sec. 5209-5210, 5315)
 - Ready Reserve Corps will serve as emergency or backup support for Commissioned Corps in public health emergencies

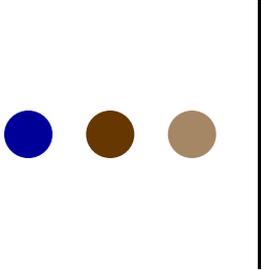


Health Care Workforce: Public Health

○ United States Public Health Sciences Track

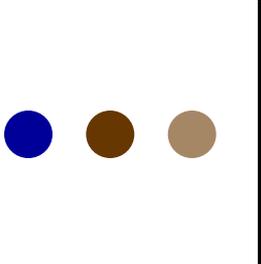
(Secretary shall transfer funds from Public Health and Social Services Emergency Fund as are necessary, Sec. 5315)

- Program to appropriate advanced degrees including curricula with units on team-based service, public health, epidemiology and emergency preparedness
- Aims to graduate 100 students in the dental fields, 250 in nursing, 100 in public health, 100 behavioral and mental health professionals, 100 physician assistants and nurse practitioners, and 20 pharmacy students annually
- Students will receive tuition and stipend by the Surgeon General in return for maintaining designated GPA



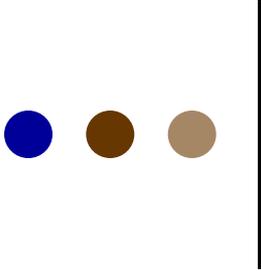
Health Care Workforce: Dentistry

- Grants to institutions to train dentists, dental hygienists, or others for general, pediatric or public health dentistry
(Authorizes sums necessary in FY 2011-2015, Sec. 5303)
 - Grants for: financial aid to students and professionals who plan to teach; meeting costs or improving faculty development in dentistry; creating loan repayment program for faculty; and providing technical assistance to education programs
- Grants to demonstration projects to train alternative dental health care providers in rural and other underserved communities to increase services
(Authorizes funds necessary, each grant for not less than \$4M over 5 years, Sec. 5304)



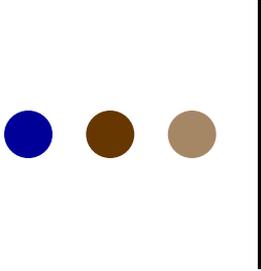
Health Care Workforce: Nursing

- Funding to expand the nursing workforce
(Authorizes sums necessary in FY 2011-2016 for Parts B-D of Title VIII – Advanced Education Nursing, Increasing Nursing Workforce Diversity, Basic Nursing Education and Practice -- of the Public Health Service Act, Sec. 5312)
 - Increases individual loan amounts for nursing student loan program (Sec. 5202)
 - Advance nursing; Nurse education, practice and retention grant; loan repayment and scholarship (Authorizes funds necessary, Sec. 5308-5309)
- Individual loan amounts increased to faculty at accredited nursing schools through the Nurse Faculty Loan program (Authorizes funds necessary, Sec. 5310, 5311)
- Existing nursing diversity grants expanded
 - Now offer student stipends to complete associate degrees, bridge programs, advance degrees
 - May also be used for school preparation and retention purposes (Sec. 5404)



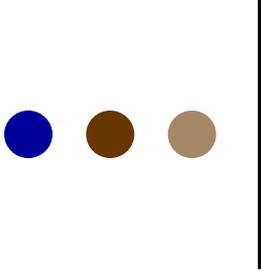
Health Care Workforce: Nursing

- Family nurse practitioner grants:
 - Demonstration projects to support recent family nurse practitioner graduates in primary care in FQHCs and nurse-managed health clinics
(Authorizes sums necessary FY 2011-2014, Section 5316 as added by Sec. 10501)
- Graduate Nurse Education Demonstration
 - Offers payment for up to five hospitals that start qualified clinical training programs for their advanced practice nurses
(Appropriates \$50M for each FY 2012-2015, Sec. 5509)
 - Training to provide primary, preventive, and chronic disease care for Medicare beneficiaries; at least half of training in non-hospital community-based settings



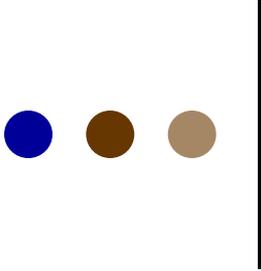
Health Care Workforce: Direct Care Workers

- Direct care workforce: establish new training opportunities for direct care workers in long-term care settings (Authorizes \$10M for FY 2011-2013, Sec. 5302)
- Demonstration projects to provide low-income individuals opportunities for education, training, and career advancement in health professions (Appropriates \$85M in each FY 2010-2014, of which \$5M shall be to develop training and certification programs for personal or home care aides, Sec. 5507)
 - Programs must target Temporary Assistance for Needy Families (TANF) recipients and other low-income individuals
- Elder Justice: Authorizes funding to increase training and support for direct care workers, improve management practices (Authorizes: \$20M FY 2011, \$17.5M FY 2012, \$15M in each FY 2013-2014, Sec. 6703)



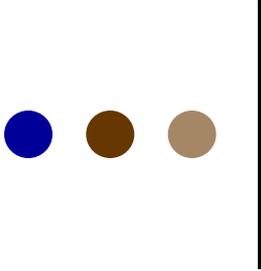
Health Care Workforce: Community Workers

- Patient Navigator Programs. Funding to support patient navigator training programs.
(Authorizes such sums necessary, Sec. 3510)
- Grants for community health workers to promote positive health behaviors in public health departments, free clinics, hospitals or FQHCs
(Authorizes such sums as necessary for FY 2010-2014, Sec. 5313)



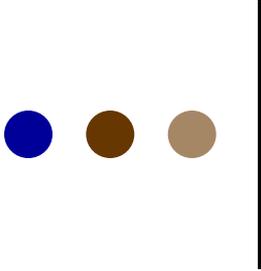
Health Care Workforce: Integrated Quality Care

- Offers grants to institutions to carry out demonstration projects to develop and implement academic curricula that integrates patient safety and quality improvement (Sec. 3508)
- Offers grants to organizations to recruit, train and employ community members as patient navigators (Authorizes such sums necessary; Sec. 3510)
- Offer grants to coordinate quality improvement initiatives through state Hubs whose work will include implementing medical home, disseminating research findings, and sharing best practices (Authorizes \$120M for each FY 2011-2012, and for such sums as necessary from 2013-2014, Sec. 5405)



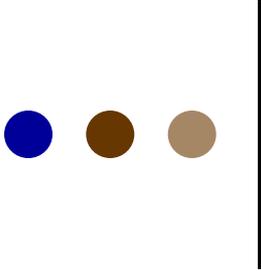
Health Care Workforce: Encouraging Diversity

- Many of the grant provisions give priority to minorities or the medically underserved
- Programs of excellence in health professionals education for under-represented minorities (Authorizes \$50 M in each FY 2010-2015, and sums necessary thereafter for health professional schools, Sec. 5401)
- Increase in the amount of scholarship money available from students of disadvantaged backgrounds for health professions schools (Authorizes such sums as necessary, Sec. 5402)
 - Raises the amount of loan funding available for health professions education for disadvantaged populations (Authorizes a raise for loan repayments and fellowships from \$1.1M to \$5M for each FY 2010-2014, Sec. 5402)
 - Offers \$30,000/ year to full-time students who agree to serve as faculty following graduation (Sec. 5402)



Health Care Workforce: Encouraging Diversity

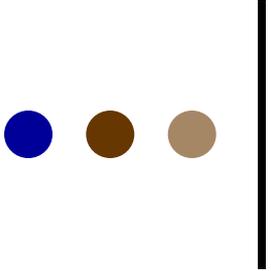
- Interdisciplinary, community-based linkages: Funding for AHECs to recruit and support under-represented minorities; foster community-based interdisciplinary training and education; and prepare individuals to more effectively provide health services to underserved areas and health disparity populations
(Authorizes \$125M for each FY 2010-2014, Sec. 5403)
 - Infrastructure Awards for planning, developing and operating community health education center
 - Point of Service Awards for maintaining and improving existing health education centers
- Grants designated for minority or disadvantaged nurses to enter degree completion programs (Sec. 5404)



Health Care Workforce: Health Disparities

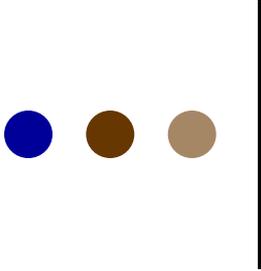
- Grants for institutions to develop curricula for cultural competency, reducing health disparities and disabilities training

(Authorizes such sums as necessary for 2010-2015, Sec. 5307)



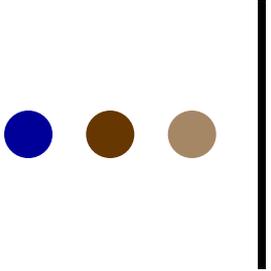
Community College

- Appropriates \$500M for each FY 2011-2014 to community colleges for grants to develop and improve educational or career training programs. (Sec. 1501 of Reconciliation)
 - To create job training programs for dislocated workers and those who may be laid off



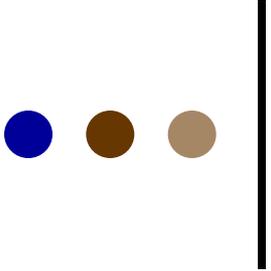
Quality Overview

- Providers and payers will be required to report data to measure quality of care
 - HHS Secretary will develop quality measures for different populations and organizations
 - Data will be made available to the public
 - Increased emphasis on value-based payments to providers and insurers
- Efforts to test new models of care to improve quality and efficiency
 - Patient-centered medical home, accountable care organizations, bundled payments



Quality

- HHS Secretary will establish national strategy to improve health care quality with Interagency Working Group on Health Care Quality (Sec. 3011, 3012)
 - Funding to CMS to develop quality measures (i.e., health outcomes, functional status, transitions, consumer decision making, meaningful use of HIT, safety, efficiency, equity and health disparities, patient experience) (Authorizes \$75M for each FY 2010-2014; Sec. 3013-3014)
 - Secretary must develop health plan reporting standards within 2 years and develop methods to measure health plan value (Sec. 1001, 10329)
 - Plan for the collection and public reporting of quality data (Sec. 3015, 10305, 10331)



Quality

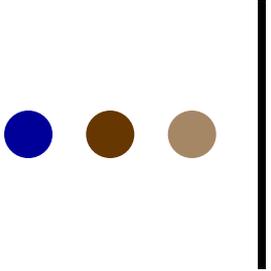
- Development of quality measures:

- Appropriates \$60M for each FY 2010-2014 to develop initial adult health quality measures in Medicaid by Jan. 2012, with annual state reporting requirement (Sec. 2701)
- Funding to Agency for Healthcare Research and Quality (AHRQ) for research to identify and disseminate innovating strategies for quality improvement quality, safety and efficiency of health services (Authorizes \$20M for FY 2010-2014; Sec. 3501)

- Research and treatment for pain care management

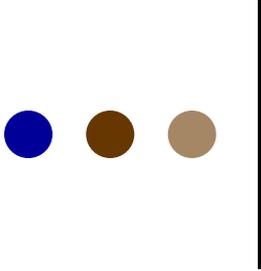
(Sec. 4305)

- Directs the Institute of Medicine and National Institutes of Health to conduct research on pain causes and treatments
- Establishes a grant program to improve health professionals understanding and ability to assess and treat pain



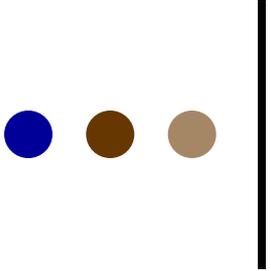
Quality

- Patient-Centered Outcomes Research Institute will establish research priorities and fund comparative effectiveness research: (Sec. 6301)
 - Appropriated \$10M (FY 2010)-\$150M (FY 2012); thereafter money from insurers and self-insured plans shall help support along with appropriations of \$150M in each fiscal year (FY2013-2019)
 - Transfers from Medicare trust fund: \$1/Medicare beneficiary (FY 2013), \$2/Medicare beneficiary (FY 2014)
 - Findings shall be distributed by the AHRQ Office of Communication and Knowledge Transfer



Quality: Hospitals

- Medicare value-based hospital incentive payments based on achievement or improvement for general hospitals (beginning FY 2013) (Sec. 3001, 3004, 3008, 10335)
 - Funded through 1% (FY 2013) to 2% (FY 2017) reductions to diagnosis-related group (DRG) payments for most hospitals
 - Reduction to hospital payments for hospital acquired infections (2015)
 - Data available to the public
- Development of quality standards and general reporting requirement for other hospitals and providers, and testing value-based purchasing (i.e., long-term care hospitals, inpatient rehab hospitals, PPS-exempt cancer hospitals, hospice)
(Sec. 3002, 3004, 3005, 10326)



Quality: Physicians

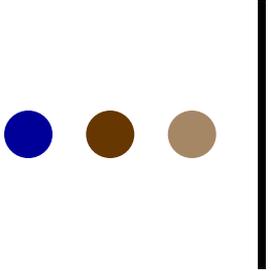
○ Medicare physician reporting requirements

(Sec. 3002, 3003, 3007, 10327)

- Extends incentive payment system for reporting quality measures to CMS through 2014
- Beginning 2014, Medicare payments reduced if providers do not report quality measures
- Some quality information made available to the public
- Risk-adjustment feedback to physicians
- HHS Secretary to develop cost-neutral value-based payment modifier
- Public reporting of physician performance data for those enrolled in Medicare or participating in the Physician Quality Reporting Initiative (Sec. 10331)

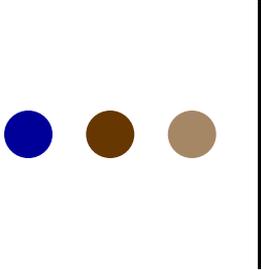
Quality: Other Providers

- HHS Secretary must submit a plan to Congress by October 1, 2011, to: (Sec. 3006)
 - Develop value-based purchasing program for skilled nursing facilities and home health (2012)
 - Reimburse Ambulatory Surgery Centers based on quality and efficiency
- Architectural and Transportation Barriers Compliance Board and FDA must establish standards for accessibility of medical diagnostic equipment for people with disabilities (Sec. 4203)



Quality

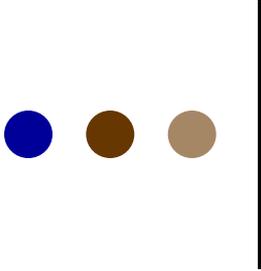
- Funding to AHRQ for research to identify and disseminate innovating strategies for quality improvement quality, safety, and efficiency of health services (Authorizes \$20M for FY 2010-2014; Sec. 3501)



Testing New Models

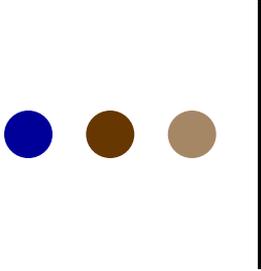
- Center for Medicare and Medicaid Innovation
(Sec. 3021, 10306)

- Some of the new models include: payment and practice reform in primary care (including medical home), geriatric interdisciplinary teams, care coordination and community-based teams for chronically ill individuals, integrating care for dual eligibles, improving post-acute care, Healthcare Innovation Zones, payment reform
- Appropriates \$10 billion to implement models (FY 2011-2019)



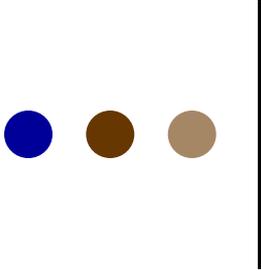
Testing New Models of Care (Medicare)

- Shared savings program with accountable care organizations (Sec. 3022, 10307)
- Demonstration for payment bundling of inpatient and outpatient hospital, physician services, and post-acute services (not later than 2013) (Sec. 3023, 10308)
 - HHS Secretary will develop episode of care grouper (Sec. 3003(a)(4))
- Transfers \$5 million each FY 2010-2015 to CMS to support the Independence at Home Demonstration Program to use physician and nurse practitioner home-based primary care teams to high-risk beneficiaries with two or more chronic illnesses and prior hospitalization and functional dependencies (to begin by Jan. 1, 2012) (Sec. 3024)



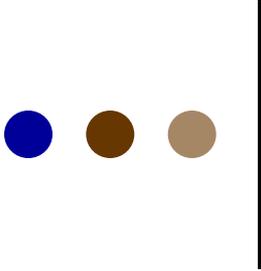
Testing New Models of Care (Medicare)

- Hospital Readmissions Reduction Program (Sec. 3025, 10309)
 - Hospitals will have payments reduced for excess readmissions
 - Programs to improve readmission rates through use of patient safety organizations
- Community-Based Care Transitions Program (Sec. 3026)
 - Transfers \$500 million for the period FY 2011-2015 to CMS to support improved care transition services to high-risk Medicare beneficiaries
 - Focus on high-risk Medicare beneficiaries with chronic illnesses, including cognitive impairment, depression, and history of multiple readmissions



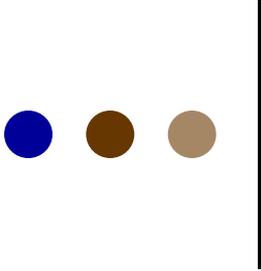
Testing New Models of Care (Medicaid)

- State option: Health homes for people with chronic illness (Sec. 2703)
 - 90% match for payments to health home for eight FY quarters
 - Total amount of payments made to states shall not exceed \$25M
- Bundled payments episodes of care during hospitalizations: up to 8 states demonstration (Effective 2012-2016, Sec. 2704)
- Demonstration to change payments to an eligible safety net hospital system or network from fee-for-service to global capitated payment model: five states (Effective 2010-2012; Authorizes such sums as necessary, Sec. 2705)



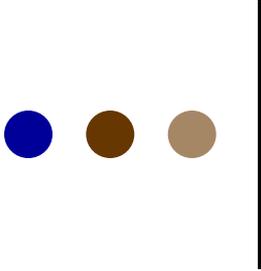
Testing New Models of Care (Medicaid)

- Pediatric accountable care organization shared savings demonstration project
(Effective 2012-2016; Authorizes sums necessary, Sec. 2706)
- Emergency psychiatric demonstration project for up to 3 years (Effective through 2015; Sec. 2707)
 - Payment to private Institutions of Mental Diseases (IMD) for Medicaid eligibles, ages 21-64, who need psychiatric care to stabilize threats to self or others
 - Appropriates \$75 million for FMAP for participating states
- Improved coordination for dual-eligible beneficiaries: 5-year demonstrations (Sec. 2601, 2602)



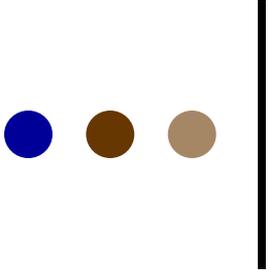
Testing New Models of Care

- Co-location of primary and specialty care in community-based mental health settings.
(Authorizes such sums as necessary in FY 2011-2014; Sec. 5604)
- Community-based interprofessional health teams to support patient-centered medical home: HHS Secretary will establish grants program.
(Authorizes sums necessary, Sec. 3502, 10321)
- Medication management: HHS Secretary shall establish grants or contracts to provide medication management for people with 4 or more medications, high risk medications, and/or chronic diseases to reduce overall costs.
(Authorizes sums necessary, Sec. 3503, 10328)



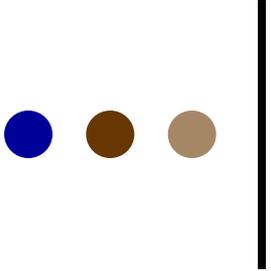
Testing New Models of Care

- Program to facilitate shared decision-making to provide patients, caregivers information on trade-offs among treatment options. (Sec. 3506)
- Hospice Concurrent Care demonstration: Allows individual to receive hospice care and regular services. (Medicare (Sec. 3140), Medicaid children (Sec. 2302))



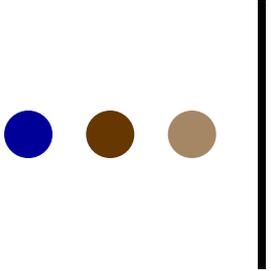
Safety Net

- New funding for community health centers (CHCs)
(Sec. 10503, Sec. 2303 of Reconciliation)
 - Appropriates a total of \$9 billion over five years for operations (\$1 billion in FY 2011 increasing to \$3.6 billion in FY 2015); and \$1.5 billion over five years for construction and renovation of community health centers (FY 2011-2015) (Sec. 10503, Sec. 2303 of Reconciliation)
 - New Medicare prospective payment methodology (Sec. 5502, 10501)
 - Demonstration program in up to 10 CHCs to test individualized wellness plans (Sec. 4206)
- Certified health plans in the Exchanges must contract with essential community providers, if provider agrees to generally applicable rates. (Sec. 1311)



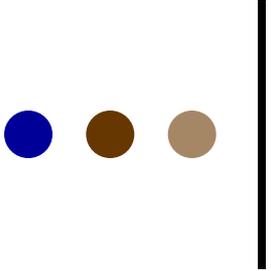
Safety Net

- Appropriates \$50M each FY 2010-2013 to support school-based health centers (Sec. 4101, 10402)
- Appropriates \$1.5 B over 5 years (FY 2011-2015) for National Health Service Corps
(Appropriates \$290M in FY 2011 increasing to \$310 in FY 2015, Sec. 10503; Authorized to be appropriated \$320M in FY 2010 - \$1.2B in FY 2015)
- Grants to support nurse-managed health clinics
(Authorizes such sums as necessary for FY 2011-2014 for Sec. 5208)



Safety Net

- 340B discount drug program expanded to more hospitals (Sec. 7101, as amended Sec. 2302 of Reconciliation)
 - Eligible entities expanded to include: children's hospitals, free-standing cancer hospital, critical access hospital, sole community hospitals
- Support community-based collaborative networks of care (Authorizes such sums as necessary FY 2011-2015; Sec. 10333)
- States may award grants to support health care providers who serve a high percentage of medically-underserved populations. (Sec. 5606, 10501)

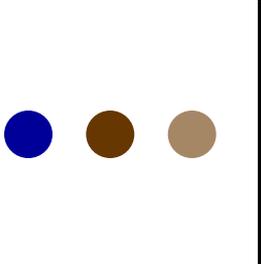


Safety Net

- New requirements for charitable 501(c)(3) hospitals
(Sec. 9007, 10903)
 - Must conduct a community needs assessment and identify an implementation strategy; have a financial assistance policy; provide emergency services; and limit charges to people eligible for assistance to amounts generally billed
- Trauma centers and emergency services
 - Appropriates \$24 million in each FY 2010-2014 for competitive grants for regionalized systems for emergency response
(Sec. 3504)
 - Authorizes \$100 million in each FY 2010-2015 in grants for trauma care centers and to expand service availability (Sec. 3505)
 - Emergency services for children
(Authorized \$25M FY 2010-\$30.4M FY 2014; Sec. 5603)

● ● ● | Long-Term Care (LTC)

- Establishes a national voluntary insurance program to purchase community living assistance services and supports (CLASS) financed through payroll deduction. (Sec. 8001-8002, 10801)
 - Plans provide for a 5-year vesting period and cash benefits of not less than an average of \$50/day to purchase non-medical services and supports
 - Financed through automatic payroll deduction (unless opt-out)
- Nursing Home Compare Medicare website will be expanded to include information on nursing facility staffing, links to state survey data, information about complaints, and criminal violations (March 2011) (Sec. 6103)



Medicaid Long-Term Care Provisions

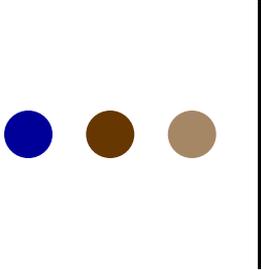
- Community First Choice Option

(Sec. 2401, amended by Sec. 1205 of Reconciliation)

- States can provide home and community-based attendant services and supports to people eligible for Medicaid whose income does not exceed 150% FPL, or higher if they would otherwise need institutional care (Oct. 2011)
- Increase FMAP rate by 6 percentage points for these services

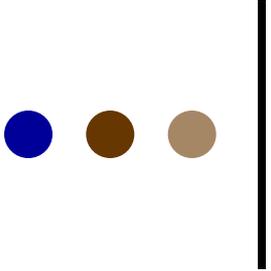
- States can expand full Medicaid services to individuals who are receiving home and community-based services (HCBS) (Sec. 2402)

- Can expand HCBS to individuals with incomes up to 300% Supplemental Security Income (SSI) limits, if otherwise meet the needs standards
- Protections against spousal impoverishment apply to individuals receiving HCBS (CY 2014-2018) (Sec. 2404)



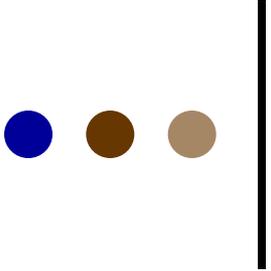
Medicaid Long-Term Care Provisions

- State Balancing Incentive Program: States are eligible for different percentage point increase in their FMAP rates for long-term care services if they increase the percentage of long-term care funds spent on non-institutionally based long-term care services and supports (Sec. 10202)
 - North Carolina may be eligible for a 2 percentage point increase in its FMAP rate
 - Effective October 2011 – September 2015



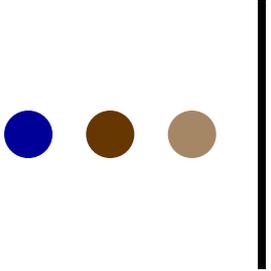
Long-Term Care

- Expansion of state aging and disability resource centers: Appropriates \$10 million in each FY 2010-2014 (Sec. 2405)
- National demonstration projects on culture change and use of information technology in nursing facilities (Authorizes such sums; Sec. 6114)
- Direct care workers must be trained on dementia management and patient abuse prevention (Sec. 6121)
- Establish nationwide background check program for direct care workers (Sec. 6201)



Elder Justice

- Elder Justice: provides greater protection to older adults to be free from abuse, neglect and exploitation, focusing on long-term care. Authorizes funding for: (Sec. 6703)
 - Research (Authorizes \$6.5M FY 2011, \$7M in each FY 2012-2014)
 - Exploitation forensic centers (Authorizes \$4M FY 2011, \$6M FY 2012, \$8M in each FY 2013-2014)
 - Support for direct care workers; improve management practices; and adopt EHRs (Authorizes: \$20M FY 2011, \$17.5M FY 2012, \$15M in each FY 2013-2014)
 - General grants to state adult protective services (Authorizes: \$100M in each FY 2011-2014; authorizes for demonstration programs: \$25M in each FY 2011-2014)
 - LTC ombudsman program (Authorizes for capacity building: \$5M FY 2011, \$7.5M FY 2012, \$10M FY 2013-2014; authorizes for training: \$10M in each FY 2011-2014)
 - Funding to state survey agencies (Authorizes \$5M in each FY 2011-2014)

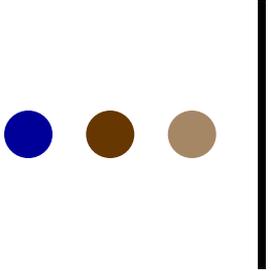


Malpractice

- State demonstration programs to evaluate alternatives to medical tort litigation

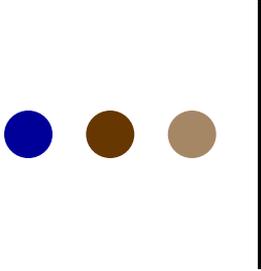
(Authorizes \$50M for FY 2011-2015; Sec. 6801, 10607)

- States can seek \$500,000 for planning grants to develop demonstration project
- Extension of medical malpractice coverage to free clinics (Sec. 10608)



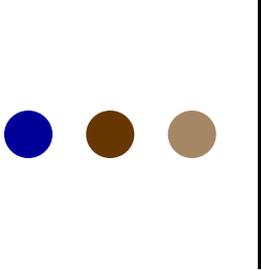
Other Provisions

- Minority health (Sec. 10334)
 - Office of Minority Health transferred to the Office of the HHS Secretary and new offices of minority health appointed in CDC, HRSA, CMS, SAMHSA, AHRQ, FDA
 - HHS Secretary will designate proportion of each agencies budget for minority health purposes
- Women's health (Sec. 3509)
 - Office of Women's Health established in CDC, HRSA, AHRQ, FDA



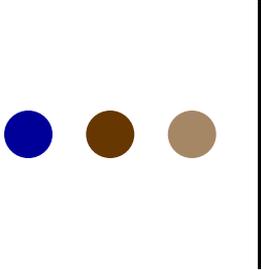
States Roles

- States would be required to:
 - Expand Medicaid to cover new eligibles and facilitate enrollment for eligibles. (Sec. 1413, 2001, 2201)
 - Create and operate new health benefit exchange for individuals and small group. (Sec. 1311-1324)
 - Oversee insurance plans to make sure insurers meet new insurance regulations (i.e., consumer protections, rate review, market regulations, premium taxes).
 - States can form health care choice compacts to facilitate the purchase of individual insurance across state lines. (Sec. 1333)



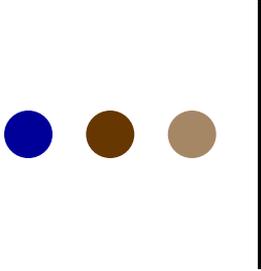
Basics of National Health Reform--Overview

- Overview of health reform legislation
- Immediate implementation
- Changes in public coverage
- Private coverage
- Other provisions
- **Cost containment and financing**
 - **Cost containment**
 - **New revenues**
- CBO estimates



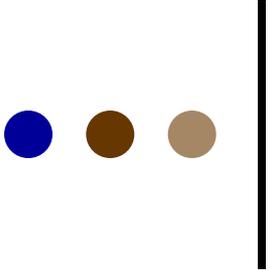
Cost Containment & Financing

- Reduction in existing health care costs through:
 - Increased emphasis on: reducing fraud & abuse, administrative simplification, reducing excess provider/insurance payments
- Increased revenues through:
 - Fees paid by individuals/employers for failure to have/offer insurance
 - Taxes/fees on insurers, pharmaceuticals, tanning salons, “Cadillac” insurance plans, wealthier individuals



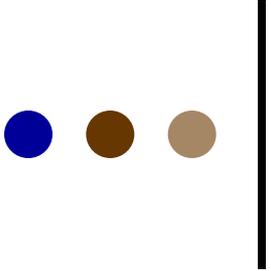
Cost Containment

- \$10 million appropriated for each FY 2011-2020 to support more aggressive efforts to eliminate fraud and abuse and recover overpayments
(Secs. 1313, 1323, 1324, 6401-6403, 6406-6408, 6411, 6501-6502, 6504, 6506, 6601-6607, 8002, 10605-10606, and Sec. 1301-1304 of Reconciliation)
- Bills would simplify health insurance administration, implement health information technology, and include changes to provider payments to encourage efficiency and quality (Sec. 1104)
- Additional Medicaid drug rebates
(Sec. 2501; as amended Sec. 1206 of Reconciliation)



Cost Containment

- Phase out extra Medicare and Medicaid payments to hospitals (disproportionate share hospital payments) as the numbers of uninsured decrease (Sec. 2551, 3133, 10201, 10316, Sec. 1104, 1203 of Reconciliation)
- Reduces payments to hospitals for hospital-acquired infections and excess readmissions, and makes changes to market-basket updates (Sec. 2702, 3008, 3025; Sec. 1105 of Reconciliation)
- Reduces payments to Medicare Advantage plans (Effective 2012, Medicare Advantage provisions amended in Sec. 1102, 1103 of Reconciliation)



Financing

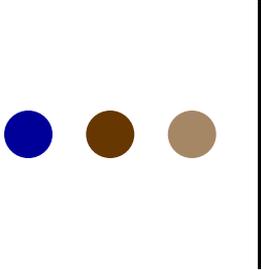
- Some of the financing is available through:
 - New taxes for people without qualifying coverage (unless exempt) and large employers who do not provide coverage
 - Limits on contributions to flexible savings arrangements (\$2,500/year)(2013) and increase on tax on distributions from Health Savings Accounts (HSAs) that are not used for health expenses
(Limit on contributions to FSAs effective 2013, excise tax for nonqualified distributions to HSAs. Sec. 9004-9005, 10902, amended by Sec. 1403 of Reconciliation)
 - Increased threshold for itemized deductions from 7.5% to 10% of adjusted gross income (seniors maintain 7.5% threshold until 2017) (Sec. 9013)

Financing (cont'd)

- Increased taxes/fees on certain health sector and tanning services (pharmaceuticals, durable medical equipment (DME), insurers, etc.) (Fees for insurers effective Jan. 1, 2014 for premiums in 2013; pharmaceutical companies effective 2011 for sales 2010; DMEs effective to sales beginning 2013. Sec. 9008-9010, 9014, 9017, 10904-10905, 10907 amended in Sec. 1404-1406 of Reconciliation)
- Eliminates the employer deduction allowed for prescription drug coverage offset by Part D subsidy provided to retirees (Effective 2013, Sec. 9012, amended by Sec. 1407 of Reconciliation)
- Increases Medicare Part A tax on wages from 1.45% to 2.35% on earnings above \$200,000 for individuals and \$250,000 for married couples and 3.8% tax on unearned income for higher-income individuals (Effective 2013, Sec. 9015, 10906, amended by Sec. 1402 of Reconciliation)
- Imposes excise tax on insurers of employer-sponsored plans that exceed \$10,200 for individual coverage and \$27,500 for family coverage (effective 2018)* (Sec. 9001, 10901, amended by Sec. 1401 of Reconciliation)

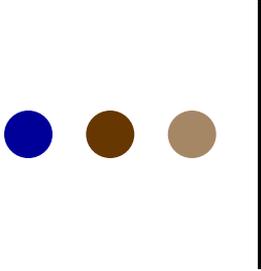


*Higher threshold for people in high-risk professions or retirees: \$11,850/\$30,950; excludes stand-alone dental and vision plans (dollar thresholds are indexed to inflation).



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CBO Estimates of Coverage and Costs

- Covers 92% of all nonelderly residents (94% of legal, nonelderly residents)
 - Would cover an additional 32 million people (leaving 23 million nonelderly residents uninsured by 2019)
- Expansion of insurance coverage and new appropriations included in PPACA will cost \$938 billion over 10 years
 - However, with new revenues and other spending cuts, PPACA estimated to reduce the federal deficit by \$124 billion over 10 years.

PPACA: Summary

Costs

PPACA creates the infrastructure, but does less to immediately reduce health care cost escalation. The legislation begins to change the way health care is delivered and providers are reimbursed to reduce unnecessary care. PPACA also reduces fraud and abuse, administrative overhead, and excess costs currently in the system.

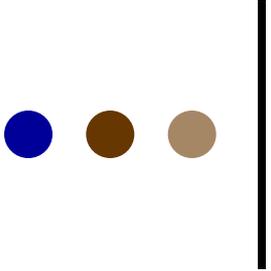
Access

PPACA significantly increases access by providing more affordable insurance to most people and expanding the safety net. The bill includes some provisions to increase provider supply.



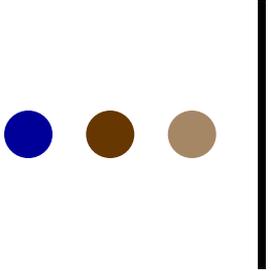
Quality

PPACA improves quality by investing in: prevention, comparative effectiveness research, and the development of quality outcome measures. PPACA also requires data reporting, will provide information to the public, and pay providers and insurers for improved quality.



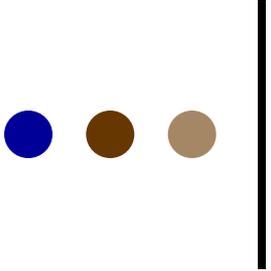
Other NCIOM Resources

- NCIOM's Interim Report on the Implementation of the Patient Protection and Affordable Care Act in North Carolina (2011). Available at:
<http://www.nciom.org/publications/?implementation-of-the-patient-protection-and-affordable-care-act-in-north-carolina>
- Other resources on health reform are available at:
<http://www.nciom.org/task-forces-and-projects/?aca-info#pres>.



Useful Resources

- Patient Protection and Affordable Care Act
<http://www.nciom.org/wp-content/uploads/2010/09/Consolidated-PPACA.pdf>
- Kaiser Family Foundation
<http://www.kff.org/healthreform/upload/8061.pdf>
- Congressional Budget Office
<http://www.cbo.gov/doc.cfm?index=12119>
- Internal Revenue Service (IRS) ACA Tax Provisions Information
<http://www.irs.gov/newsroom/article/0,,id=220809,00.html>



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