

Understanding National Health Reform:

Focus on Health Professionals

Prepared by
North Carolina Institute of Medicine

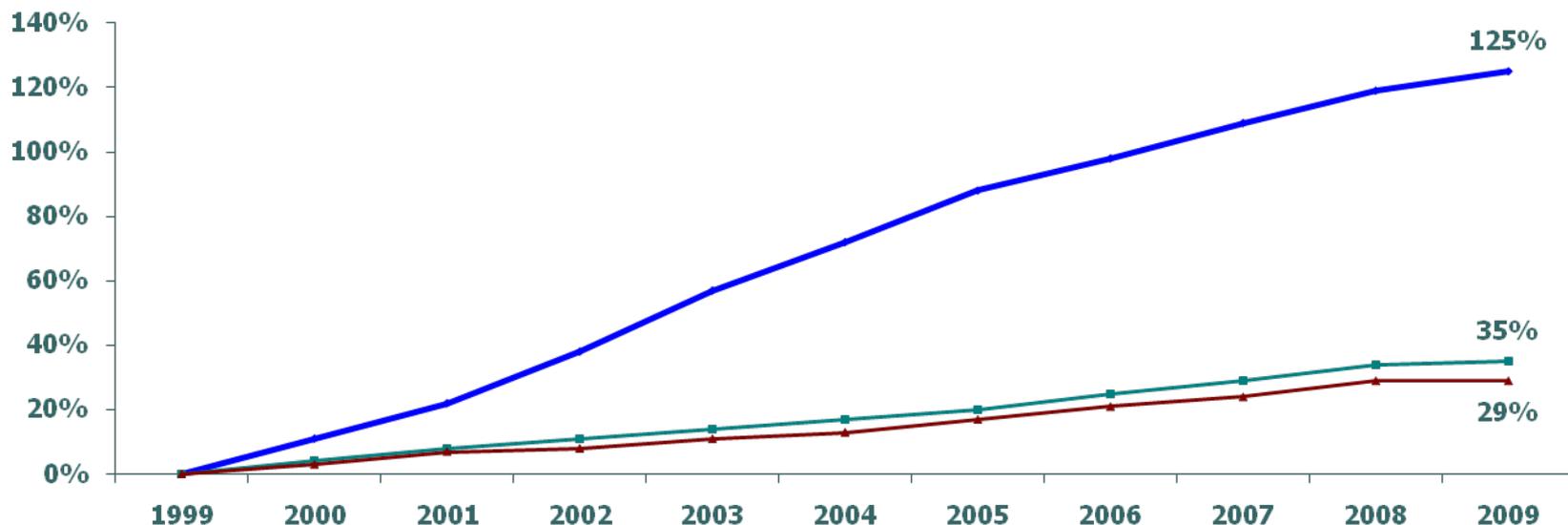
Background

- Estimates of the uninsured (2009):
 - 2009 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



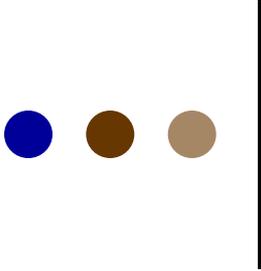
Source: NCIOM. Health Care Costs and Insurance Coverage in Five Southern States. Data Snapshot. 2009-3. North Carolina's Increase in the Uninsured: 2007-2009; US Census, Historical Health Insurance Tables. HI6.

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



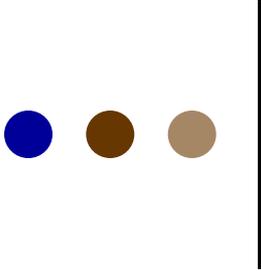
Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2000-2008. Bureau of Labor Statistics, Consumer Price Index, U.S. City Average of Annual Inflation (April to April), 2000-2008; Bureau of Labor Statistics, Seasonally Adjusted Data from the Current Employment Statistics Survey, 2000-2008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





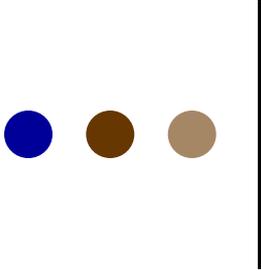
Legislation

- 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
- Changes in public coverage
- Private coverage
- Other provisions
- Cost containment and financing
- Congressional Budget Office (CBO) estimates

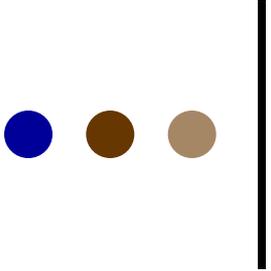


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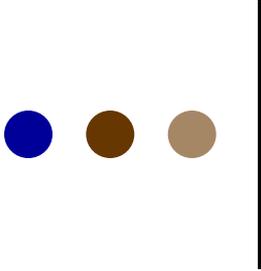
Overview of Health Reform

- 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

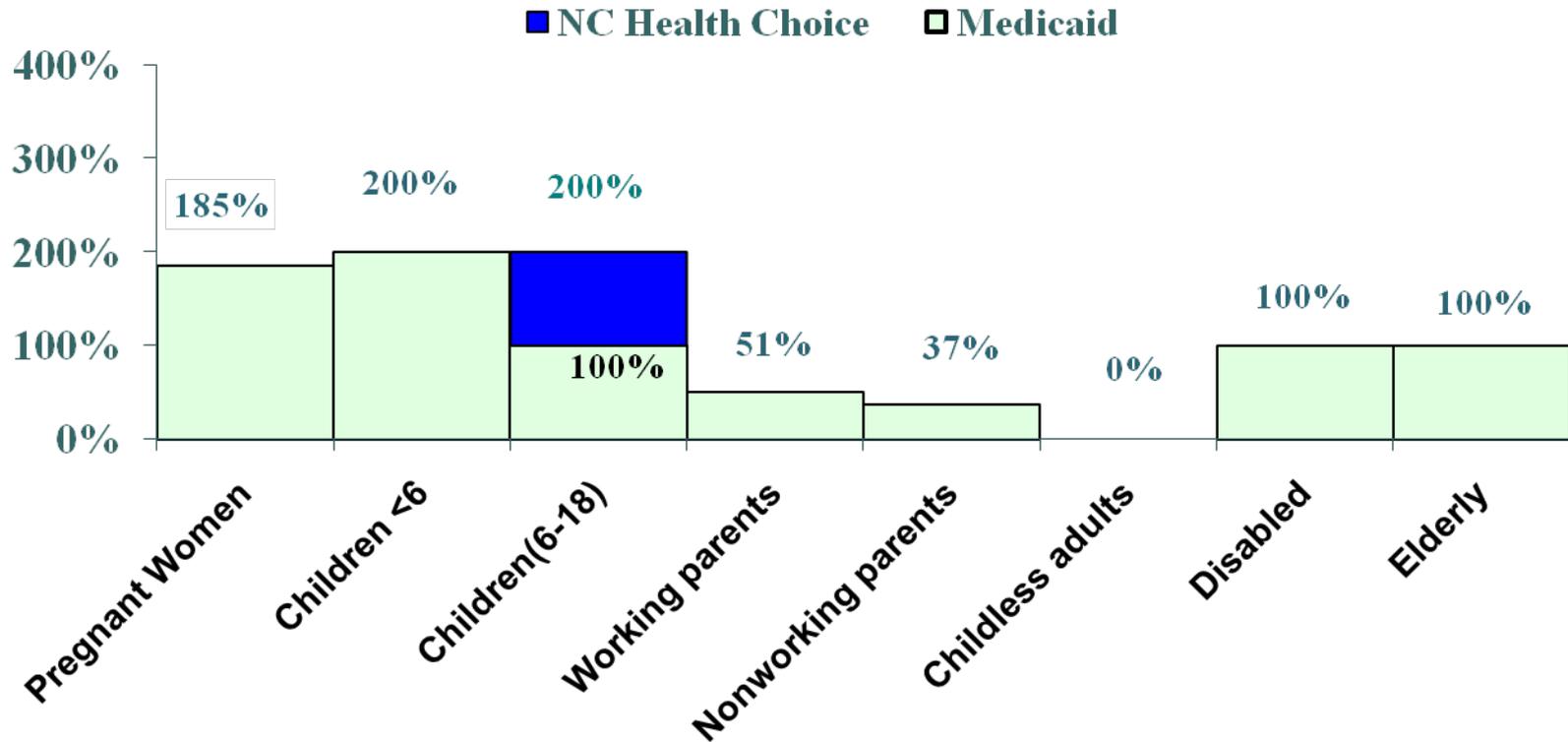
- Insurance reform to:
 - Cover more people and make it more affordable to many
 - Cover preventive services and essential health benefits
- New funding appropriated for:
 - Health promotion and wellness initiatives
 - Expansion of the safety net and National Health Service Corps
- New funding authorized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

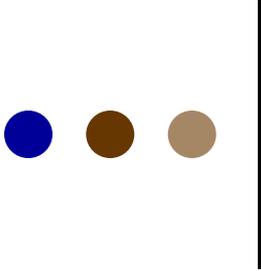


Basics of National Health Reform--Overview

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



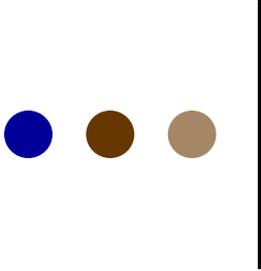


Expansion of Public Programs

- 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

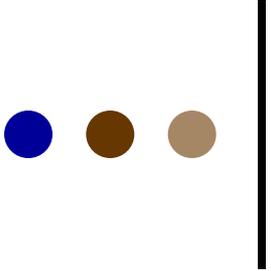


Enhanced Federal Match for Medicaid Expansion

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

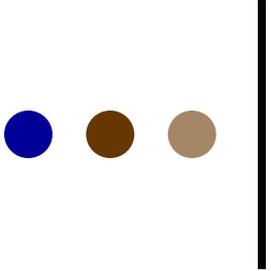
(Sec. 2001(3), amended Sec. 1201 Reconciliation)

- 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

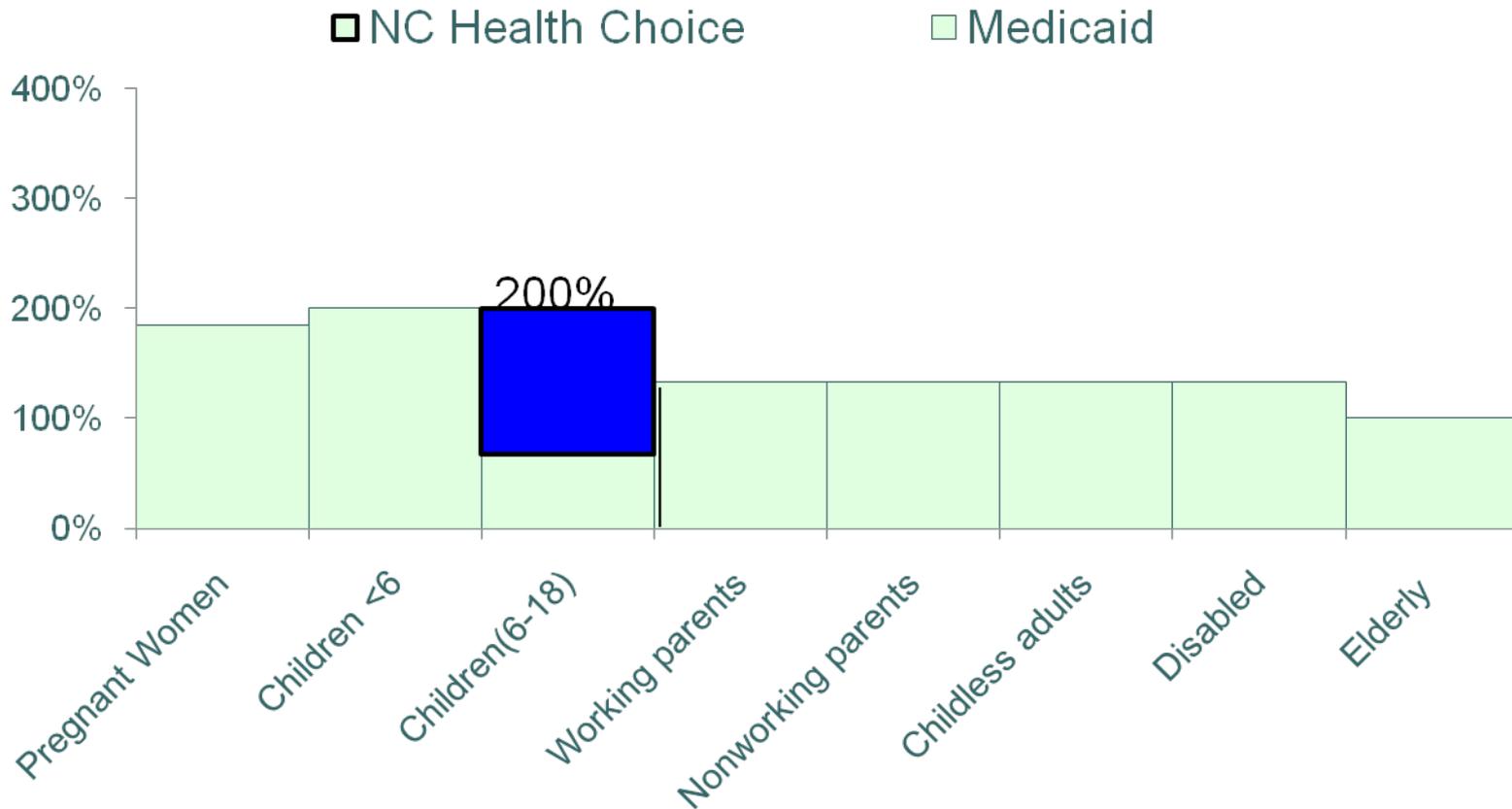
- All newly eligible adults will be guaranteed a benchmark benefit package that includes essential health benefits (Sec. 2001(a)(2))
- States may cover adult preventive services (Effective Jan. 1, 2013; Sec. 4106)
 - Increased Federal Medical Assistance Percentage (FMAP) by one percentage point if state covers all recommended immunizations and preventive services for adults
- States will be required to simplify enrollment and coordinate between Medicaid, CHIP and the new Health Benefit Exchange (Sec. 2201; 1413)

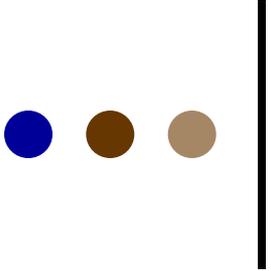


CHIP (NC Health Choice)

- 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 \$40 million
(2009-2015)
(Sec. 10203)

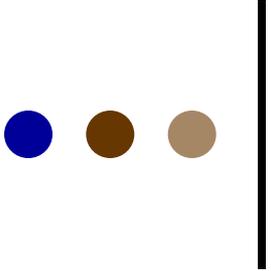
After Health Reform Fully Implemented (Beginning 2014)





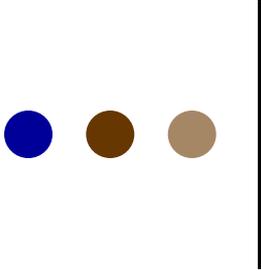
Medicare

- 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 (Sec. 3301)



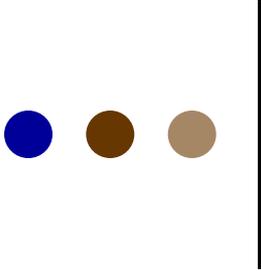
Medicare

- Increases Medicare payments:
 - 10% bonus payment to primary care physicians and general surgeons practicing in health professional shortage areas (2011-2015) (Sec. 5501, 10501)
- 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



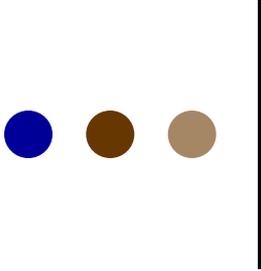
Medicare

- Appropriates \$15 million increased by 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 is unsustainable, Board's proposals will take effect unless Congress passes alternative proposal
 - Cannot enact proposals to ration care, raise taxes or Part B premiums, change benefits, eligibility or cost-sharing, reduce premium supports



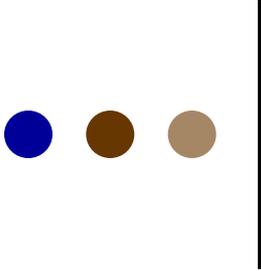
Basics of National Health Reform--Overview

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



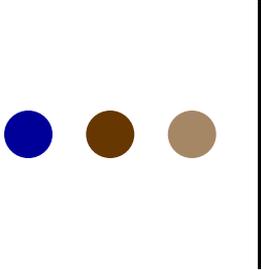
Essential Benefits Package

- 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*



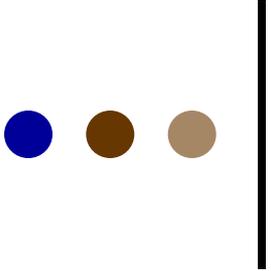
Essential Benefits Package

- 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 and hearing services for children under age 21 (Sec. 1001, 1302)
 - Plans must cover preventive services recommended by the 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))



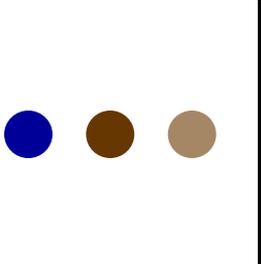
Essential Benefits Package

- Four levels of plans, all must cover essential benefits package: (Sec. 1302(d))
 - Bronze (minimum creditable coverage): must cover 60% of the benefit costs of the plan
 - **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)



Individual Mandate

- Citizens and legal immigrants will be required to pay penalty if they do not have qualified health insurance, unless exempt. (Sec. 1312(d), 1501, amended Sec. 1002 in Reconciliation)
 - 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).
 - Some of the exemptions include people who are not required to file taxes, and those for whom the lowest cost plan exceeds 8% of an individual's income (Sec. 1501(d)(2)-(4),(e))



Subsidies to Individuals

- Refundable, 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 by Sec. 1001 of Reconciliation)
 - Legal immigrants who are barred from Medicaid (during first 5 years) are eligible for premium credits
 - 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)



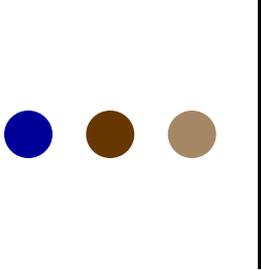
***2011 Federal Poverty Levels are: \$10,890 for an individual, or \$22,350 for a family of four.**

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 limit)
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 ^{rds} 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)

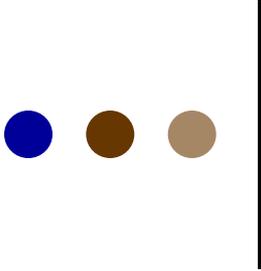


Employer Responsibilities

- 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 insurance exchange
 - Employer penalty only for full-time employees, not dependents

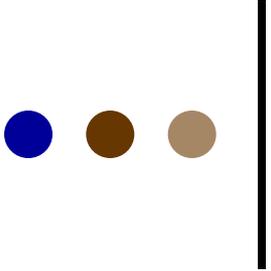
Employer Responsibilities

- 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))



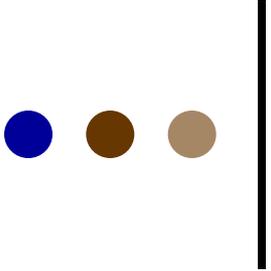
Subsidies for Small Employers

- 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-later):* 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)
 - Exchanges will provide standardized information to help consumers choose between plans and develop rating system based on quality and cost, determine eligibility for subsidy, and help individuals enroll in Medicaid or CHIP (if appropriate). (Sec. 1311, 1411, 1413)
 - 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))



Insurance Reform

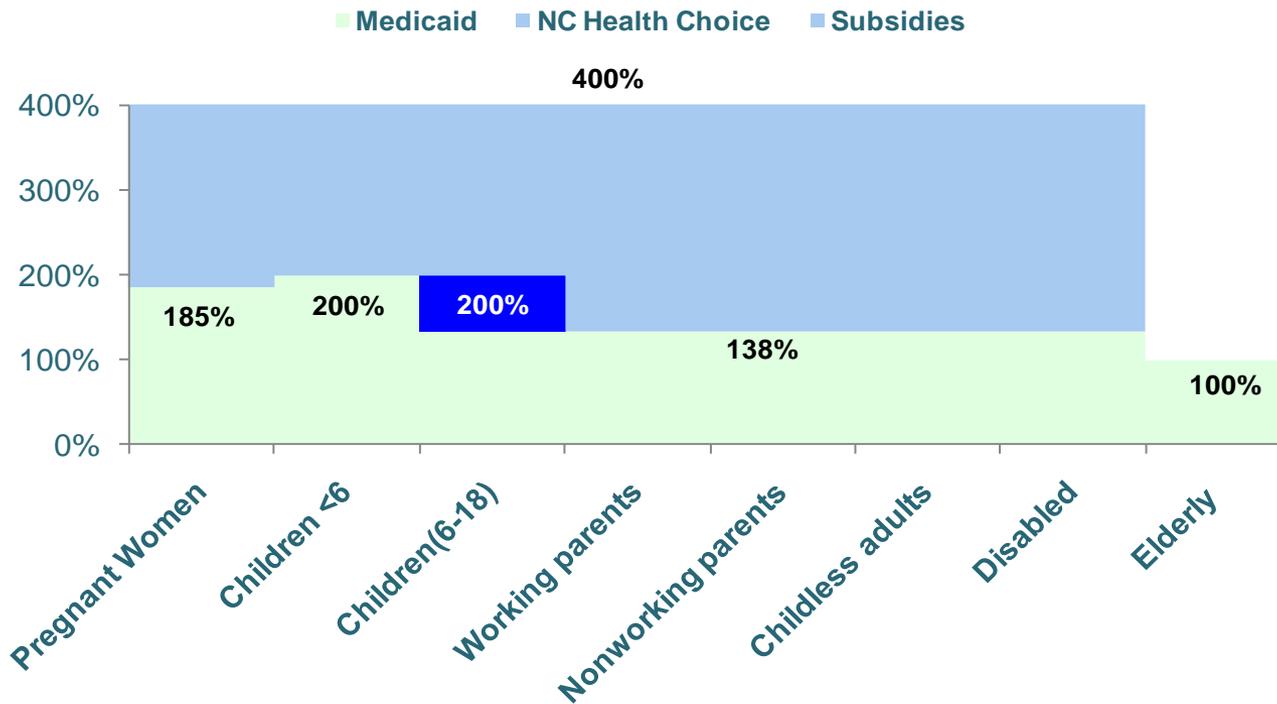
○ Insurers are required to:

- 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)
- Submit premium rate increases to regulators for review and/or approval if allowed under state law (Sec. 1003)

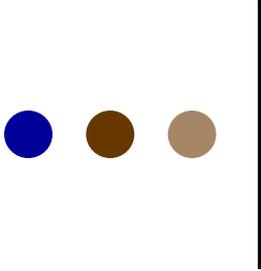
○ Insurers are prohibited from:

- 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)

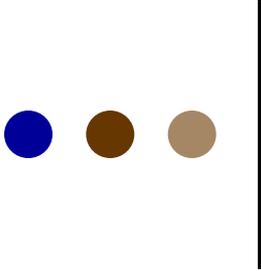


Beginning 2014, most people with incomes $\leq 400\%$ FPL who do not have Medicaid, Medicare, Health Choice, TRICARE, or access to employer-based coverage can qualify for subsidies to purchase insurance in the Exchange



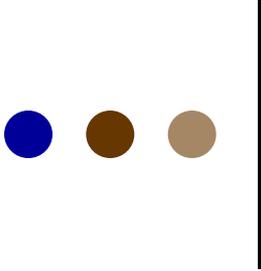
Basics of National Health Reform--Overview

- Overview of health reform legislation
- 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



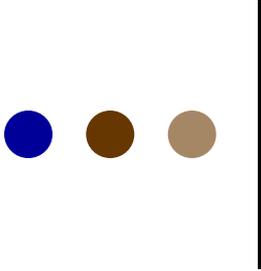
Prevention and Wellness: Overview

- 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



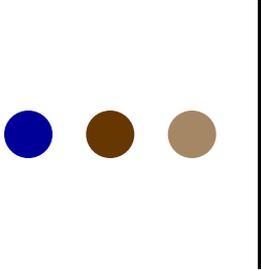
Workforce Overview

- 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*.



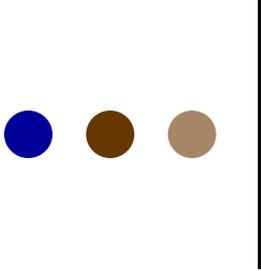
Health Care Workforce: Governance

- 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)



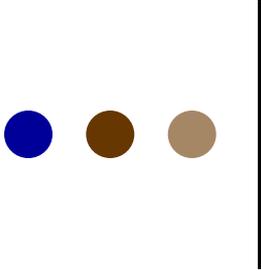
Health Care Workforce: Governance

- 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 to medical schools to recruit and train students to practice in underserved rural areas (Authorizes \$4M each FY 2010-2013, Sec. 5606, 10501)

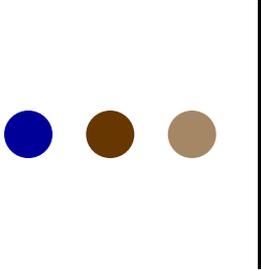


Health Care Workforce: Underserved Areas

- 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)

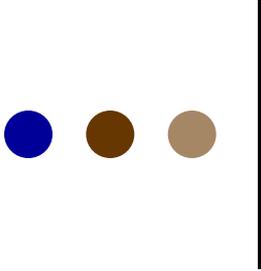
Health Care Workforce: Primary Care

- Federally-supported student loan funds (Sec. 5201, 10501)
 - Eases criteria for students and schools to qualify for loans, shortens 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.



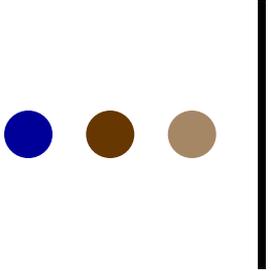
Health Care Workforce: Primary Care

- Primary care extension grants: Funds to educate primary care providers 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 projects to support 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)



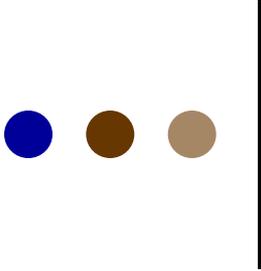
Health Care Workforce: Specialists

- 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)



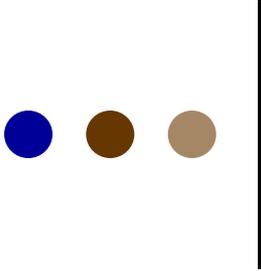
Health Care Workforce: Residencies

- 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)



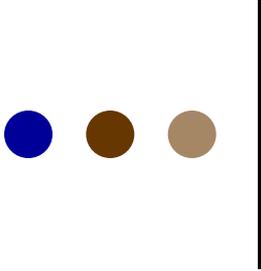
Health Care Workforce: Residencies

- 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 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 with an upper limit of \$230 million over 5 years (FY 2011-2015) to fund the indirect and direct expenses of teaching health centers to provide graduate medical education training



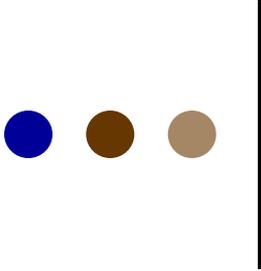
Health Care Workforce: Mental Health

- 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)



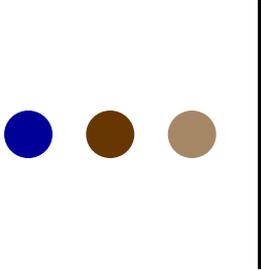
Health Care Workforce: Public Health and Allied Health

- 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

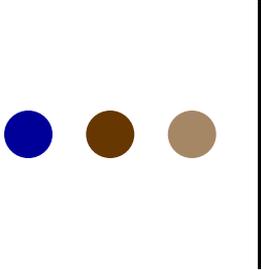


Health Care Workforce: Public Health

○ United States Public Health Sciences Track

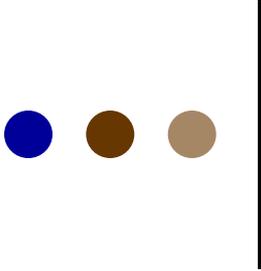
(Secretary shall transfer funds from Public Health and Social Services Emergency Fund as are necessary, Sec. 5315)

- 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.



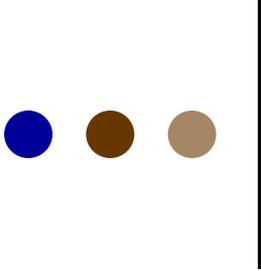
Health Care Workforce: Dentistry

- 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
- Demonstration grants 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)



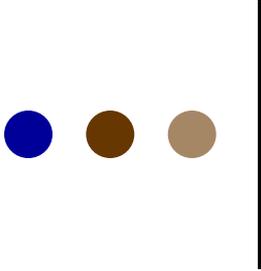
Health Care Workforce: Nursing

- **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)



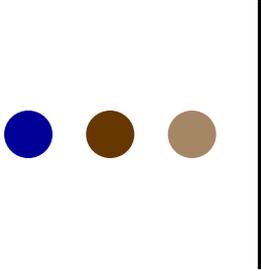
Health Care Workforce: Nursing

- 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



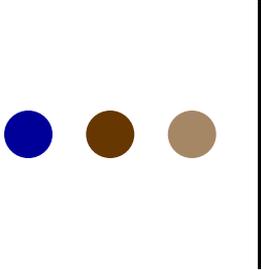
Health Care Workforce: Direct Care Workers

- 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 Act: 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)



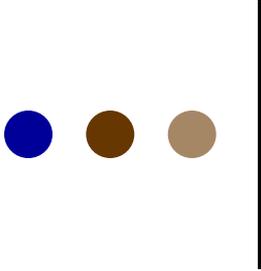
Health Care Workforce: Community Workers

- Patient Navigator Programs: Funding to support patient navigator training programs.
(Authorizes such sums as 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,)



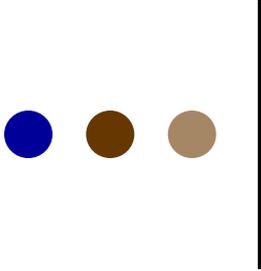
Health Care Workforce: Integrated Quality Care

- 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 as needed; Sec. 3510)
- Offers 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)



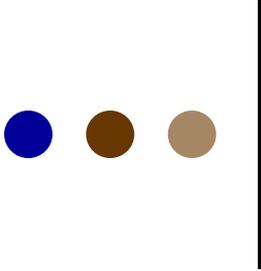
Health Care Workforce: Encouraging Diversity

- 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 \$50M 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

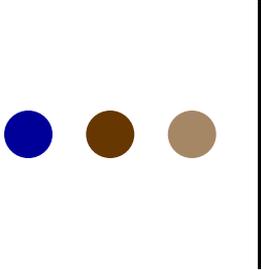
- Interdisciplinary, community-based linkages: Funding for AHECs to recruit and support under-represented minorities; foster community-based interdisciplinary training and education; and prepare individuals to more effectively provide health services to underserved areas and health disparity populations
(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

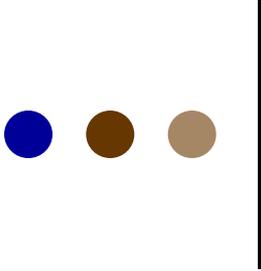
- Grants to institutions to develop curricula for cultural competency, reducing health disparities and disabilities training

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



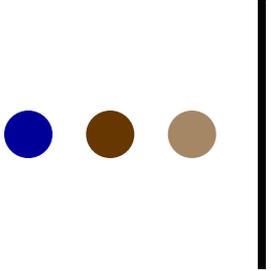
Health Care Workforce: Community Colleges

- Appropriates \$500M for each FY 2011-2014 in grants to community colleges 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

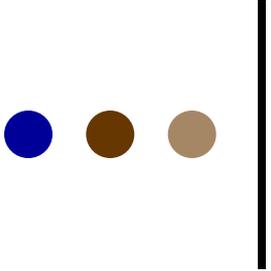
- HHS Secretary will establish national strategy to improve health care quality with Interagency Working Group on Health Care Quality (Sec. 3011, 3012)
 - Funding to CMS to develop quality measures (i.e., health outcomes, functional status, transitions, consumer decision making, meaningful use of HIT, 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

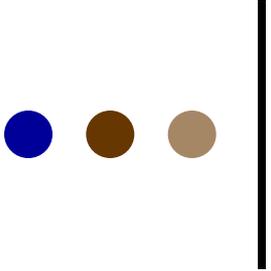
- Development of quality measures:

- 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)



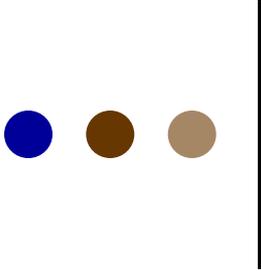
Quality

- 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



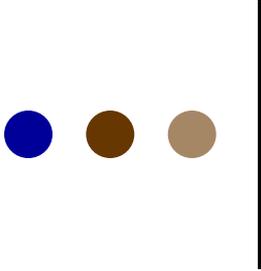
Quality: Physicians

- 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
 - 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)



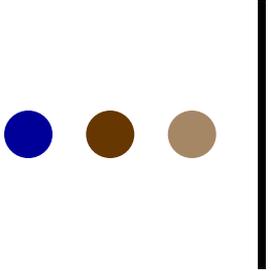
New Models Overview

- Efforts to test new models of care to improve quality and efficiency
- 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)



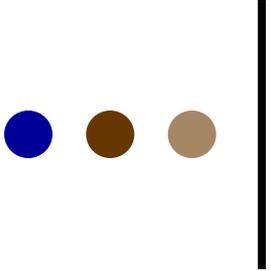
Safety Net Overview

- New funding for safety net organizations
 - Includes new appropriations for community health centers and school-based health centers
 - Funding for National Health Service Corps to place providers in underserved communities
 - Regional emergency systems
- Funding authorized, but not appropriated for other safety net organizations
- 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



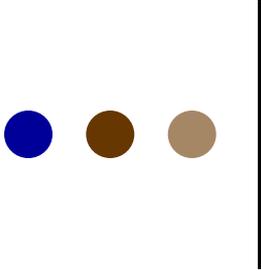
Long-Term Care

- 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)
- New Medicaid options to expand home and community-based services



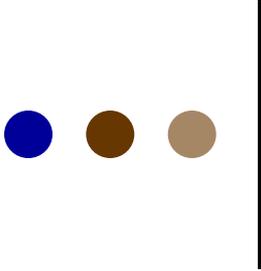
Malpractice

- 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)



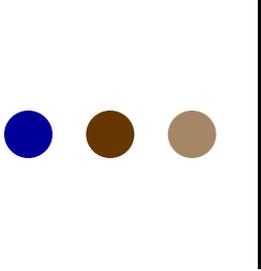
Basics of National Health Reform--Overview

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



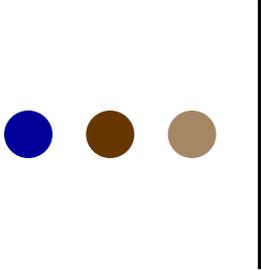
Cost Containment & Financing

- 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



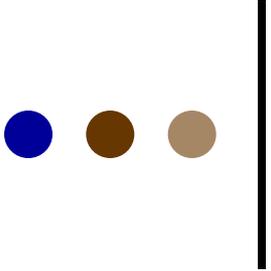
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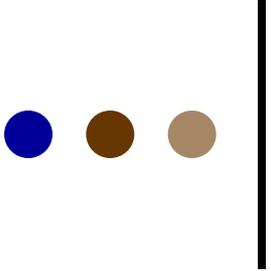
CBO Estimates of Coverage and Costs

- 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 is estimated to reduce the federal deficit by \$124 billion over 10 years.



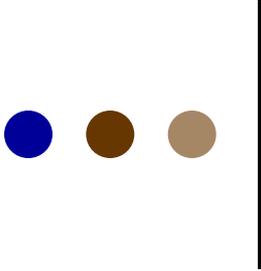
Other NCIOM Resources

- 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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