

Understanding National Health Reform:

Focus on the Safety Net

Prepared by
North Carolina Institute of Medicine

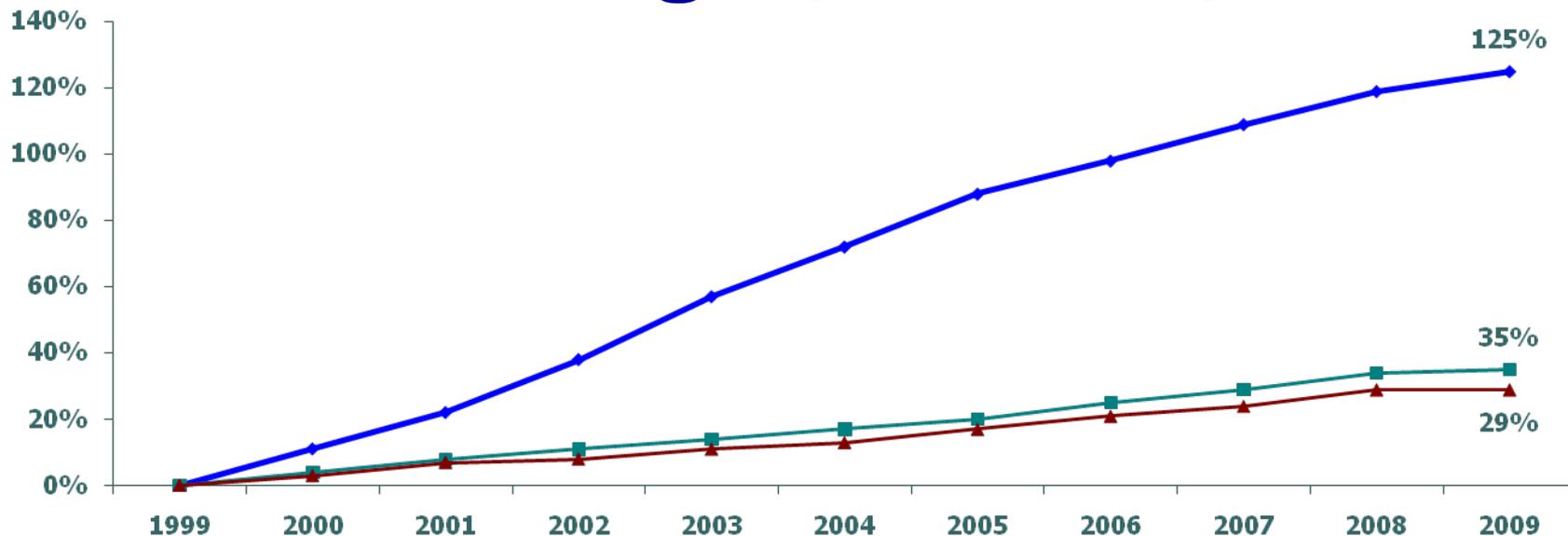
Background

- 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 Care Costs Rising 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 Insurance Premiums
■ Workers' Earnings
▲ Overall Inflation

Health Care: Three Legs of a Stool

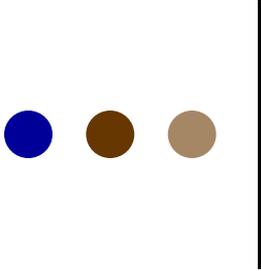
Health reform must address the three critical components of our health care system—costs, quality, and access.

Costs

Access

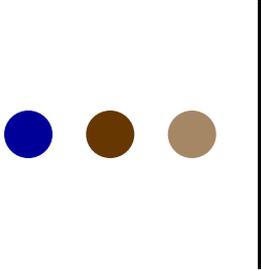


Quality



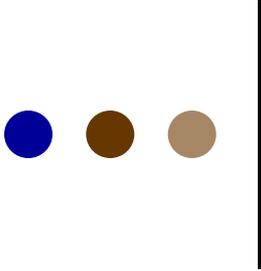
Legislation

- 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).



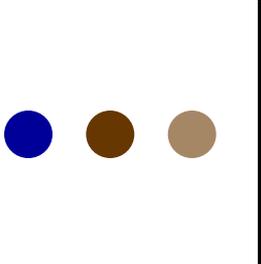
Basics of National Health Reform--Overview

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



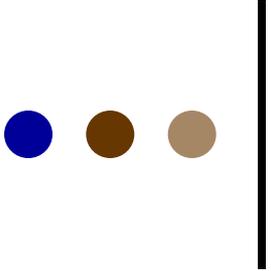
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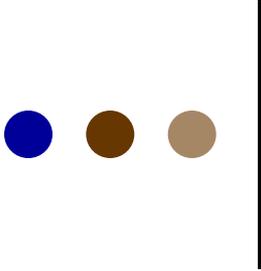
Overview of Health Reform

- 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



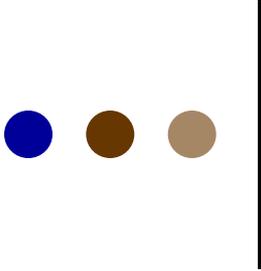
Overview of Health Reform

- 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



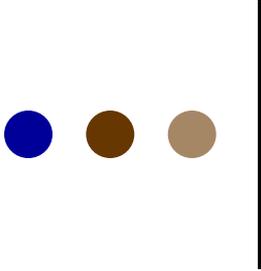
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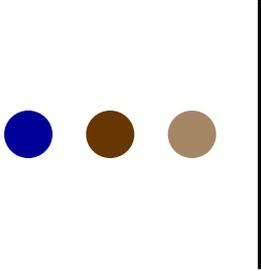
Immediate Implementation: Coverage

- HHS Secretary will create a website with standardized format 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 (FY 2010-2014) (Sec. 1101)
- Appropriated \$5B to create a temporary reinsurance program for employers providing health insurance coverage to early retirees ages 55-64 (2010). (Sec. 1102)



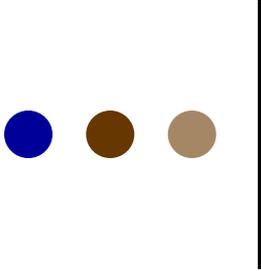
Immediate Insurance-Related Provisions

- Effective for plan years that begin after September 23, 2010:
 - Prohibits insurers from imposing pre-existing condition exclusions for children (Sec. 10103(e))
 - Prohibits insurers from dropping coverage to people when they get sick (Sec. 1001)
 - 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)
 - *New private plans must cover preventive services with no cost sharing* (Sec. 1001)



Immediate Medicare Provisions

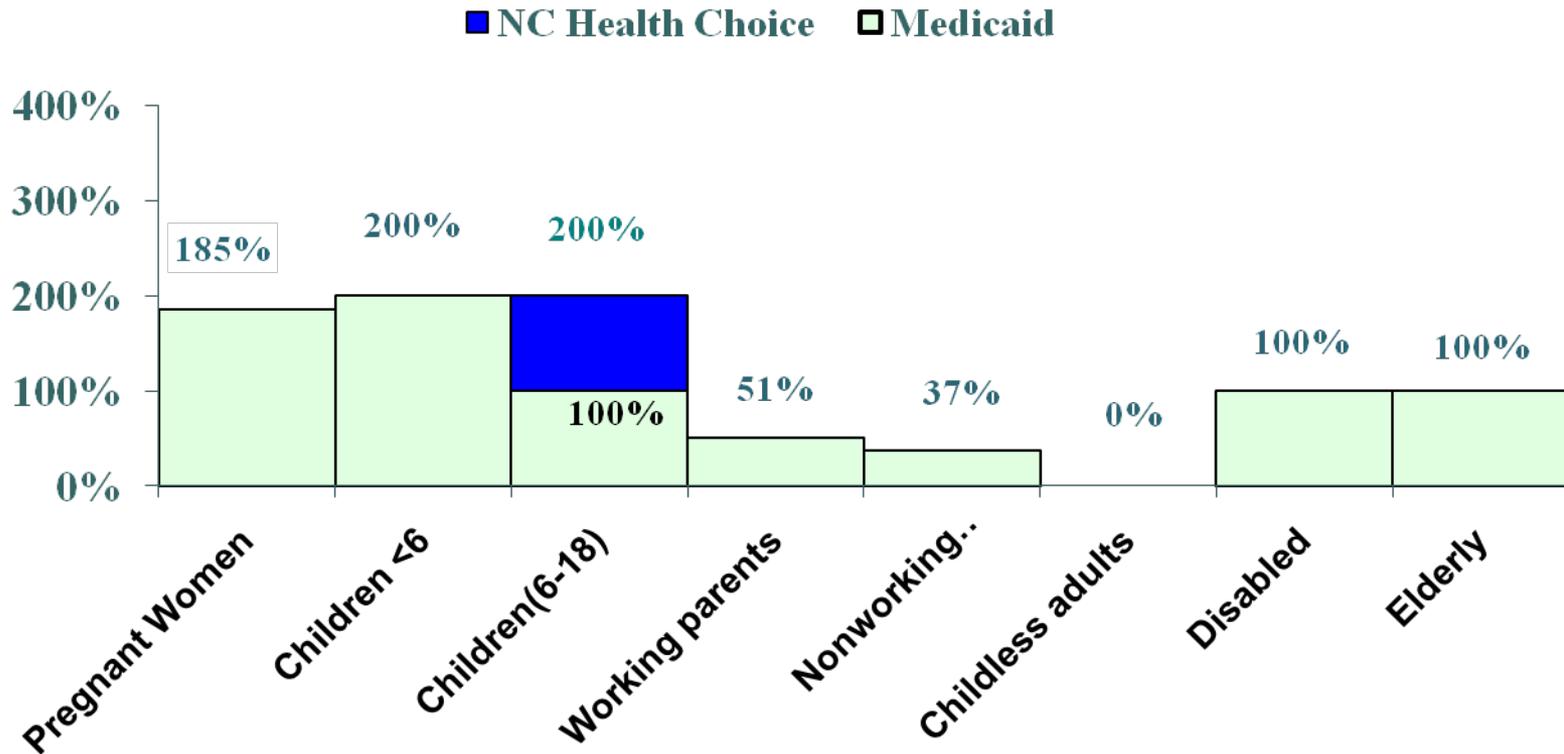
- Medicare beneficiaries receive a 50% discount on brand-name drugs and biologics in donut hole (2011) (Sec. 3301, Sec. 1101 of Reconciliation)
- Expands Medicare to cover more preventive services with no cost-sharing (2011) (Sec. 4104)
- Provides a 10% bonus payment for primary care physicians and general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

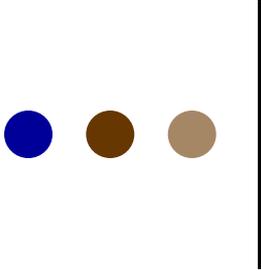


Basics of National Health Reform--Overview

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



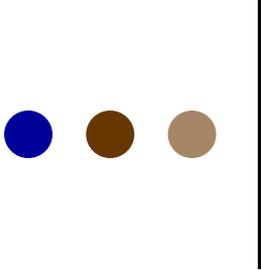


Expansion of Public Programs

- 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)

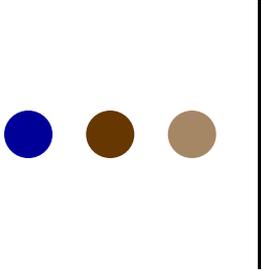
Family Size	138% FPL/yr. (2011)
1	\$15,028
2	\$20,300
3	\$25,571
4	\$30,843

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



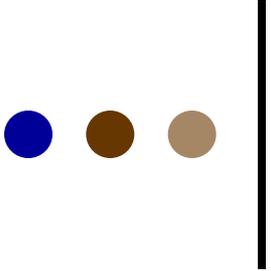
Enrollment Simplification and Coordination

- 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 Insurance 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)



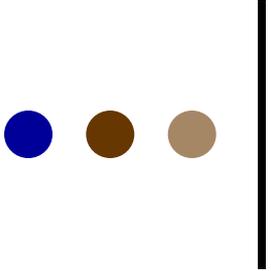
Enhanced Federal Match for Medicaid Expansion

- 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)



CHIP (NC Health Choice)

- States must maintain current income eligibility for children in Medicaid and CHIP until 2019.

(Sec. 2101(b), 10203)

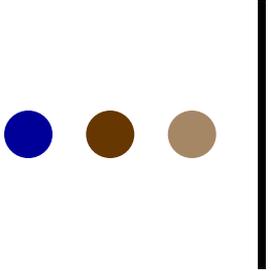
- Beginning in 2015, states will receive a 23 percentage point increase in the CHIP match rate (up to cap of 100%).

(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))

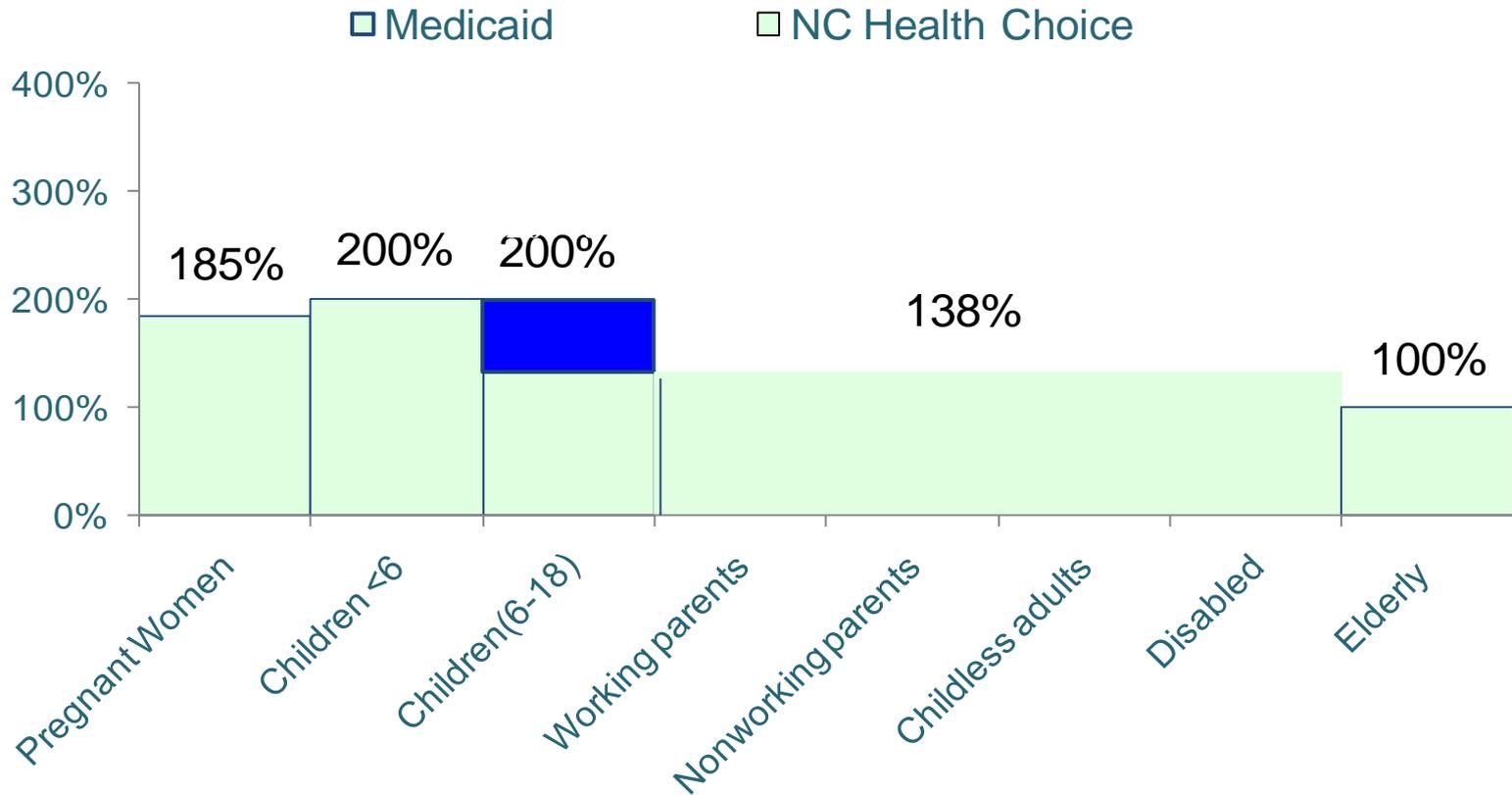
- Increases outreach and enrollment grants by \$40M (2009-2015). (Sec. 10203)

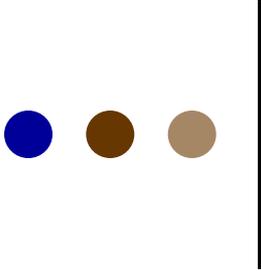


Medicaid & CHIP

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

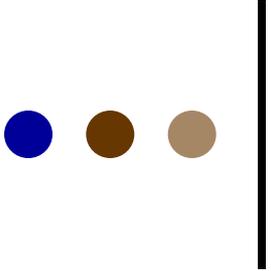
After Health Reform Fully Implemented (Beginning 2014)





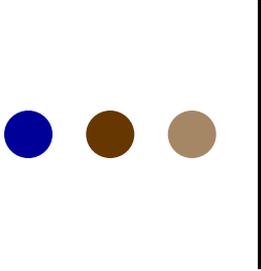
Medicare

- **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)



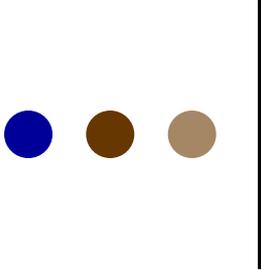
Medicare

- 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)



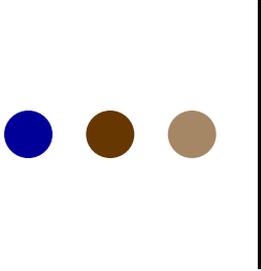
Medicare

- 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 \$15M 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 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



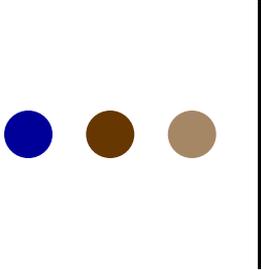
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- Overview of health reform legislation
- Immediate implementation
- Changes in public coverage
- **Private coverage**
 - **Standardized benefit package**
 - **Individual mandate and subsidies**
 - **Employer responsibilities**
 - **Health insurance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



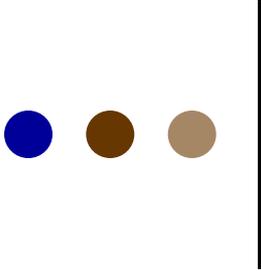
Essential Benefit Package

- 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*



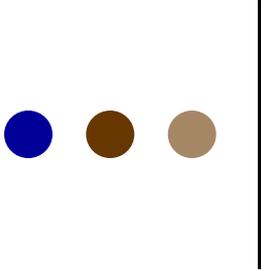
Essential Benefits Package

- Essential benefits must cover:
 - Hospitalizations; 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 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 a 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; those without coverage for less than three months; and those for whom the lowest cost plan exceeds 8% of an individual's income.
- Individuals are not required to change coverage under group plans or individual policies 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, advanceable premium credits will be available to individuals with incomes up to 400% FPL on a sliding scale basis (\$45,560/yr. for one person, \$89,400 for a family of four in 2011).* (Sec. 1401, as amended 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 IRS)



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

Sliding Scale Subsidies

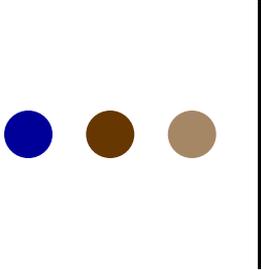
Individual or family income	Maximum premiums (Percent of family income)	Out-of-pocket cost sharing:* gov't. subsidies (individual responsibility)	Out-of-pocket cost sharing limits**
<138% FPL	2% of income	94% (6%)	\$1,983 (ind)/ \$3,967 (fam) (1/3 rd HSA limits)
138-150% FPL	3-4%	94% (6%)	\$1,983 / \$3,967
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 ^{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, amended by Sec. 1001 of Reconciliation).

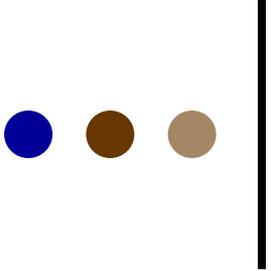
Employer Responsibilities

- Employers with more than 50 employees will be required to pay into fund if they do not provide coverage that meets minimum requirements. (Sec. 1513, amended 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))



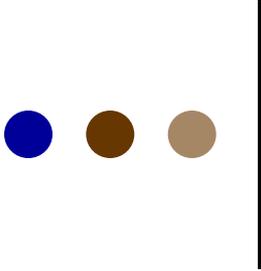
Subsidies for Small Employers

- 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

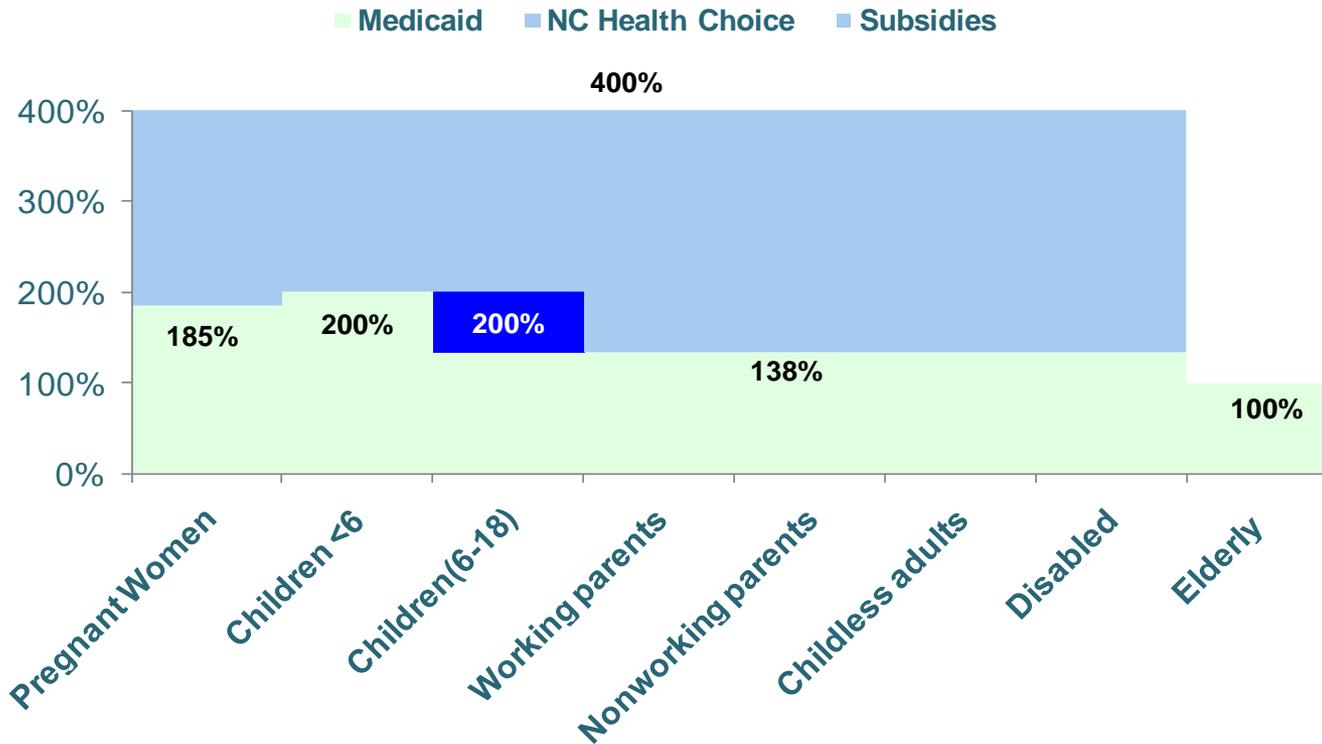
- States will create a Health Benefit Exchange and Small Business Health Options (SHOP) Exchange for individuals and small businesses (Sec. 1311, 1321)
 - Exchanges will provide standardized information to help consumers choose between plans and develop rating system based on quality and cost, determine 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))



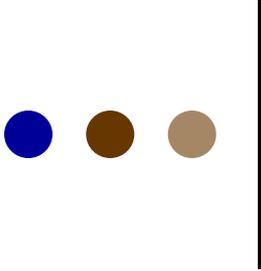
Insurance Reform

- 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)

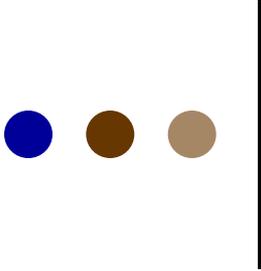


Beginning 2014, most people with incomes $\leq 400\%$ FPL who do not have Medicaid, Medicare, Health Choice, TRICARE, or access to employer-based coverage can qualify for subsidies to purchase insurance in the Exchange



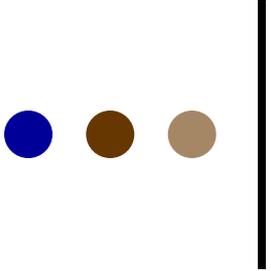
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- **Other provisions**
 - **Prevention and Wellness; Workforce; Quality and New Models of Care; Safety Net; Long-term Care**
- Cost containment and financing
- CBO estimates



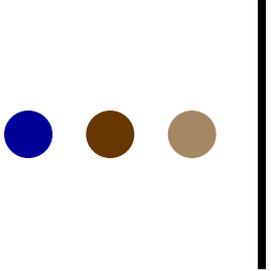
Prevention and Wellness: Overview

- Federal government will provide 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



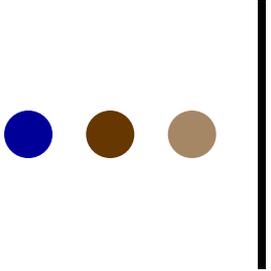
Workforce Overview

- Increased efforts to expand and promote better training for the health professional workforce
 - Includes loan forgiveness and scholarships to train primary care, pediatrics, geriatrics, nursing, dental health, public health, *mental health/substance abuse*, allied health and direct care workforce
 - Increased emphasis on increasing the supply of health professionals in underserved areas
 - Enhanced training in prevention, quality initiatives, interdisciplinary care, community based education, and diversity
- Note: PPACA primarily *authorized* new programs but did not provide new appropriations for most workforce provisions.



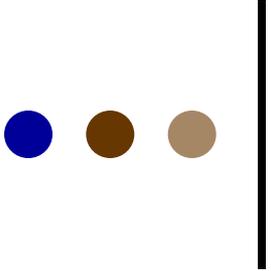
Quality Overview

- 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



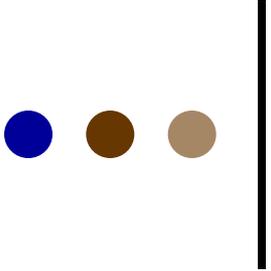
Safety Net

- New funding for community health centers (CHCs)
(Sec. 10503, Sec. 2303 of Reconciliation)
 - Appropriates a total of \$9B over five years for operations (\$1B in FY 2011 increasing to \$3.6B in FY 2015); and \$1.5B 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)



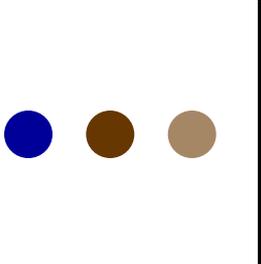
Safety Net

- 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 needed for FY 2011-2014 for Sec. 5208)



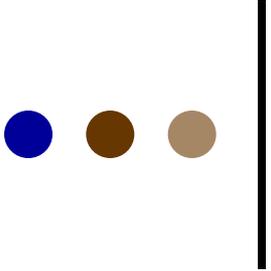
Safety Net

- 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)



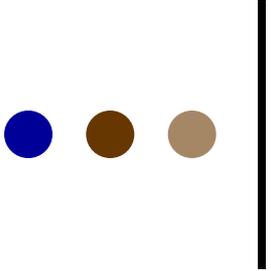
Safety Net

- 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 \$24M in each FY 2010-2014 for competitive grants for regionalized systems for emergency response
(Sec. 3504)
 - Authorizes \$100M 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

- 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)
- Other options to expand home and community-based services in Medicaid



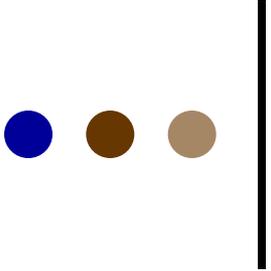
Malpractice

- State demonstration programs to evaluate alternatives to medical tort litigation

(Authorizes \$50M for FY 2011-2016; 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

- Health Disparities

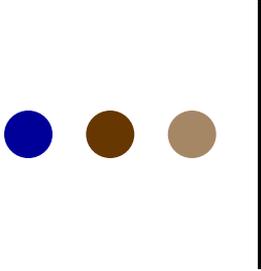
- HHS Secretary must ensure that all publicly-funded health programs, surveys and reports collect data on: race, ethnicity, sex, primary language, and disability status and that data be collected at the smallest geographic level possible
(Authorizes such funds needed as necessary, Sec. 4302)

- Minority health (Sec. 10334)

- Office of Minority Health transferred to the Office of the Secretary and new offices of minority health appointed in CDC, HRSA, CMS, SAMHSA, AHRQ, FDA

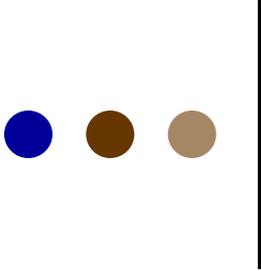
- Women's health (Sec. 3509)

- Office of Women's Health established in CDC, HRSA, AHRQ, FDA



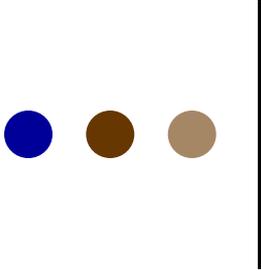
Basics of National Health Reform--Overview

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



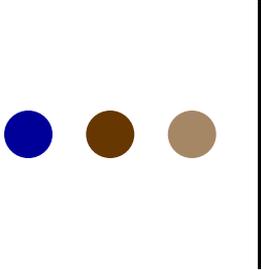
Cost Containment & Financing

- 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



Basics of National Health Reform--Overview

- Overview of health reform
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- **CBO estimates**



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.

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.

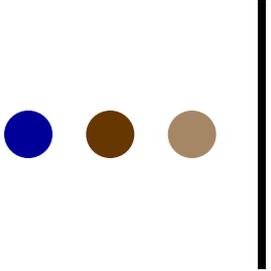
Access

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.



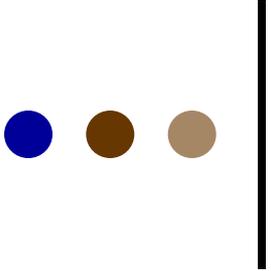
Quality

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.



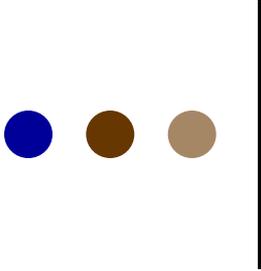
Other NCIOM Resources

- 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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