



ANA POLICY & PROVISIONS of HEALTH REFORM LAW
April 27, 2010

The chart below compares the key elements of ANA's *Health System Reform Agenda* (2008) with provisions of the recently enacted Patient Protection and Affordable Care Act (including modifications made by the 2010 Reconciliation Act).

ANA	HEALTH REFORM LAW PROVISIONS (Pub. L. 111-148 + Reconciliation provisions)
ACCESS	
1. Health Care is a human right	No. -While the law extends health care to many millions more Americans, and protects those who already have coverage from many of the abuses of insurers, the law does not declare health care to be a human right.
2. Available (geographic; times; alternative sites; disabled; elderly)	Yes. -No insurance discrimination based on employee's wages (effective 10/2010) -No discrimination by insurers based on health status, medical condition or history, claims experience, genetic information, disability, evidence of insurability, or other factors HHS deems (effective 2014) - Insurance rating variability only on age, family composition, geographic location, tobacco use. No rating based on health or gender (effective 2014) -Medicaid expanded to all individuals under age 65 at 133% federal poverty level (FPL) - states can begin to offer in 2010; phased-in government contribution to Medicaid increased 2014-2019.
3. Acceptable (respect autonomy & culture; patient-centered)	Yes. -Workforce provisions promote cultural competence training of health care professionals - Promotes training of a diverse workforce -Religious and Native American exemptions from individual mandate to obtain coverage. -Reauthorizes and amends Indian Health Care Improvement Act (effective immediately) -Funds \$11B for Community Health Centers and National Health Service Corp over 5 yrs (effective 2011) -Establishes new programs to support school-based health centers and nurse-managed health centers (effective 2010)
4. Affordable (treatment and followup care; based on ability to pay)	Yes. -Premium and cost-sharing subsidies for individuals, through the Health Exchanges, sliding scale dependent on income 100-400% FPL. -Refundable, advanceable premium credits to individuals and families between 133-400% FPL. -Expands Medicaid to all people under age 65, up to 133%FPL.
5. All citizens and residents	Almost -US citizens and legal residents. Undocumented immigrants are not included, except as they are exempt from the individual mandate to obtain coverage.

6. Standard package of essential health services	<p>Yes.</p> <ul style="list-style-type: none"> -Plans in the individual or small group market must provide the essential health benefits package (effective 2014) -Creates essential benefits package that provides comprehensive set of services -Covers at least 60% of actuarial value of covered benefits -Limits annual cost-sharing to current Health Savings Account limits (\$5950/\$11,900). -Requires all “qualified” health benefits plans to offer at least the essential benefits package – includes Exchanges, individual and small group markets outside the Exchanges (some grandfathering) (effective 2014) - Prohibits abortion coverage from being required as part of the essential benefits package (effective 2014)
7. Mental health parity	<p>Yes.</p> <ul style="list-style-type: none"> -Mental health parity was assured by a successful legislative effort spearheaded in 2009 by Rep. Patrick Kennedy (D-MA). As current law, it was incorporated into the health reform bill, which creates an essential benefits package providing comprehensive set of services, including mental health benefits. -Creates new Medicaid state plan option to permit enrollees with at least one serious and persistent mental health condition to designate a provider as a health home. (effective 2011) -creates new demonstration project to provide Medicaid payments to mental institutions for adult enrollees who require stabilization of an emergency condition (effective 10/2011 through 12/ 2015). -Workforce provision supports development of interdisciplinary mental and behavioral health training programs (effective 2010) -Supports development of training programs that focus on primary care models that integrate physical and mental health services. (Funds for five years starting in Fiscal Year 2010)

ANA	HEALTH REFORM LAW PROVISIONS
QUALITY	
IOM 2001, <i>Crossing the Quality Chasm</i> (1 st 6 items below)	
1. Safe	<p>Yes.</p> <ul style="list-style-type: none"> - Quality reporting to HHS by group health insurers with respect to plan or coverage benefits and health care provider reimbursement structures that implement activities to improve patient safety and reduce medical errors through the appropriate use of best clinical practices, evidence based medicine and health information technology under the plan or coverage. (Section 1001). - Center for Quality Improvement and Patient Safety (in AHRQ) to conduct and gather research on changes in processes of care and the redesign of systems used by providers that will reliably result in intended health outcomes, improve patient safety, and reduce medical errors (such as skill development for health care providers in team-based health care delivery and rapid cycle process improvement) and facilitate adoption of improved workflow. (Section 3501) -5 year demonstration grant to states to evaluate tort litigation alternatives; preference goes to proposals likely to increase patient safety and decrease medial errors and adverse events.
2. Effective	<p>Yes.</p> <ul style="list-style-type: none"> -Supports comparative effectiveness research – non-profit “Patient-Centered Outcomes Research Institute.” Research findings not to be construed as mandates or recommendations for payment, coverage, treatment. AHRQ responsible for dissemination. (Section 6301) -Also see #4
3. Patient-centered	<p>Yes.</p> <ul style="list-style-type: none"> -many provisions, particularly including the establishment of a Patient-Centered Outcomes Research Institute
4. Timely	<p>Yes.</p> <ul style="list-style-type: none"> - In awarding grants/ contracts for quality measure development, the HHS Secretary must give priority to measures that allow the assessment of, among other things, the safety, effectiveness, patient-centeredness, appropriateness, and timeliness of care; the efficiency of care; the equity of health services and health disparities across health disparity populations and geographic areas; patient experience and satisfaction. (Section 3013).
5. Efficient	<p>Yes.</p> <ul style="list-style-type: none"> -Establishes Center for Medicare and Medicaid Innovation within the Center for Medicare and Medicaid Services (CMS) to test innovative payment and service delivery models to reduce program expenditures while preserving or enhancing the quality of care (effective 1/11) -Establishes a hospital value-based purchasing program (Medicare), under which value-based incentive payments are made to hospitals that meet certain performance standards. Initially a minimum of five measures will be selected, at least one of which is required to be an efficiency measure (program to begin in 2013). (Section 3001). -Establishes a payment modifier for physicians under the Medicare fee schedule based upon the composite measure of quality of care furnished compared to cost. HHS Secretary will adopt performance measures reflecting health outcomes. after 1/1/17, applicable to all eligible professionals, including APRNs) (Sec. 3007)
6. Equitable (eliminate health disparities)	<p>Yes.</p> <ul style="list-style-type: none"> -requires more collection and reporting of data on race, ethnicity, gender, primary language, disability status, and for underserved rural and “frontier” populations. - Requires collection of access and treatment data from people with disabilities. - HHS Secretary required to analyze data to monitor trends in disparities -Rural protections (Section 3121)

	-See also #4 above
7. Continuity of care	<p>Yes.</p> <ul style="list-style-type: none"> - Creates a Federal Coordinated Health Care Office within CMS to, among other goals, improve care continuity and ensure safe and effective care transitions for dual eligible(Medicare and Medicaid) individuals. (Section 2602) - In awarding grants/ contracts for quality measure development, the HHS Secretary must give priority to measures that allow the assessment of, among other things, the management and coordination of health care across episodes of care and care transitions for patients across the continuum of providers, health care settings, and health plans. (Section 3013).
8.Chronic disease management	<p>Yes.</p> <ul style="list-style-type: none"> -quality reporting to HHS by group health insurers with respect to plan or coverage benefits and health care provider reimbursement structures that improve health outcomes through the implementation of activities such as quality reporting, effective case management, care coordination, chronic disease management, and medication and care compliance initiatives. (Sec. 1001). -Establishes community-based Collaborative Care Network Program – support consortiums of health care providers to coordinate and integrate health care services for low-income, uninsured and underinsured populations. (5 yrs of initial funding beginning FY2011)
9. Disease prevention & health promotion	<p>Yes.</p> <ul style="list-style-type: none"> -Require “qualified plans” to provide floor of preventive services as recommended by US Preventive Services Task Force, with no cost sharing. Also must include recommended immunizations, preventive care for infants, children and adolescents, and certain screenings for women (ex: bone density, mammograms). -Cover preventive services (as recommended by US Preventive Services Task Force), and eliminate cost-sharing for these services for Medicare and Medicaid (effective immediately.). -Make available to Medicare beneficiaries comprehensive risk assessment and personalized prevention plan (model developed within 18 mos. (~Sept. 2011). -Requires Medicaid to cover tobacco cessation services for pregnant women (effective 10/1/10) -Permits variation in insurance rating based on tobacco use (ratio of 1.5 to 1 differential in rates) -Establish National Prevention, Health Promotion and Public Health Council – coordinate federal prevention, wellness, and public health activities. Develop national strategy to improve nation’s health. (Strategy due 3/26/11). -Create Prevention and Public Health Fund (expand and sustain existing funding), incl. education and outreach campaigns for preventive benefits and immunizations. (\$7B starting FY2010). - Create task forces on Preventive Services and Community Preventive services – develop, update, disseminate evidence-based recommendations for clinical and community prevention services. (effective immediately) -Provide grants to small employers that establish wellness programs for employees; provide technical assistance; survey workplace policies (5 yrs, beginning FY 2011) -Permit employers to offer rewards – premium discounts, for ex. -- to employees for participating in wellness programs and meeting certain health-related standards (effective 1/1/14) and establish pilot programs to evaluate success of programs. -require nutritional information for all chain restaurants and vending machine foods (proposed regulations within 1 yr.).

ANA	HEALTH REFORM LAW PROVISIONS
COST/FUNDING	
<p>1. Support single payer as “most desirable option” – (supported public health insurance option in legislative negotiations)</p>	<p>No. – Instead, law calls for all individuals to obtain minimum essential coverage for themselves and their dependents, effective 2014. Exemptions permitted on hardship or religious grounds. -no public health insurance option</p>
<p>2. Public funding thru Medicare expansion, based on payroll taxes, general fund revenues; employers play or pay & indivs can buy into system; add'l services purchased thru private insurers</p>	<p>No. -Individual mandate (see above) -States required to establish health exchanges to facilitate individuals’ and small businesses’ purchase of coverage; states can join to form regional exchanges; states can opt out if they can create coverage systems that meet or exceed the federal requirements/standards; HHS will help state with funding exchanges’ set-up and will create exchange in states that do not comply by 1/1/14 -Plans in the Exchange must provide at least the essential basic benefits package (4 benefits categories of increasing actuarial value – bronze, silver, gold, platinum) -Employers with more than 50 employees must provide “qualified” (minimum essential benefits) coverage to employees; employers with more than 200 employees required to automatically enroll all new employees into health plans. – Includes penalties for noncompliance.</p>
<p>3. Cost of essential services should be borne by private-public partnership</p>	<p>Yes. -Premium credits and cost-sharing available through the Exchanges to US citizens and legal immigrants, based on income. -Refundable, advanceable premium credits on sliding scale for individuals and families with incomes between 133-400% federal poverty level (FPL). -Cost-sharing subsidies to individuals and families on sliding scale from 100-400% FPL.</p>
<p>4. Protect families from impoverishment from high medical expenses</p>	<p>Yes. -Prohibits insurance companies from denying coverage based on “pre-existing conditions,” effective 2014. -Prohibition of discrimination based on “pre-existing conditions” for children, effective 10/2010. -Guaranteed renewal - no rescissions, effective 2014. -No lifetimes or annual limits on coverage, effective 10/2010 -</p>
<p>5. Personal responsibility (beneficiaries pay portion of care)</p>	<p>Yes. -All individuals required to purchase insurance coverage; federal subsidies are income-based on “sliding scale.”</p>
<p>6. Rebalance investment in acute vs. primary & preventive care</p>	<p>Yes. -10% bonus Medicare payment to primary care providers – including nurse practitioners – in 2011-2015 (effective 1/1/11) -Increase Medicaid payments for primary care <i>physicians</i> to 100% Medicare rates for 2013 & 2014 (effective 1/1/13). -Increases in grant funding for programs and services that increase primary care workforce.</p>
<p>7. Recognize economic value of RNs</p>	<p>Yes, in part. -The Center for Quality Improvement and Patient Safety (in AHRQ) to conduct and assess research that identifies health care providers, including health care systems, single institutions, and individual providers, that (A) deliver consistently high-quality, efficient health care services; and (B) employ best practices that are adaptable and scalable to diverse health care settings or effective in improving care across diverse settings. (Section 3501.)</p>

<p>8. Administrative simplification/ Health IT</p>	<p>Yes.</p> <ul style="list-style-type: none"> - Requires insurers to develop and use uniform explanation of coverage documents for enrollees, with uniform format, understandable language and standardized contents and definitions. (within 12 months of enactment) (Section 1001) -Builds on investment in 2009 “stimulus” legislation - HHS Secretary shall adopt a single set of operating rules for each health information electronic transaction (financial and administrative) with the goal of creating as much uniformity in the implementation of the electronic standards as possible. The National Committee on Vital and Health Statistics will oversee the adoption of standards, including an evaluation of whether operating rules represent a consensus view of the health care stakeholders and are consistent with and do not conflict with other existing Standards (permitting evaluation and inclusion of nursing taxonomy). (Sec. 1104).
<p>9. Money for HC provider education; R & D</p>	<p>Yes.</p> <p>See Workforce portion of Nursing Provisions document</p>

ANA	HEALTH REFORM LAW PROVISIONS
WORKFORCE	
1. Supply – recruitment and retention of RNs; improve RN work environment; increase RN diversity	Yes, in part. - Establish a multi-stakeholder Workforce Advisory Commission to develop a national workforce strategy. Goal to determine dynamic workforce demand; evaluate capacity and effectiveness of education and training (including faculty development); identify barriers to coordination among federal, state and local institutions; and encourage innovation. Nursing workforce issues noted as high priority for Committee’s work. Includes examination of scopes of practice and best way for professionals in an interdisciplinary team to work to maximize their skill sets. Opportunity for significant nursing input. (Section 5101) -Commission must send recommendations to Congress, HHS and Department of Labor, for improving safety, health, and worker protections in the workplace for the health care workforce. (Section 5101) -Initial (staggered) appointments for Commission due Sept. 30, 2010. (Section 5101) -Establish a youth public health program to expose and recruit high school students into health careers, with a focus on careers in public health (Section 5403) -Promote training of a diverse workforce (Section 5402) -Promote cultural competence training for health care professionals -Grants to increase representation of minority faculty members (Section 5403) -Workforce diversity grants (Section 5404) - More in Nursing Provisions document
2. Education – expand # nursing faculty; create stable RN funding streams for loans and scholarships	Yes. See Nursing Provisions document
3. Distribution – financial and other incentives to bring RNs to rural and underserved areas; National RN Corp funding; distance learning	Yes. -Workforce Advisory Commission (see #1 above) - part of their charge is to evaluate the geographic distribution of health care providers as compared to the identified health care workforce needs of States and regions. (Sec. 5101) See Nursing Provisions document
4. Utilization – address barriers to practice in current reimbursement system; Scopes of practice; APRNs as primary case mgrs (amend Medicaid)	Yes, in part. - see Nursing Provisions document