



National Health Council's Values in Health Reform Legislation

Putting Patients First Principles	Key Values	Patient Protection and Affordable Care Act*
<p>Achieves Health Care Coverage for Everyone</p>	<p>Enable access to affordable health care coverage for all individuals</p>	<ul style="list-style-type: none"> • Requires states to establish an exchange for the individual market and separately for the small group market by 2014. <ul style="list-style-type: none"> ○ Provides states with planning and establishing grants within 1 year of enactment until 2015 ○ If the Secretary determines before 2013 that a state will not have an exchange operational by 2014, requires the Secretary to establish and operate the exchange in that state ○ Allows states to form regional or interstate exchanges, subject to approval by the Secretary • Authorizes \$6 billion in funding for a CO-OP program to serve individuals in one or more states and compete in the reformed individual and small group markets. <ul style="list-style-type: none"> ○ If a CO-OP does not form in every state, allows the Secretary to use planning grants to encourage formation of new CO-OPs or expansion of existing CO-OPs
	<p>Require health plans to offer comprehensive coverage options that allow for access to quality and medically necessary care</p>	<ul style="list-style-type: none"> • Qualified Health Benefits Plans (QHBP) must cover Essential Health Benefits including: <ul style="list-style-type: none"> ○ Ambulatory patient services ○ Emergency services ○ Hospitalization ○ Maternity and newborn care ○ Mental health and substance abuse services ○ Prescription drugs ○ Rehabilitative and habilitative services and devices ○ Laboratory services ○ Preventive and wellness services and chronic disease management ○ Pediatric services (including oral and vision care) • Requires the Secretary to define and update at least annually the categories of covered treatments, items, and services within benefit classes for individual plans. <ul style="list-style-type: none"> ○ Must be done through a transparent process that allows for a public comment period • Benefits standards are a floor and do not pre-empt state mandates, however states must make payments to cover the cost of additional benefits directly to individuals or plans, not to exchanges

*As amended by H.R. 4872, Health Care and Education Affordability Act of 2010



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	Individual mandate should be premised on availability of affordable coverage options	<ul style="list-style-type: none"> • Individual mandate exempts individuals who cannot afford coverage and individuals with incomes below the tax filing threshold • Effective December 31, 2013
Curb Costs Responsibly	Promote activities related to care coordination, quality improvement, and patient safety	<ul style="list-style-type: none"> • Requires Secretary to develop a national quality improvement strategy by January 1, 2011. <ul style="list-style-type: none"> ○ Directs the Secretary to update the strategy and provide a progress report to Congress at least annually • Requires the President to convene an Interagency Working Group on Health to coordinate Federal implementation of the national quality strategy. <ul style="list-style-type: none"> ○ The group must deliver a report to relevant Congressional committees and post report online by December 31, 2010, and annually thereafter • Allocates \$20 million (FY 2010-2014) to the AHRQ Director to establish a Center for Quality Improvement and Patient Safety.
	Eliminate financial barriers to appropriate health-seeking behaviors	<ul style="list-style-type: none"> • Eliminates cost sharing for covered preventive services, effective 6 months after enactment • Narrows the size of the Part D coverage gap so that there is 25% cost-sharing for non-low income subsidy beneficiaries after the deductible until catastrophic coverage
	Encourage development of quality measures where none exist or where they fall short of intended goals	<ul style="list-style-type: none"> • Provides \$95 million annually from 2010 to 2014 for quality measure development, dissemination, endorsement, and review. • Requires the Secretary to determine quality measure gaps at least triennially, in consultation with the AHRQ Director, and provide grants for the prioritization and development of measures to fill the identified gaps.

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	Test innovative care models	<ul style="list-style-type: none"> • Creates a new Center for Medicare and Medicaid Innovation within CMS to test innovative payment and service delivery models in Medicare and Medicaid by January 1, 2011. <ul style="list-style-type: none"> ○ Gives broad authority to determine what models will be tested, in what populations, and for how long, with a preference for models that address deficits in care leading to poor clinical outcomes or potentially avoidable expenditures. • Permits Secretary to grant funds to state or state-designated entities to implement multidisciplinary "Health Teams" to support implementation of the patient-centered medical home model. <ul style="list-style-type: none"> ○ Grant recipients must use certified electronic health records (EHR) ○ Health teams must collaborate with local primary care providers and state resources to coordinate disease prevention and chronic disease management • Requires the Secretary to establish a Medicare Shared Saving (i.e., ACO) program that promotes accountability for a patient population and coordinates services under Medicare Parts A and B starting January 1, 2012. <ul style="list-style-type: none"> ○ ACOs would be groups of providers (regardless of specialty) and suppliers that voluntarily meet certain quality benchmarks and achieve spending targets in order to be eligible for shared savings payments • Requires the Secretary to conduct a pilot program to test a payment incentive and service delivery model that utilizes physician and nurse practitioner directed home-based primary care teams designed to reduce expenditures and improve health outcomes in the provision of items and services for chronically ill Medicare beneficiaries.
	Facilitate shared decision making	<ul style="list-style-type: none"> • Requires Secretary to contract ("as soon as practicable" after law enactment) with an entity to develop over 18 months standards for certifying patient decision aids • Establishes a grant program to develop, update, implement, and evaluate patient decision aids (educational pamphlets, videos, etc.) on improving patient understanding and decision-making of treatment options.
	Encourage preventive health services	<ul style="list-style-type: none"> • Eliminates cost sharing for covered preventive services, effective 6 months after enactment • Expands Medicare and Medicaid coverage of preventive services to include: any clinical preventive service recommended with a grade of A or B by the USPSTF and immunizations recommended by the Advisory Committee on Immunization Practices. Effective January 1, 2013.

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		<ul style="list-style-type: none"> • Allows the Secretary to award grants to States to provide incentives for Medicaid beneficiaries to participate in programs providing incentives for healthy lifestyles.
Guarantees Coverage Despite Pre-existing Conditions	Strict prohibition on pre-existing conditions exclusions	<ul style="list-style-type: none"> • Requires all plans to issue coverage to those seeking it, prohibits pre-existing condition exclusion, effective January 1, 2014 • Prohibits pre-existing condition exclusions for children under 19 years old, beginning 6 months after enactment • Provides \$5 billion to establish within 90 days of enactment a temporary high-risk pool for uninsured individuals who have been denied coverage due to a pre-existing condition <ul style="list-style-type: none"> ○ Terminates when the exchange is established on January 1, 2014
	Federal requirement for guaranteed issue and renewal	<ul style="list-style-type: none"> • Requires guarantee issue renewability, effective January 1, 2014 • Prohibits health plans from rescinding coverage except in the case of clear and convincing evidence of fraud, effective 6 months after enactment • Prohibits employers from limiting coverage eligibility based on employee salary, effective 6 months after enactment • Prohibits insurers from dropping or denying coverage for individuals participating in approved clinical trials
	Limits on insurers' ability to vary premiums through unfair underwriting practices	<ul style="list-style-type: none"> • Requires modified community rating allowing insurers to vary premiums based only on: <ul style="list-style-type: none"> ○ Geography ○ Family composition ○ Age, variation limited to 3:1 ○ Tobacco use, variation limited to 1.5:1 • Rating requirements in the large-group market apply only to fully-insured groups, not self-insured groups. • Effective January 1, 2014
Eliminates Lifetime Caps on Health Insurance	Eliminate annual and lifetime benefit caps	<ul style="list-style-type: none"> • Prohibits all plans from establishing lifetime and or annual limits on the dollar value of coverage beginning in 2014 • Prior to 2014, plans cannot have lifetime limits and may only apply annual limits on the dollar value of coverage as approved by the Secretary
Ensures Access to Quality Long-Term Care and Respect at the End of Life	Ensure that people with functional disabilities can obtain services and supports	<ul style="list-style-type: none"> • Establishes Community Living Assistance Services and Supports (CLASS) program - a voluntary, opt-out, national insurance program. <ul style="list-style-type: none"> ○ Wage or income-earning adults are eligible for enrollment ○ Requires the Secretary to create three actuarially sound benefit models for benefit plan

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		<ul style="list-style-type: none"> ○ Premiums must maintain viability of the program based on 75 year actuarial model ○ Average benefit value at least \$50 per day ○ Requires the Secretary to designate a benefit plan by October 1, 2012 • Provides a lifetime cash benefit for enrollees who have paid premiums for five years and meet disability criteria. <ul style="list-style-type: none"> ○ Beneficiaries can use cash to purchase long-term care services and supports in order to remain in the community or pay for institutional care expenses • Financed by enrollee premiums
	<p>Improve the quality of long-term care and end-of-life services</p>	<ul style="list-style-type: none"> • Establishes an Elder Justice Coordinating Council to recommend to the Secretary possible actions aimed at preventing the abuse, neglect and exploitation of elders. Also establishes an Advisory Board on Elder Abuse, Neglect, and Exploitation to make multi-disciplinary strategic plans to make improvements in the long-term care of elders and to make recommendations to the Coordinating Council. • Directs the Secretary to carry-out activities to improve the long-term care delivery system including: <ul style="list-style-type: none"> ○ Providing incentives for the recruitment, training, and retention of direct care staff ○ Authorizing grants to assist long-term care providers in the purchase and implementation of electronic health records

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