

The Social Health of Nevada

Leading Indicators and Quality of Life in the Silver State

Health Care Access and Insurance Availability in Nevada

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The U.S. Department of Health and Human Services (2012) defines healthcare access as “the timely use of health services to achieve the best health outcomes.” The Department specifies that efficient health care access is contingent on several steps, including (1) entry into the healthcare system, (2) availability of needed services, and (3) accessibility of providers with whom individuals can establish relationships founded on mutual communication and trust.

Using this definition as a basic premise, the U.S. Department of Health and Human Services (2012) has concluded in its recent review that healthcare access in this country is poor, particularly for persons of color and limited economic means. Furthermore, while quality of healthcare in America is improving, access to health services is not (U.S. Department of Health and Human Services, 2012). Healthcare access problems are compounded by lack of insurance, limited sources of care, and misperception on the part of patients.

This chapter examines the nature of healthcare

Chapter Highlights

- 49.1 million American citizens lack medical insurance.
- In the U.S., healthcare access remains poor, especially for people of color and limited economic means, as well as Blacks, Hispanics, and American Indians.
- Only 70% of low income individuals are insured compared to 94% of high income individuals.
- Nearly 25% of uninsured adults forgo health care compared to only 4% of privately insured adults
- Uninsurance, source of care, and patient perception of need are significant barriers to healthcare access.

How to Cite this Report

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access and insurance availability nationally and in the state of Nevada. Special attention is given to the cultural barriers that impede healthcare access and the role that the Affordable Health Care Act plays in increasing healthcare access and insurance availability.

Access and Insurance Availability in Nevada

Twenty one percent of Nevadans are uninsured, a significant percentage greater than the national average of 16% (Henry J. Kaiser Foundation, 2012a). Yet a slightly larger percentage of Nevadans are insured by employers than the national average, with fewer Nevadans on average participating in Medicaid and Medicare than in the nation as a whole (Henry J. Kaiser Family Foundation, 2012a).

Table 1: Health Care Insurance Coverage in Nevada and Nationally

	Uninsured	Employer Insured	Medicaid	Medicare	Other Public Insurance	Individual
Nevada	21%	51%	10%	11%	2%	5%
U. S.	16%	49%	16%	12%	1%	5%

Source: Henry J. Kaiser Family Foundation, 2012a

Given the rate of uninsurance and its significant implications for healthcare access, it is important to note several facts about the uninsured. According to the Henry J. Kaiser Family Foundation (2011),

- Uninsurance is an issue disproportionately impacting individuals with low to moderate income: 9 of every 10 uninsured individuals are individuals below 400% of poverty.
- Uninsurance is experienced by a significant percentage of individuals in working families: over 75% of the uninsured are in working families.
- Uninsurance forces adults to forgo needed healthcare: nearly 25% of uninsured adults fail to obtain needed care compared to only 4% of privately insured adults.

As of the fiscal year 2010-2011, two community centers in Nevada operate 26 delivery sites and health centers without financial support from the state. While not focused solely on community health centers, many workforce development policies in our state are aimed at increasing primary care providers practicing in underserved areas. The Nevada Health Services Corps offers loan repayment assistance for health care practitioners in exchange for agreeing to practice in a medically underserved area of the state. The Office of Rural Health administers this program, which has slowed down recently, due to the poor economy and the inability to raise funds. Established by the state legislature in 1993, the Rural Obstetrical Access Program subsidizes medical malpractice insurance for health care professionals specializing in obstetrics and prenatal care. Due to budget cuts, this program is operating on a limited basis. As of June 2011, it operates only in Lyon County.

The Office of Health Information Technology within the Nevada Department of Health and Human Services is responsible for facilitating the establishment of a statewide health exchange system, pursuant to the ARRA HIGHTECH Act and Nevada's ARRA HIGHTECH State Health Information Exchange Cooperative Agreement. Senate Bill 43, the necessary enabling legislation, was passed by the Nevada Legislature and approved by the Governor. In 2009, the governor of Nevada established by executive order the Nevada Health Information Technology Blue Ribbon Task Force to oversee the implementation of a statewide health information exchange. The Task Force finished its work in January 2011, with June, 30, 2011, being its sunset date.

A 2009 report was presented to the Committee on Ways and Means United States House of Representatives Public Hearing on "Health Reform in the 21st Century: Expanding Coverage, Improving Quality and Controlling Costs" which highlighted the importance of improving health care access for the uninsured.

The committee composed of 14 members convened in 2008 with funding from the Robert Wood Johnson Foundation to update the six prior Institute of Medicine reports on the consequences of being uninsured issued from 2001 through 2004. The investigative committee included health economists, physicians, a nurse, and experts in health policy and public health with substantial leadership experience in state and federal government, private-sector corporations, health-care delivery, and medical research.

The committee report singled out three relevant questions: (1) what are the dynamics driving downward trends in health insurance coverage, (2) is being uninsured harmful to the health of children and adults, (3) are insured people affected by high rates of insurance in their community?

Several indicators point to a continuing decline of health insurance coverage in the Silver State. Health care costs and insurance premiums have been growing substantially faster than the economy and family incomes. Rising health care costs and a severely weakened economy threaten not only employer-sponsored insurance, the cornerstone of private health coverage in the United States, but also undercut recent expansions in public health insurance through Medicaid and the Children's Health Insurance Program.

Employment-based health benefits have served as the primary source of health coverage for several generations of workers and their families. However, in the years 2000 through 2007, according to the committee findings, the rates of employer sponsored coverage declined by 9% points for children (from 66% to 57%) and by 5% points for non-elderly adults (from 69% to 64%). The principle cause of declining rates in private insurance coverage is the ever rising cost of health care. Between 1999 and 2008, family health insurance premiums rose 119%, more than triple the 34% increase in worker's earnings in the same time period. Employers are finding it more difficult to sponsor coverage and their employees are increasingly unable to afford the premiums if offered coverage, particularly those workers with lower wages.

Fundamental changes in the workplace are also contributing to the decline in coverage. Jobs in the U. S. have shifted away from industries with traditionally high rates of health coverage, for instance, manufacturing, to service jobs, such as wholesale and retail trade, which historically have lower rates of coverage. In some industries, employers are relying more heavily on jobs without health benefits, including part-time and short employment, as well as contract and temporary jobs. Early retirees are also less likely to obtain health insurance benefits than in the past. Many more low-income Americans would be uninsured today were it not for state and federal efforts to expand coverage in the past decade. By expanding eligibility and conducting outreach to people already eligible, states and federal government have substantially increased health coverage among low-income children and to lesser degree among adults. The net result of eroding employment based coverage and improved public programs in that the portion of children who are uninsured has remained at about 11% from 2000-2007, while the portion of adults under age 65 who are uninsured has increased from 17 to 20%.

For those Americans without access to employer-sponsored or public insurance, acquiring health insurance in the non-group health insurance market can be very difficult if not impossible. In most states, insurers may deny applicants for non-group coverage completely, impose a permanent or temporary preexisting condition restriction on coverage, or charge a higher premium based on health status, occupation, and other personal characteristics. As a result, non-group insurance policies are often unaffordable, particularly for those with preexisting conditions. Individual medical insurability also depends on how recently one has been covered by a group health plan. Applicants with recent group coverage have some protections under the federal Health Insurance Portability and Accountability Act (HIPAA). HIPAA coverage can also be expensive, include high cost-sharing requirements, and offer only limited benefits. Moreover, HIPAA's rules offer no protection for individuals against future premium increases. As a consequence, someone who suffers a serious medical condition or trauma may be charged extremely high premiums.

The committee concluded that there is no evidence that the access trends will reverse without concerted actions on the part of policymakers. Current economic conditions and rising unemployment only exacerbate the problem as more individuals and families lose employment-based benefits, many of them turning to public insurance programs in an exceptionally challenging fiscal time for state and local governments. The Administration and Congress have already taken steps beyond the reauthorization of the CHIP program to deal with the impact of the recession. To mitigate the effects of expected private-sector coverage losses and increased costs to state programs, short term financing for some of the cost of COBRA benefits has been provided for workers who have lost their jobs, and supplemental federal matching has been extended to hard-pressed state Medicaid programs. However, net losses in overall coverage rates are still expected in the near term.

Health Care Disparities: A National Picture of Rates, Incidence, and Prevalence

Health disparities are getting the attention of legislatures across the country. The literature has documented the magnitude of this pervasive problem across several dimensions of health care (Courtwright, 2008; Harris, 2010; Safran al., 2009). Many issues related to health care disparities are centered on sociocultural issues (King, 2005). Health care disparities are not a new issue. Already in 1964 the Surgeon General underscored the uneven access to health care across the United States. What is new is the degree to which citizens, state policymakers and other stakeholders are asking important questions concerning healthcare availability and the need to change practices that sanction health care disparities. This nation-wide discussion has brought to light the problems of insurance availability, racial/ethnic disparities, increasing health care access, and the role of cultural competency. It also produced recommendations for increasing health care availability.

New research has emerged since 2002 when the Institute of Medicine (IOM) examined the impact of uneven health care access on children and adults. Nearly 100 studies reviewed by the Committee confirmed and extended the evidence gathered in previous studies regarding the serious harm of being uninsured. Rigorous new research in the past six years has demonstrated the benefits of gaining health insurance for both children and adults.

Uninsured Americans frequently delay or forgo doctor's visits, prescription medications, and other effective treatments, even in the face of serious disease or life threatening conditions. Uninsured children are 20 to 30% more likely to lack immunizations, prescription medications, asthma care, and basic dental care. Uninsured children with conditions requiring ongoing medical attention, such as asthma or diabetes, are 6 to 8 times more likely to have their health care needs unmet. Uninsured children are also known to miss more school days due to health reasons than insured children.

Among working-age uninsured adults, 40% have one or more chronic health conditions such as asthma, hypertension, depression, diabetes, chronic lung disease, cancer, or heart disease. Uninsured adults with similar chronic conditions are two to four times more likely than their uninsured counterparts to have received no medical attention in the prior year. Because uninsured adults seek health care less often than insured adults, they are often unaware of health problems such as high blood pressure, high cholesterol, or early-stage cancer. Uninsured adults are also less likely to receive vaccinations, cancer screening services like mammography and colonoscopy, and other effective preventative services.

These deficits in care have important consequences for uninsured adults. Middle-aged adults with chronic conditions like diabetes or hypertension experience more rapid declines in health than insured adults with these conditions. Uninsured adults are more likely to be diagnosed with later-stage cancers compared to their insured peers. If hospitalized for serious acute conditions, such as heart attack, stroke, or major trauma, uninsured adults are more likely to die after admission to a hospital. Uninsured adults

are 25% more likely to die prematurely than insured adults overall, and with serious conditions such as heart disease, diabetes, or cancer; their risk of premature death can be 40 to 50% higher.

The data from the 1990's reveal a high incidence of chronic disease among African Americans in Nevada (Woodson, Braxton-Calhoun, Black, & Marinelli, 2009). Several steps were taken to increase awareness of the problem by the University of Nevada Cooperative Extension (UNCE) and several other groups forming the Community Partners for Better Health (CPBH). These groups included churches and health-related agencies such as the American Cancer Society, American Diabetes Association American Heart Association, Clark County Health District, Community Health Centers of Southern Nevada, and the Las Vegas Coalition of National Black Leadership Initiative on Cancer. In 1999, UNCE and CPBH collaborated with the Center for Disease Control and Prevention (CDC) for Racial and Ethnic Approaches to Community Health (REACH 2010), helping educate the public on health priorities within identified minority populations. Collaborative efforts triggered intervention steps to aid community needs. Thus, CPBH obtained funding to complete the Ryan White Title I Comprehensive Assessment for Clark County (spring 2005); the Office of Minority Health for Nevada established (spring 2005); Open Meadows Foundation and Harrah's Entertainment Corporation focused on nutrition and physical activities for adolescent girls (August 2006) and conducted focus groups to bring awareness of health disparities in the African American community of Southern Nevada (spring 2007); and Nevada Office of Minority Health and CPBH increased funding for pregnant teenager girls receiving prenatal care.

Two national initiatives, Healthy People 2000 and Healthy People 2010, were organized to strengthen the Agency for Healthcare Research and Quality (AHRQ) as a companion to bring greater awareness to improving the nation's health.

Ethnic Disparities in Health Care Access and Insurance Availability

According to Kim, Kumanyika, Shive, Igweatu, and Kim (2010, p. 224), a health care disparity among ethnic minorities exemplifies social injustice:

Studies suggest that social inequalities, not individual behaviors, are the main reason why racial and ethnic minorities get sicker and die sooner than the rest of the population. This 'social determinants of health' perspective – which has gained increased attention in recent years – asserts that the root causes of disparities in health are inequalities in social, economic, physical, and environmental conditions, because these directly influence health and indirectly constrain opportunities for healthy behaviors, access to health care, and even genetic predisposition for disease.

To address disparities in health care, Nevada legislators established the National Center on Minority Health and Health Disparities and empowered it to follow minority health trends. Another legislative initiative was The Minority Health and Health Disparities

Research Education Act of 2000 that focused on research, education, and training related to minority health issues. Among the issues that received top attention were the screening for cancer, cardiovascular disease, and diabetes.

The term “disparities” refers to population specific differences in the presence of disease, health outcomes, quality of health care, and access to health care services that exist across racial and ethnic groups. As such, it is closely linked to the question of social values and justice (Braveman et al., 2011). We should note that the term “disparity” is controversial, with some observers seeing it as a manifestation of social injustice and others tying it to divergent cultural, philosophical, or legal perspectives (Braveman et al., 2011; Le’Cook et al., 2012). Although there is evidence of vagueness, The National Institutes of Health has embraced the concept of differences in the incidence, prevalence, mortality, and burden of diseases and other adverse health conditions that exist among specific population groups in the United States (Braveman et al., p. 149).

Braveman et al. (2011) cites several key factors implicated in health disparities. According to this approach, (1) all people, including those who are socially disadvantaged, should be valued equally and have access to services that allow them to fully obtain optimum care; (2) the value health is essential to a person’s well-being; (3) the prosperity of our nation correlates with the health of its population and thus obligates the government to ensure the equal opportunity for all its citizens to attain the highest level of health; (4) the distribution of health resources is an ethical issue rather than simply a matter of one’s ability to pay or a function of social status; and (5) health equity reflects the improvements that close the health access gap between the advantaged and disadvantaged groups.

When considering disparity, problematic areas include preferences, geography, and insurance status (Le’Cook, McGuire, & Zaslavsky, 2012). Patient preferences are usually not provided in the data base and patients may not be fully aware of their clinical options. Minority patients may be adversely affected by language or cultural barriers that impede understanding of the health benefits certain procedures offer, just as they may suffer from the past experience of inferior care (Harris, 2010). The research has shown the relationship between geographical and racial/ethnic disparity, with high disparity levels associated with areas where the minority population was high, underserved, or offered poor quality service.

As Le’Cook et al. (2012) noted, there is a substantial difference between the insurance status of minorities and whites. More Blacks and Latinos had enrolled in Medicaid than whites. Another study showed that individuals enrolled in Medicaid were more likely to receive mental health care than patients serviced by private insurance plans. These findings suggest that the insurance status in a particular health category and social economic status (SES) are components of the health care system highly sensitive to disparities in health care access and quality.

Disparities point to the inefficiency within the health care system, which in turn suggests unnecessary costs. According to a 2009 study conducted by the Joint Center for Political and Economic Studies, eliminating health disparities for minorities would have reduced

direct medical care expenditures by \$229.4 billion between 2003 and 2006. SAMHSA, the nation's leading mental health service agency are concerned with the imbalance of power that affects practices, quality of service, outcomes of service, and the rate of disease incidence, prevalence, morbidity, mortality, and survival of a specific population (Safran et al., 2009).

Many factors contribute to racial, ethnic, and socioeconomic health disparities, including inadequate access to care, poor quality of care, community features, such as poverty, residential segregation, education, geographical location, violence, cultural and personal behaviors (Bull & Miller, 2008). These factors are often associated with underserved racial and ethnic minority groups, individuals who have encountered economic barriers, persons with disabilities and individuals living within medically underserved communities. Examples include distrust of the healthcare system, cultural linguistic interpretations, a lack of minority healthcare workers, and unequal access to care (King, 2005, pg. 36). The Tuskegee syphilis experiment is a reminder of why African Americans may not trust or follow through with treatment, especially if the patient and provider represent different racial/ethnic backgrounds (Harris, 2010).

According to Harris (2010), there are additional factors that impact disparities from the perception of the provider level and the system's response as a major contributor to health care disparities. Stereotypes and biases from the media or other sources that may influence the provider's judgment and the treatment process, pressure of time to respond with limited patient information, a provider's limited exposure in the medical field were among the factors of disparities.

Despite continuous efforts to reduce health disparities in the United States, racial and ethnic disparities in both health and health care persist. Even when we control for income, health insurance and access to care, disparities loom large. Low performance on a range of health indicators, such as infant mortality, life expectancy, prevalence of chronic disease, and insurance coverage reveal differences between racial and ethnic minority populations and their white counterparts. Here are a few examples:

- Infants born to black women are 1.5 to 3 times more likely to die than those born to women of other races/ethnicities and American Indian and Alaska Native infants die from SIDS at nearly 2.5 times the rate of white infants.
- Cancer is the second leading cause of death for most racial and ethnic minorities; African American men are more than twice as likely to die from prostate cancer as whites and Hispanic women are more than 1.5 times as likely to be diagnosed with cervical cancer.
- African Americans, American Indians and Alaska Natives are twice as likely to have diabetes as white individuals; diabetes rates among Hispanics are 1.5 times higher than those for whites; and African Americans with diabetes have an amputations rate seven times higher than whites and are more likely to have kidney failure more often.

Studies have also shown that Hispanics and African Americans tend to visit emergency rooms rather than primary care doctors, and that African American women are more prone to die from breast cancer than White women (King, 2005).

Research has documented racial differences in life expectancy by state between African American and European American populations. The sources of information included the 1997 – 2004 death certificate data from the Multiple Cause of Death public use files and the 2000 US Census data. Additionally, in this study there was consideration given to the differences in data estimations given due to specific racial populations, their mobility and mortality rates. In addition to the black-white disparities, significant variations in the health experiences are present on other populations. Here is the relevant data reported by Bharmal, Tseng, Kaplan, & Wong (2012):

- The national average life expectancy for white men is currently 74.79 years and 67.66 for black men.
- Life expectancy for white women is 79.84 years and 74.64 for black women.
- Nine states, including Nevada, were identified as having the smallest gap in the racial disparity in life expectancy – 4.72 years.
- Along with New Jersey, Nebraska, Wisconsin, Michigan, Pennsylvania, and Illinois, Washington D.C. has the largest racial disparity gap in life expectancy due to the short life expectancy of black men.
- In Nevada, along with four states, white men have a lower than average life expectancy, even though the life expectancy of black men is closer to the national average.

White women living in Illinois, Rhode Island, Kansas, New Jersey, Wisconsin, Minnesota, Iowa, Florida, and Washington D. C. have higher than average or average life expectancy. Different statistics have been noted for states such as New York, California, Texas, Florida, Georgia, Illinois, North Carolina, Maryland, Michigan, and Louisiana, which have the largest black populations. Michigan and Illinois have shorter life expectancies for the black population; white women in Florida have a higher than average life expectancy.

Cultural Competence as a Strategy to Reduce Health Disparities

As globalization and diversity increase in the United States, medical issues may be influenced by social or cultural backgrounds. Since 2002, researchers have been more attuned to the role that cultural competency plays in developing effective healthcare policies. Cultural competence is defined as a set of behaviors, attitudes, and policies that enable an agency, system, organization, and individual to work effectively in diverse settings (Betancourt et al, 2012; Harris, 2010; Selig et al., 2006).

Cultural competence is a key component of the effective patient-provider relationship (Harris, 2010). Culturally competent health care practices ensure a heightened

awareness of vulnerability, the protection of human rights, and dignity to those who have experienced the effects of low status and inferior social roles (Flaskerud, 2007). When patients discuss their illnesses, their descriptions may not align with medical textbooks due to language differences, specific expectations of treatment, and skeptical feelings toward a medical provider's recommendation. A second example in research has raised the issue of patient satisfaction. Inadequate clinical results result from the sociocultural differences between patients and healthcare providers (Betancourt, Green, Carrillo, & Park, 2005).

Literature review points to several promising initiatives designed to resolve problems caused by cultural competency and unequal access health care. Funded by the Center of Disease Control (CDC), REACH initiative got underway in 2010 that produced a course on cultural competency to be taught at the University of Michigan, Flint. The rationale for the course was to help students acquire skills necessary to work with diverse populations, understand the impact of racism on health disparities, and dismantle communication barriers impacting the use of health care services (Selig, Tropicano, Green-Moton, 2006).

While health care reform hangs in the balance, a more immediate way to improve health care disparities is through improving cultural competence and promoting education among ethnic minorities. As Ross et al. (2010, p. 160) argue,

In order to improve the health of the diverse U.S. population, it is essential to develop and implement educational programs that teach physicians about the pervasiveness of racial and ethnic health disparities and help them develop strategies to deliver quality care to diverse and underserved populations.

Betancourt et al. (2005, p. 503) describe specific ways to include “components of culturally competent care” as “diversity among staff and providers; system capacities, including data collection (to assess the needs of the patient population and track progress in improving health outcomes) and effective interpreter services; and cultural competence education for management, providers, and staff”). In addition to promoting cultural competency within the health care field, Thomas (2006, p. 9) suggests specific protocols that will help improve health care disparities:

Successful protocols require a Top Down/Bottom Up approach which often diametrically opposes traditional organizational styles where leadership and decision making rests exclusively in the hands of a few. The Top Down/Bottom Up approach requires collaboration from all parties. It is a commitment from all stakeholders, including policy makers, administrators, advocates, patients, providers, organizations, and the communities being served.

Culturally competent practices help alleviate health care disparities, as Wilkerson, Fung, May, and Elliott (2010. Pp. 89-90) argue: “While it is not firmly established that a patient-centered care approach is associated with a reduction in health disparities, there is sufficient theoretical support for this effect, and... [is] being recommended as one approach to improving communication and reducing health disparities.” Overall,

research reveals that by including culturally competent practices, education, and protocols in health care delivery, we can shrink health care disparities. As Betancourt et al. (2005, p. 502) report, “Informants saw a clear link between cultural competence and eliminated racial/ethnic disparities in health care.”

Another way to improve ethnic disparities in health care is to promote education among minorities. Education affects many factors of the minority population, including socioeconomic status, and ultimately, health. Eide and Showalter (2011, P. 782) indicate that “attending college increases the likelihood of receiving a physical exam by 5 percentage points, a dental exam by 8 percentage points, a flu shot by 5 percentage points, and a cholesterol test by 3 percentage points.” Eide and Showalter (2011, p. 782) also find “a post-graduate degree reduces the average predicted probability of smoking by 8.9 percentage points, a college degree by 4.3 percentage points, and a high school degree by 3.1 percentage points.” While reducing ethnic disparities in health care depends on health care reform and cultural competence, the educational attainment of minorities can have beneficial effects on the overall health and access to health care by minorities.

While ethnic disparities in health care have been documented since the 1960s, it is only at the turn of the 21st century that concerted efforts were mounted to diminish their magnitude. According to Kim et al. (2010), “health disparities are a social injustice and . . . we have a moral imperative to ensure health equity for all, especially for the most disadvantaged” (p. 224). While research points the ways to improve these egregious disparities, it is up to health care providers and government agencies to implement the necessary changes.

Resources for Increasing Healthcare Access and Insurance Availability

On March 23, 2010, President Obama signed the Affordable Health Care Act. The Affordable Health Care Act aims to improve the current health care system by increasing access to health coverage for Americans and introducing new protections for individuals with health insurance. The law puts in place comprehensive health insurance reforms that will roll out over the period of four years and beyond, with most changes taking place in 2014. Some provisions of this law have already begun to be implemented.

Formally known as the Patient Protection and Affordable Care Act, this statute ensures that all Americans have access to quality, affordable health care, and it contains specific provisions to contain costs. The Congressional Budget Office (CBO) has determined that, fully paid for, the Patient Protection and Affordable Care Act will provide more than 94% of Americans health insurance coverage, bend the health care cost curve, and reduce the federal budget deficit by \$118 billion over the next ten years, with more savings projected in the next decade.

The following is a brief summary of the reform components in the Patient Protection and Affordable Care Act:

- Quality, affordable health care for all Americans

- The role of public programs
- Improving the quality and efficiency of health care
- Prevention of chronic disease and improving public health
- Health care workforce
- Transparency and program integrity
- Improving access to innovative medical therapies
- Community living assistance services and supports
- Revenue provisions

Title I. Quality, Affordable Health Care for All Americans

The *Patient Protection and Affordable Care Act* will accomplish a fundamental transformation of health insurance in the United States through shared responsibility. Systemic insurance market reform will eliminate discriminatory practices by health insurers such as pre-existing condition exclusions. Achieving these reforms without increasing health insurance premiums will mean that all Americans must have coverage. Tax credits for individuals, families, and small businesses will make insurance affordable for everyone. These three elements are the essential links to achieving meaningful reform.

Immediate Improvements. Implementing health insurance reform will take time, but several immediate reforms became effective in 2010. The Patient Protection and Affordable Care Act will:

- Eliminate lifetime and unreasonable annual limits on benefits, with annual limits prohibited in 2014
- Prohibit rescissions of health insurance policies
- Provide assistance for those who are uninsured because of a pre-existing condition
- Prohibit pre-existing condition exclusions for children
- Require coverage of preventive services and immunizations
- Extend dependent coverage up to age 26
- Develop uniform coverage documents so consumers can make apples-to-apples comparisons when shopping for health insurance
- Cap insurance company non-medical, administrative expenditures
- Ensure consumers have access to an effective appeals process and provide consumer a place to turn for assistance navigating the appeals process and accessing their coverage
- Create a temporary re-insurance program to support coverage for early retirees
- Establish an internet portal to assist Americans in identifying coverage options
- Facilitate administrative simplification to lower health system costs

Health Insurance Market Reform. Beginning in 2014, further reforms will be implemented. Across individual and small group health insurance markets, new rules will end medical underwriting and pre-existing condition exclusions. Insurers will be prohibited from denying coverage or setting rates based on gender, health status,

medical condition, claims experience, genetic information, evidence of domestic violence, or other health-related factors. Premiums will vary only by family structure, geography, actuarial value, tobacco use, participation in a health promotion program, and age (by not more than three to one).

Available Coverage. A qualified health plan, to be offered through the new American Health Benefit Exchange, must provide essential health benefits which include cost sharing limits. No out-of-pocket requirements can exceed those in Health Savings Accounts, while deductibles in the small group market cannot exceed \$2,000 for an individual and \$4,000 for a family. Coverage will be offered at four levels with actuarial values defining how much the insurer pays: Platinum – 90%; Gold – 80%; Silver – 70%; and Bronze – 60%. A less costly catastrophic-only plan will be offered to individuals under age 30 and to others who are exempt from the individual responsibility requirement.

American Health Benefit Exchanges. By 2014, each state will establish an Exchange to help individuals and small employers obtain coverage. Each plan submitted to the Exchanges will be accredited for quality, present its benefit options in a standardized manner for easy comparison, and use one simple enrollment form. Individuals qualified to receive tax credits for Exchange coverage must be ineligible for affordable, employer-sponsored insurance under any form of public insurance coverage. Undocumented immigrants are ineligible for premium tax credits. Federal support will be available for new non-profit, member run insurance cooperatives, and the Office of Personnel Management is scheduled to supervise the offering by private insurers of multi-State plans, available nationwide. States will have flexibility to establish basic health plans for non-Medicaid, lower-income individuals; states may also seek waivers to explore other reform options; and states may form compacts with other states to permit cross-state sale of health insurance. No federal dollars may be used to pay for abortion services.

Making Coverage Affordable. New, refundable tax credits will be available for Americans with incomes between 100 and 400 percent of the federal poverty line (FPL) (about \$88,000 for a family of four). The credit is calculated on a sliding scale beginning at two percent of income for those at 100% FPL and phasing out at 9.8% of income at 300-400 percent FPL. If an employer offer of coverage exceeds 9.8% of a worker's family income, or the employer pays less than 60% of the premium, the worker may enroll in the Exchange and receive credits. Out of pocket maximums (\$5,950 for individuals and \$11,900 for families) are reduced to one – third for those with income between 100-200% FPL, one-half for those with incomes between 200-300% FPL, and two - thirds for those with income between 300 - 400 percent FPL. Credits are available for eligible citizens and legally-residing aliens. A new credit will assist small businesses with fewer than 25 workers for up to 50 percent of the total premium cost.

Shared Responsibility. Beginning in 2014, most individuals will be responsible for maintaining minimum essential coverage or paying a penalty of \$95 in 2014, \$495 in 2015 and \$750 in 2016, or up to 2% of income by 2016, with a cap at the national average bronze plan premium. Families will pay half the amount for children up to a cap

of \$2,250 for the entire family. After 2016, dollar amounts will increase by the annual cost of living adjustment. Exceptions to this requirement are made for religious objectors, those who cannot afford coverage, taxpayers with incomes less than 100 percent FPL, Indian tribe members, those who receive a hardship waiver, individual's not lawfully present, incarcerated individuals, and those not covered for less than three months.

Any individual or family who currently has coverage and would like to retain that coverage can do so under a „grandfather“ provision. This coverage is deemed to meet the individual responsibility to have health coverage. Similarly, employers that currently offer coverage are permitted to continue offering such coverage under the “grandfather” policy.

Employers with more than 200 employees must automatically enroll new full-time employees in coverage. Any employer with more than 50 full-time employees that does not offer coverage and has at least one full-time employee receiving the premium assistance tax credit will make a payment of \$750 per full-time employee. An employer with more than 50 employees that offers coverage that is deemed unaffordable or does not meet the standard for minimum essential coverage and but has at least one full-time employee receiving the premium assistance tax credit because the coverage is either unaffordable or does not cover 60 percent of total costs, will pay the lesser of \$3,000 for each of those employees receiving a credit or \$750 for each of their full-time employees total.

Title II. The Role of Public Programs

The Patient Protection and Affordable Care Act expands eligibility for Medicaid to lower income persons and assumes federal responsibility for much of the cost of this expansion. It provides enhanced federal support for the Children’s Health Insurance Program, simplifies Medicaid and CHIP enrollment, improves Medicaid services, provides new options for long-term services and supports, improves coordination for dual-eligibles, and improves Medicaid quality for patients and providers.

Medicaid Expansion. States may expand Medicaid eligibility as early as April 1, 2010. Beginning on January 1, 2014, all children, parents and childless adults who are not entitled to Medicare and who have family incomes up to 133% FPL will become eligible for Medicaid. Between 2014 and 2016, the federal government will pay 100% of the cost of covering newly-eligible individuals. In 2017 and 2018, states that initially covered less of the newly – eligible population (“Other States”) will receive more assistance than states that covered at least some non-elderly, non-pregnant adults (“Expansion States”). States will be required to maintain the same income eligibility levels through December 31, 2013 for all adults, and this requirement would be extended through September 30, 2019 for children currently in Medicaid.

Children’s Health Insurance Program. States will be required to maintain income eligibility levels for CHIP through September 30, 2019. The current reauthorization period of CHIP is extended for two years, to September 30, 2015. Between fiscal years 2016 and 2019, states would receive a 23% point increase in the CHIP federal match

rate, subject to a 100 percent cap.

Simplifying Enrollment. Individuals will be able to apply for and enroll in Medicaid, CHIP and the Exchange through state-run websites. Medicaid and CHIP programs and the Exchange will coordinate enrollment procedures to provide seamless enrollment for all programs. Hospitals will be permitted to provide Medicaid services during a period of presumptive eligibility to members of all Medicaid eligibility categories.

Community First Choice Option. A new optional Medicaid benefit is created through which states may offer community-based attendant services and supports to Medicaid beneficiaries with disabilities who would otherwise require care in a hospital, nursing facility, or intermediate care facility for the mentally retarded.

Disproportionate Share Hospital Allotments. States disproportionate share hospital (DSH) allotments are reduced once a state's uninsured rate decreases by 45%. The initial reduction for States that spent 99.90% of their allotments over the five-year period of 2004 through 2008 would be 50%, unless they are defined as low DSH states, in which case they would receive a 25% reduction. The initial reduction for states that spent greater than 99.90% of their allotments would be 35%, or 17.5% for low DSH states in this category. As the uninsured rate continues to decline, states DSH allotments would be reduced by a corresponding amount. At no time could a state's allotment be reduced by more than 50% compared to its FY2012 allotment.

Dual Eligible Coverage and Payment Coordination. The Secretary of Health and Human Services (HHS) will establish a Federal Coordinated Health Care Office by March 1, 2010, to integrate care under Medicare and Medicaid and improve coordination among the federal and state governments for individuals enrolled in both programs (dual eligibles).

Title III. Improving the Quality and Efficiency of Health Care

The Patient Protection and Affordable Care Act will improve the quality and efficiency of U.S. medical care services for everyone, and especially for those enrolled in Medicare and Medicaid. Payment for services will be linked to better quality outcomes, and the Patient Protection and Affordable Care Act will make substantial investments to improve the quality and delivery of care and support research to inform consumers about patient outcomes resulting from different approaches to treatment and care delivery. New patient care models will be created and disseminated, rural patients and providers will see meaningful improvements, and payment accuracy will improve. The Medicare Part D prescription drug benefit will be enhanced and the coverage gap, or donut hole, will be reduced. An Independent Payment Advisory Board will develop recommendations to ensure long-term fiscal stability.

Linking Payment to Quality Outcomes in Medicare. A value-based purchasing program for hospitals will launch in FY2013 to link Medicare payments to quality performance on common, high-cost conditions. The Physician Quality Reporting Initiative (PQRI) is extended through 2014, with incentives for physicians to report Medicare quality data- physicians will receive feedback reports beginning in 2012. Long-

term care hospitals, inpatient rehabilitation facilities, certain cancer hospitals, and hospice providers will participate quality measure reporting starting in FY2014, with penalties for non-participating providers.

Strengthening the Quality Infrastructure. The HHS Secretary will establish a national strategy to improve health care service delivery, patient outcomes, and population health. The President will convene an Interagency Working Group on Health Care Quality to collaborate on the development and dissemination of quality initiatives consistent with the national strategy.

Encouraging Development of New Patient Care Models. A new Center for Medicare & Medicaid Innovation will research, develop, test, and expand innovative payment and delivery arrangements. Accountable Care Organizations (ACOs) that take responsibility for cost and quality of care will receive a share of savings they achieve for Medicare. The HHS Secretary will develop a national, voluntary pilot program encouraging hospitals, doctors, and post-acute providers to improve patient care and achieve savings through bundled payments. A new demonstration program for chronically ill Medicare beneficiaries will test payment incentives and service delivery using physician and nurse practitioner-directed home-based primary care teams. Beginning in 2012, hospital payments will be adjusted based on the dollar value of each hospital's percentage of potentially preventable Medicare readmissions.

Ensuring Beneficiary Access to Physician Care and Other Services. The Act extends a floor on geographic adjustments to the Medicare fee schedule to increase provider fees in rural areas and gives immediate relief to areas affected by geographic adjustment for practice expenses. The Act extends Medicare bonus payments for ground and air ambulance services in rural and other areas. The Act creates a 12 month enrollment period for military retirees, spouses (and widows/widowers) and dependent children, who are eligible for TRICARE and entitled to Medicare Part A based on disability or ESRD, who have declined Part B.

Rural Protections. The Act extends the outpatient hold harmless provision, allowing small rural hospitals and Sole Community Hospitals to receive this adjustment through FY2010 and reinstates cost reimbursement for lab services provided by small rural hospitals from July 1, 2010 to July 1, 2011. The Patient Protection and Affordable Care Act extends the Rural Community Hospital Demonstration Program for five years and expands eligible sites to additional states and hospitals.

Improving Payment Accuracy. The HHS Secretary will rebase home health payments starting in 2014 to better reflect the mix of services and intensity of care provided to patients. The Secretary will update Medicare hospice claims forms and cost reports to improve payment accuracy and revise the underlying payment system to better reflect the cost of providing care to hospice patients. The Secretary will revise Disproportionate Share Hospital (DSH) payments to better account for hospitals' costs of treating the uninsured and underinsured, including adjustments to DSH payments to reflect lower uncompensated care costs resulting from increases in the number of insured patients. The bill also makes changes to improve payment accuracy for imaging

services and power-driven wheelchairs. The Secretary will study and report to Congress on reforming the Medicare hospital wage index system and will establish a demonstration program to allow hospice eligible patients to receive all other Medicare covered services during the same period.

Medicare Advantage (Part C). Medicare Advantage (MA) payments will be based on the average of the bids submitted by insurance plans in each market. Bonus payments will be available to improve the quality of care and will be based on an insurer's level of care coordination and care management, as well as achievement on quality rankings. New payments will be implemented over a four-year transition period. MA plans will be prohibited from charging beneficiaries cost sharing for covered services greater than what is charged under fee-for-service. Plans providing extra benefits must give priority to cost sharing reductions, wellness and preventive care prior to covering benefits not currently covered by Medicare.

Medicare Prescription Drug Plan Improvements (Part D). In order to have their drugs covered under the Medicare Part D program, drug manufacturers will provide a 50% discount to Part D beneficiaries for brand-name drugs and biologics purchased during the coverage gap beginning July 1, 2010. The initial coverage limit in the standard Part D benefit will be expanded by \$500 for 2010.

Ensuring Medicare Sustainability. A productivity adjustment will be added to the market basket update for inpatient hospitals, home health providers, nursing homes, hospice providers, inpatient psychiatric facilities, long-term care hospitals and inpatient rehabilitation facilities. The Act creates a 15-member Independent Payment Advisory Board to present Congress with proposals to reduce costs and improve quality for beneficiaries. When Medicare costs are projected to exceed certain targets, the Board's proposals will take effect unless Congress passes an alternative measure to achieve the same level of savings. The Board will not make proposals that ration care, raise taxes or beneficiary premiums, or change Medicare benefit, eligibility, or cost-sharing standards.

Health Care Quality Improvements. The Patient Protection and Affordable Care Act will create a new program to develop community health teams supporting medical homes to increase access to community-based, coordinated care. It supports a health delivery system research center to conduct research on health delivery system improvement and best practices that improve the quality, safety, and efficiency of health care delivery. And, it support medication management services by local health providers to help patients better manage chronic disease.

Title IV. Prevention of Chronic Disease and Improving Public Health

To better orient the nation's health care system toward health promotion and disease prevention, a set of initiatives will provide the impetus and the infrastructure. A new interagency prevention council will be supported by a new Prevention and Public Health Investment Fund. Barriers to accessing clinical preventive services will be removed. Developing healthy communities will be a priority, and a 21st century public health infrastructure will support this goal.

Modernizing Disease Prevention and Public Health Systems. A new interagency council is created to promote healthy policies and to establish a national prevention and health promotion strategy. A Prevention and Public Health Investment Fund is established to provide an expanded and sustained national investment in prevention and public health. The HHS Secretary will convene a national public/private partnership to conduct a national prevention and health promotion outreach and education campaign to raise awareness of activities to promote health and prevent disease across the lifespan.

Increasing Access to Clinical Preventive Services. The Act authorizes important new programs and benefits related to preventive care and services:

- For the operation and development of School-Based Health Clinics.
- For an oral healthcare prevention education campaign.
- To provide Medicare coverage – with no co-payments or deductibles – for an annual wellness visit and development of a personalized prevention plan.
- To waive coinsurance requirements and deductibles for most preventive services, so that Medicare will cover 100 percent of the costs.
- To provide States with an enhanced match if the State Medicaid program covers: (1) any clinical preventive service recommended with a grade of A or B by the U.S. Preventive Services Task Force and (2) adult immunizations recommended by the Advisory Committee on Immunization Practices without cost sharing.
- To require Medicaid coverage for counseling and pharmacotherapy to pregnant women for cessation of tobacco use.
- To award grants to states to provide incentives for Medicaid beneficiaries to participate in programs providing incentives for healthy lifestyles.

Creating Healthier Communities. The Secretary will award grants to eligible entities to promote individual and community health and to prevent chronic disease. The CDC will provide grants to states and large local health departments to conduct pilot programs in the 55-to-64 year old population to evaluate chronic disease risk factors, conduct evidence-based public health interventions, and ensure that individuals identified with chronic disease or at-risk for chronic disease receive clinical treatment to reduce risk. The Act authorizes all states to purchase adult vaccines under CDC contracts. Restaurants which are part of a chain with 20 or more locations doing business under the same name must disclose calories on the menu board and in written form.

Support for Prevention and Public Health Innovation. The HHS Secretary will provide funding for research in public health services and systems to examine best prevention practices. Federal health programs will collect and report data by race, ethnicity, primary language and any other indicator of disparity. The CDC will evaluate best employer wellness practices and provide an educational campaign and technical assistance to promote the benefits of worksite health promotion. A new CDC program will help state, local, and tribal public health agencies to improve surveillance for and responses to infectious diseases and other important conditions. An Institute of

Medicine Conference on Pain Care will evaluate the adequacy of pain assessment, treatment, and management; identify and address barriers to appropriate pain care; increase awareness; and report to Congress on findings and recommendations.

Title V. Health Care Workforce

To ensure a vibrant, diverse and competent workforce, the Patient Protection and Affordable Care Act will encourage innovations in health care workforce training, recruitment, and retention, and will establish a new workforce commission. Provisions will help to increase the supply of health care workers. These workers will be supported by a new workforce training and education infrastructure.

Innovations in the Health Care Workforce. The Patient Protection and Affordable Care Act establishes a National Health Workforce commission to review current and projected workforce needs and to provide comprehensive information to Congress and the Administration to align federal policies with national needs. It will also create competitive grants to enable state partnerships to complete comprehensive workforce planning and to create health care workforce development strategies.

Increasing the Supply of Health Care Workers. The federal student loan program will be modified to ease criteria for schools and students, shorten payback periods, and to make the primary care student loan program more attractive. The Nursing Student Loan Program will be expanded and updated. A loan repayment program is established for pediatric subspecialists and providers of mental and behavioral health services to children and adolescents who work in a Health Professional Shortage Area, a Medically Underserved Area, or with a Medically Underserved Population. Loan repayment will be offered to public health students and workers in exchange for working at least three years at a federal, state, local, or tribal public health agency. Loan repayment will be offered to allied health professionals employed at public health agencies or in health care settings located in Health Professional Shortage Areas, Medically Underserved Areas, or with Medically Underserved Populations. A mandatory fund for the National Health Service Corps scholarship and loan repayment program is created. A \$50 million grant program will support nurse-managed health clinics. A Ready Reserve Corps within the Commissioned Corps is established for service in times of national emergency. Ready Reserve Corps members may be called to active duty to respond to national emergencies and public health crises and to fill critical public health positions left vacant by members of the Regular Corps who have been called to duty elsewhere.

Enhancing Health Care Workforce Education and Training. New support for workforce training programs is established in these areas:

- Family medicine, general internal medicine, general pediatrics, and physician assistantship.
- Rural physicians.
- Direct care workers providing long-term care services and supports.
- General, pediatric, and public health dentistry.
- Alternative dental health care provider.

- Geriatric education and training for faculty in health professions schools and family caregivers.
- Mental and behavioral health education and training grants to schools for the development, expansion, or enhancement of training programs in social work, graduate psychology, professional training in child and adolescent mental health, and pre-service or in-service training to paraprofessionals in child and adolescent mental health.
- Cultural competency, prevention and public health and individuals with disabilities training.
- Advanced nursing education grants for accredited Nurse Midwifery programs.
- Nurse education, practice, and retention grants to nursing schools to strengthen nurse education and training programs and to improve nurse retention.
- Nurse practitioner training program in community health centers and nurse-managed health centers.
- Nurse faculty loan program for nurses who pursue careers in nurse education.
- Grants to promote the community health workforce to promote positive health behaviors and outcomes in medically underserved areas through use of community health workers.
- Fellowship training in public health to address workforce shortages in state and local health departments in applied public health epidemiology and public health laboratory science and informatics.
- A U.S. Public Health Sciences Track to train physicians, dentists, nurses, physician assistants, mental and behavior health specialists, and public health professionals emphasizing team-based service, public health, epidemiology, and emergency preparedness and response in affiliated institutions.

Supporting the Existing Health Care Workforce. The Patient Protection and Affordable Care Act reauthorizes the Centers of Excellence program for minority applicants for health professions, expands scholarships for disadvantaged students who commit to work in medically underserved areas, and authorizes funding for Area Health Education Centers (AHECs) and Programs. A Primary Care Extension Program is established to educate and provide technical assistance to primary care providers about evidence-based therapies, preventive medicine, health promotion, chronic disease management, and mental health.

Strengthening Primary Care and Other Workforce Improvements. Beginning in 2011, the HHS Secretary may redistribute unfilled residency positions, redirecting those slots for training of primary care physicians. A demonstration grant program is established to serve low-income persons including recipients of assistance under Temporary Assistance for Needy Families (TANF) programs to develop core training competencies and certification programs for personal and home care aides. Also, a grant program is set up to provide grant funding and payments to teaching health centers that are focused on training primary care providers in the community. Medicare is also directed to test new models for improving the training of advance practice nurses.

Improving Access to Health Care Services. The Patient Protection and Affordable

Care Act authorizes new and expanded funding for federally qualified health centers and reauthorizes a program to award grants to states and medical schools to support the improvement and expansion of emergency medical services for children needing trauma or critical care treatment. Also supported are grants for coordinated and integrated services through the co-location of primary and specialty care in community-based mental and behavioral health settings. A Commission on Key National Indicators is established.

Title VI. Transparency and Program Integrity

To ensure the integrity of federally financed and sponsored health programs, this Title creates new requirements to provide information to the public on the health system and promotes a newly invigorated set of requirements to combat fraud and abuse in public and private programs.

Physician Ownership and Other Transparency. Physician-owned hospitals that do not have a provider agreement prior to August 2010 will not be able to participate in Medicare. Drug, device, biological and medical supply manufacturers must report gifts and other transfers of value made to a physician, physician medical practice, a physician group practice, and/or a teaching hospital. Referring physicians for imaging services must inform patients in writing that the individual may obtain such service from a person other than the referring physician, a physician who is a member of the same group practice, or an individual who is supervised by the physician or by another physician in the group. Prescription drug makers and distributors must report to the HHS Secretary information pertaining to drug samples currently being collected internally. Pharmacy benefit managers (PBM) or health benefits plans that provide pharmacy benefit management services that contract with health plans under Medicare or the Exchange must report information regarding the generic dispensing rate; rebates, discounts, or price concessions negotiated by the PBM.

Nursing Home Transparency and Improvement. The Act requires that skilled nursing facilities (SNFs) under Medicare and nursing facilities (NFs) under Medicaid make available information on ownership. SNFs and NFs will be required to implement a compliance and ethics program. The Secretary of HHS will publish new information on the Nursing Home Compare Medicare website such as standardized staffing data, links to state internet websites regarding state survey and certification programs, a model standardized complaint form, a summary of complaints, and the number of instances of criminal violations by a facility or its employee. The Secretary also will develop a standardized complaint form for use by residents in filing complaints with a state survey and certification agency or a state long-term care ombudsman.

Targeting Enforcement. The Secretary may reduce civil monetary penalties for facilities that self-report and correct deficiencies. The Secretary will establish a demonstration project to test and implement a national independent monitoring program to oversee interstate and large intrastate chains. The administrator of a facility preparing to close must provide written notice to residents, legal representatives of residents, the state, the Secretary and the long-term care ombudsman program in advance of the closure.

Improving Staff Training. Facilities must include dementia management and abuse prevention training as part of pre-employment training for staff.

Nationwide Program for Background Checks on Direct Patient Access Employees of Long Term Care Facilities and Providers. The Secretary will establish a nationwide program for national and state background checks of direct patient access employees of certain long-term supports and services facilities or providers.

Patient-Centered Outcomes Research. The Patient Protection and Affordable Care Act establishes a private, nonprofit entity (the Patient-Centered Outcomes Research Institute) governed by a public-private board appointed by the Comptroller General to provide for the conduct of comparative clinical outcomes research. No findings may be construed as mandates on practice guidelines or coverage decisions and important patient safeguards will protect against discriminatory coverage decisions by HHS based on age, disability, terminal illness, or an individual's quality of life preference.

Medicare, Medicaid, and CHIP Program Integrity Provisions. The Secretary will establish procedures to screen providers and suppliers participating in Medicare, Medicaid, and CHIP. Providers and suppliers enrolling or re-enrolling will be subject to new requirements including a fee, disclosure of current or previous affiliations with any provider or supplier that has uncollected debt, has had their payments suspended, has been excluded from participating in a Federal health care program, or has had their billing privileges revoked. The Secretary is authorized to deny enrollment in these programs if these affiliations pose an undue risk.

Enhanced Medicare and Medicaid Program Integrity Provisions. CMS will include in the integrated data repository (IDR) claims and payment data from Medicare (Parts A, B, C, and D), Medicaid, CHIP, health-related programs administered by the Departments of Veterans Affairs (VA) and Defense (DOD), the Social Security Administration, and the Indian Health Service (IHS). New penalties will exclude individuals who order or prescribe an item or service, make false statements on applications or contracts to participate in a Federal health care program, or who know of an overpayment and do not return the overpayment. Each violation would be subject to a fine of up to \$50,000. The Secretary may suspend payments to a provider or supplier pending a fraud investigation. Health Care Fraud and Abuse Control (HCFAC) funding will be increased by \$10 million each year for fiscal years 2011 through 2020. The Secretary will establish a national health care fraud and abuse data collection program for reporting adverse actions taken against health care providers, suppliers, and practitioners, and submit information on the actions to the National Practitioner Data Bank (NPDB). The Secretary will have the authority to disenroll a Medicare enrolled physician or supplier who fails to maintain and provide access to written orders or requests for payment for durable medical equipment (DME), certification for home health services, or referrals for other items and services. The HHS Secretary will expand the number of areas to be included in round two of the DME competitive bidding program from 79 of the largest metropolitan statistical areas (MSAs) to 100 of the

largest MSAs, and to use competitively bid prices in all areas by 2016.

Additional Medicaid Program Integrity Provisions. States must terminate individuals or entities from their Medicaid programs if the individuals or entities were terminated from Medicare or another state's Medicaid program. Medicaid agencies must exclude individuals or entities from participating in Medicaid for a specified period of time if the entity or individual owns, controls, or manages an entity that: (1) has failed to repay overpayments; (2) is suspended, excluded, or terminated from participation in any Medicaid program; or (3) is affiliated with an individual or entity that has been suspended, excluded, or terminated from Medicaid participation. Agents, clearinghouses, or other payees that submit claims on behalf of health care providers must register with the state and the Secretary. States and Medicaid managed care entities must submit data elements for program integrity, oversight, and administration. States must not make any payments for items or services to any financial institution or entity located outside of the United States.

Additional Program Integrity Provisions. Employees and agents of multiple employer welfare arrangements (MEWAs) will be subject to criminal penalties if they provide false statements in marketing materials regarding a plan's financial solvency, benefits, or regulatory status. A model uniform reporting form will be developed by the National Association of Insurance Commissioners, under the direction of the HHS Secretary. The Department of Labor will adopt regulatory standards and/or issue orders to prevent fraudulent MEWAs from escaping liability for their actions under state law by claiming that state law enforcement is preempted by federal law. The Department of Labor is authorized to issue "cease and desist" orders to temporarily shut down operations of plans conducting fraudulent activities or posing a serious threat to the public, until hearings can be completed. MEWAs will be required to file their federal registration forms, and thereby be subject to government verification of their legitimacy, before enrolling anyone.

Elder Justice Act. The Elder Justice Act will help prevent and eliminate elder abuse, neglect, and exploitation. The HHS Secretary will award grants and carry out activities to protect individuals seeking care in facilities that provide long-term services and supports and provide greater incentives for individuals to train and seek employment at such facilities. Owners, operators, and employees would be required to report suspected crimes committed at a facility. Owners or operators of such facilities would be required to submit to the Secretary and to the state written notification of an impending closure of a facility within 60 days prior to the closure.

Sense of the Senate Regarding Medical Malpractice. The Act expresses the sense of the Senate that health reform presents an opportunity to address issues related to medical malpractice and medical liability insurance, states should be encouraged to develop and test alternative models to the existing civil litigation system, and Congress should consider state demonstration projects to evaluate such alternatives.

Title VII. Improving Access to Innovative Medical Therapies

Biologics Price Competition and Innovation. The Patient Protection and

Affordable Care Act establishes a process under which FDA will license a biological product that is shown to be biosimilar or interchangeable with a licensed biological product, commonly referred to as a reference product. No approval of an application as either biosimilar or interchangeable is allowed until 12 years from the date on which the reference product is first approved. If FDA approves a biological product on the grounds that it is interchangeable to a reference product, HHS cannot make a determination that a second or subsequent biological product is interchangeable to that same reference product until one year after the first commercial marketing of the first interchangeable product.

More Affordable Medicines for Children and Underserved Communities: Drug discounts through the 340B program are extended to inpatient drugs and also to certain children's hospitals, cancer hospitals, critical access and sole community hospitals, and rural referral centers.

Title VIII. Community Living Assistance Services and Supports

Establishment of national voluntary insurance program for purchasing community living assistance services and support (CLASS program).

The *Patient Protection and Affordable Care Act* establishes a new, voluntary, self-funded long-term care insurance program, the CLASS Independence Benefit Plan, for the purchase of community living assistance services and supports by individuals with functional limitations. The HHS Secretary will develop an actuarially sound benefit plan that ensures solvency for 75 years; allows for a five-year vesting period for eligibility of benefits; creates benefit triggers that allow for the determination of functional limitation; and provides a cash benefit that is not less than an average of \$50 per day. No taxpayer funds will be used to pay benefits under this provision.

TITLE IX. REVENUE PROVISIONS

Excise Tax on High Cost Employer-Sponsored Health Coverage. The Patient Protection and Affordable Care Act levies a new excise tax of 40 percent on insurance companies or plan administrators for any health coverage plan with an annual premium that is above the threshold of \$8,500 for single coverage and \$23,000 for family coverage. The tax applies to self-insured plans and plans sold in the group market, and not to plans sold in the individual market (except for coverage eligible for the deduction for self-employed individuals). The tax applies to the amount of the premium in excess of the threshold. A transition rule increases the threshold for the 17 highest cost states for the first three years. An additional threshold amount of \$1,350 for singles and \$3,000 for families is available for retired individuals age 55 and older and for plans that cover employees engaged in high risk professions.

Increasing Transparency in Employer W-2 Reporting of Value of Health Benefits. This provision requires employers to disclose the value of the benefit provided by the employer for each employee's health insurance coverage on the employee's annual Form W-2.

Distributions for Medicine Qualified Only if for Prescribed Drug or Insulin. Confirms the definition of qualified medical expenses for HSAs, FSAs, and HRAs to the

definition used for the medical expense itemized deduction. Over-the-counter medicine obtained with a prescription continues to qualify as qualified medical expenses.

Increase in Additional Tax on Distributions from HSAs and Archer MSAs Not Used for Qualified Medical Expenses. Increases the additional tax for HSA withdrawals prior to age 65 that are used for purposes other than qualified medical expenses from 10 percent to 20 percent and increases the additional tax for Archer MSA withdrawals from 15 percent to 20 percent.

Limiting Health FSA Contributions. This provision limits the amount of contributions to health FSAs to \$2,500 per year, indexed to CPI-U for years after December 31, 2011.

Corporate Information Reporting. This provision requires businesses that pay any amount greater than \$600 during the year to corporate providers of property and services to file an information report with each provider and with the IRS.

Non-profit Hospitals. This provision would establish new requirements applicable to nonprofit hospitals. The requirements would include a periodic community needs assessment.

Pharmaceutical Manufacturers Fee. This provision imposes an annual flat fee of \$2.3 billion on the pharmaceutical manufacturing sector beginning in 2010 allocated across the industry according to market share. The fee does not apply to companies with sales of branded pharmaceuticals of \$5 million or less.

Medical Device Manufacturers Fee. This provision imposes an annual fee of \$2 billion in years 2011 through 2017 and \$3 billion in years thereafter on the medical device manufacturing sector. The fee is allocated across the industry according to market share. The fee does not apply to companies with sales of medical devices in the U.S. of \$5 million or less. The fee also does not apply to any sale of a Class I product or any sale of a Class II product that is primarily sold to consumers at retail for not more than \$100 per unit (under the FDA product classification system).

Health Insurance Provider Fee. This provision imposes an annual fee on the health insurance sector allocated across the industry according to market share. The fee will be \$2 billion for 2011, \$4 billion for 2012, \$7 billion for 2013, \$9 billion for years 2014 through 2016, and \$10 billion for years after 2016. The fee does not apply to companies whose net premiums written are \$25 million or less, and there is a limited exemption from the fee for certain non-profit insurers with a medical loss ratio (MLR) of 90 percent or more in the individual, small group and large group markets and whose overall MLR is at least 92 percent.

Department of Veterans Affairs Report. The Secretary of the U.S. Department of Veterans Affairs will review and report to Congress on the effect that the fees assessed on pharmaceutical and medical device manufacturers and health insurance providers have on the cost of medical care provided to veterans and veterans' access to medical

devices and branded drugs.

Eliminating the Deduction for Employer Part D Subsidy. This provision eliminates the deduction for the subsidy for employers who maintain prescription drug plans for their Medicare Part D eligible retirees.

Modification of the Threshold for Claiming the Itemized Deduction for Medical Expenses. This provision increases the adjusted gross income threshold for claiming the itemized deduction for medical expenses from 7.5 percent to 10 percent. Individuals age 65 and older would be able to claim the itemized deduction for medical expenses at 7.5 percent of adjusted gross income through 2016.

Executive Compensation Limitations. This provision limits the deductibility of executive compensation for insurance providers if at least 25 percent of the insurance provider's gross premium income is derived from health insurance plans that meet the minimum essential coverage requirements in the bill ("covered health insurance provider"). The deduction is limited to \$500,000 per taxable year and applies to all officers, employees, directors, and other workers or service providers performing services for or on behalf of a covered health insurance provider.

Additional Hospital Insurance Tax for High Wage Workers. The provision increases the hospital insurance tax rate by 0.9 percentage points on an individual taxpayer earning over \$200,000 (\$250,000 for married couples filing jointly).

Special Deduction for Blue Cross Blue Shield (BCBS). Requires that non-profit BCBS organizations have a medical loss ratio of 85 percent or higher in order to take advantage of the special tax benefits provided to them, including the deduction for 25 percent of claims and expenses and the 100 percent deduction for unearned premium reserves.

Indian Tribal Health Services. The provision would provide an exclusion from gross income for the value of specified Indian tribal health benefits.

Simple Cafeteria Plans for Small Businesses. This provision would establish a new employee benefit cafeteria plan to be known as a Simple Cafeteria Plan. This eases the participation restrictions so that small businesses can provide tax-free benefits to their employees and it includes self-employed individuals as qualified employees.

Credit to Encourage Investment in New Therapies. This provision creates a two-year temporary tax credit subject to an overall cap of \$1 billion to encourage investments in new therapies to prevent, diagnose, and treat acute and chronic diseases.

TITLE X. STRENGTHENING QUALITY, AFFORDABLE CARE

Title X made many improvements to the preceding nine titles, and descriptions of those changes are included above. Changes included in Title X that do not amend previous titles are described below.

Coverage Improvements: Requires employers that offer and make a contribution towards employee coverage to provide free choice vouchers to qualified employees for the purchase of qualified health plans through Exchanges. Requires the Secretary to consult stakeholders and the National Committee on Vital and Health Statistics and the Health Information Technology Standards and Policy Committees to identify opportunities to create uniform standards for financial and administrative health care transactions, not already named under HIPAA, that would improve the operation of the health system and reduce costs.

Improvements in the Role of Public Programs: Creates financial incentives, including Federal Medical Assistance Percentage (FMAP) increases, for States to shift Medicaid beneficiaries out of nursing homes and into home and community based services (HCBS). Establishes a Pregnancy Assistance Fund for the purpose of awarding competitive grants to States to assist pregnant and parenting teens and women, with a matching requirement.

Indian Health Care Improvement: Authorizes appropriations for the Indian Health Care Improvement Act, including programs to increase the Indian health care workforce, new programs for innovative care delivery models, behavioral health care services, new services for health promotion and disease prevention, efforts to improve access to health care services, construction of Indian health facilities, and an Indian youth suicide prevention grant program.

Medicare Improvements: Makes improvements to Medicare beneficiary services, including coverage for individuals exposed to environment health hazards, prescription drug review through medication therapy management programs, development of a “Physician Compare” website to help beneficiaries learn more about their doctors, and a study on beneficiary access to dialysis services. Medicare payment changes include financial protections for states in which at least 50 percent of counties are frontier, an additional 0.5 percent bonus for physicians who report quality measures, delay of certain skilled nursing facility “RUGs-IV” payment changes, authority for the Secretary of HHS to test value-based purchasing programs for certain providers, and authorization for release and use of certain Medicare claims data to measure provider and supplier performance in a way that protects patient privacy. Other changes in this section include grants to develop networks of providers to deliver coordinated care to low-income populations, a requirement for the Secretary of HHS to develop a methodology to measure health plan value and to develop a plan to modernize computer and data systems at the Centers for Medicare & Medicaid Services, codification of the Office of Minority Health and elevation of the National Center on Minority Health and Health Disparities at NIH to the Institute level.

Public Health Program Improvements: Directs the Secretary of HHS to develop a national report card on diabetes to be updated every two years, and to work with States to improve data collection related to diabetes and other chronic diseases. Authorizes grants for small businesses to provide comprehensive workplace wellness programs. Authorizes the Cures Acceleration Network, within the National Institutes of Health (NIH), to award grants and contracts to develop cures and treatments of diseases.

Directs the Administrator of the Substance Abuse and Mental Health Services Administration to award grants to centers of excellence in the treatment of depressive disorders. Allows the Secretary of HHS to enhance and expand existing infrastructure to track the epidemiology of congenital heart disease. Amends and reauthorizes the Automated Defibrillation in Adam's Memory Act. Directs the Secretary of HHS to develop a national education campaign for young women and health care professionals about breast health and risk factors for breast cancer.

Workforce Improvements: Authorizes grants for medical schools to establish programs that recruit students from underserved rural areas who have a desire to practice in their hometowns. Amends and reauthorizes the preventive medicine and public health residency program. Improves the National Health Service Corps program by increasing the loan repayment amount, allowing for half-time service, and allowing for teaching to count for up to 20 percent of the Corps service commitment. Provides funding to HHS for construction or debt service on hospital construction costs for a new health facility meeting certain criteria. Establishes a Community Health Centers and National Health Service Corps Fund. Directs the Secretary of HHS to establish a 3-year demonstration project in States to provide comprehensive health care services to the uninsured at reduced fees.

Transparency and Program Integrity Improvements: Enhances the fraud sentencing guidelines, changes the intent requirement for fraud under the anti-kickback statute, and increases subpoena authority relating to health care fraud. Authorizes grants to States to test alternatives to civil tort litigation that emphasize patient safety, the disclosure of health care errors, and the early resolution of disputes, and allow patients to opt-out of these alternatives at any time. The Secretary of HHS would be required to conduct an evaluation to determine the effectiveness of the alternatives. Extends the protections from liability contained in the Federal Tort Claims Act to free clinics. Modifies requirements applicable to the labeling of generic drugs.

Revenue Changes: Imposes a ten percent tax on amounts paid for indoor tanning services for services provided on or after July 1, 2010. Excludes from gross income payments made under any State loan repayment or loan forgiveness program that is intended to provide for the increased availability of health care services in underserved or health professional shortage areas. Increases the adoption tax credit and adoption assistance exclusion (\$12,170 for 2009) by \$1,000, and makes the credit refundable. The credit is extended through 2011

Policy Recommendations

Several steps must be taken to alleviate the current disparities in healthcare access in Nevada.

It is important to clarify an operational definition of health disparities. Theoretically grounded, such a definition should offer benchmarks for assessing the progress in the quality and accessibility of health care and highlight the causes generating such disparities. A clear definition of health care disparities, including racial/ethnic disparities, makes possible reliable measurement of the current trends and facilitate

identifying federal and state level policies that help diminish existing inequities in health care delivery (Leacock et al., 2012).

Current curriculum designs are limited in merely providing a format of one or two courses with limited opportunities to understand the application of cultural competent practices across diverse populations. In future curriculum designs it is important to develop training models that integrate theoretical knowledge with the first hand experience of vulnerable populations. Teaching cultural competencies will improve effectiveness of patient-provider communications, curtail stereotypical cultural attitudes, and promote respect for human rights and awareness of the unmet needs of vulnerable groups.

An comprehensive assessment model will provide a framework for determining the level of cultural competence and measuring personal growth. Appendix 1 outlines a Cultural Competence Domains Model (CCDM) for assessing the personal growth and developmental experiences in cultural competency (Wakefield, Garner, Pehrsson, & Tyler, 2010). This model adds to the literature greater self-awareness, self-development, and self-knowledge, elements that are vital to achieving a culturally competent skill set (see Appendix 1 for further details).

Continuous research has the potential for providing valuable information to support efforts that can impact policy changes on a local and national level. For example, in an editorial from Health Services Research (2012), challenges related to accessing specialty care were identified and funding resulted from the collaborative work of community-based participatory research. On the national level, data has been used to examine areas such as inpatient safety indicators, the relationship of the type of quality of care and insurance coverage for child with asthma, and value of the policies utilized by the NCAA to screen Division I athletes for sickle cell. However, there are a limited number of studies related to the effectiveness of improvements that reduce disparities in the process of quality care (Hicks et al., 2010). Just as research can inform policy, policy can prompt further research.

Appendix 1

The Cultural Competency Domains Model (CCDM).

	<u>Novice</u>	<u>Apprentice</u>	<u>Proficient</u>	<u>Distinguished</u>
Disposition	<p>Little or no development or implementation</p> <p>Has little or no knowledge of diverse cultures and may deny the importance of cultural variables in counseling</p> <p>May overemphasize the importance of difference</p> <p>Lacks experiences of exploration and discussion of cultural differences</p>	<p>Limited development or partial implementation</p> <p>Demonstrating an emerging awareness of his/her own cultural biases and assumptions (Pedersen, 2002)</p> <p>Actively engaging in a continuous process of challenging personal attitudes and beliefs that do not support respecting and valuing of differences (Sue, Arredondo, & McDavis, 1992)</p> <p>Exploring the community for knowledge of the accessibility of the variety of culturally appropriate services</p>	<p>Fully functioning and operational level of development and implementation</p> <p>Demonstrates an awareness and sensitivity to one's cultural heritage having an ability to identify specific features of culture of origin and the effect of the relationship with culturally different clients</p> <p>Demonstrates a level of comfort with differences in race, ethnicity, culture, and beliefs</p> <p>Demonstrates a working knowledge of available services to meet the cultural needs of clients</p>	<p>Exemplary level of development and implementation</p> <p>Knowledgeable of institutional barriers that prevent minorities from using mental health services</p> <p>Recognizes that the process of developing cultural competency is ongoing and long-term</p> <p>Knowledgeable of relevant discriminatory practices at the social and community level</p>

Cognitive Understanding	Demonstrates inadequate experience working with a diverse population	Limited experiences in cultural discussions, working with diverse populations, and available community services	Understands how Eurocentric tradition in counseling may conflict with cultural values of other traditions	Establishes a working relationship with providers of various cultures within the community to expedite services for those at risk
	Has no knowledge of available community	Limited knowledge of the effect of oppression, racism, discrimination, and stereotyping	Possesses knowledge and understanding about how oppression, racism, discrimination, and stereotyping affect them personally in their work (Lago, 2006a)	
	Comes to training only having knowledge of their own culture - "Tunnel Vision"	Working to provide a climate and context for recognizing and understanding how diverse cultures share common ground and uniqueness (Pedersen, 2002)	Demonstrates knowledge about personal racial and cultural heritage and how it personally and professionally affects definitions of normality-abnormality and the process of counseling (Lago, 2006b)	Demonstrates a clear and explicit knowledge and understanding of the generic characteristics of counseling and therapy (culture bound, class bound, and monolingual) and how they may clash with cultural values of various minority groups
	Lacks understanding of cultural stereotypes and bias and holds preconceived notions about others who are culturally different	Identifying areas to grow in a capacity to provide competent services	Recognizes the limits of their competencies and expertise and, therefore, seeks educational, consultative, and training experiences to enrich understanding and effectiveness	Utilizes expertise in identifying and administering appropriate culturally relevant assessments

Therapeutic Skills	Lacks knowledge of assessment models	Limited awareness of assessment models	Limited skill in the use of assessment models	
	Exhibits one way of thinking	Recognizing a need for cultural competence and its affect on service	Understands how race, culture, ethnicity, gender, or disability may affect personality formation, vocational choices, manifestation of psychological disorders, help-seeking behavior and the appropriateness or inappropriateness of counseling approaches	Understands how race, culture, ethnicity, gender, or disability may affect personality formation, vocational choices, manifestation of psychological disorders, help-seeking behavior and the appropriateness or inappropriateness of counseling approaches
	Often places imposition of values onto others	Developing an understanding of how culture influences interventions with client	Familiar with relevant research findings regarding mental health and mental health disorders that affect various racial and ethnic groups	Familiar with relevant research findings regarding mental health and mental health disorders that affect various racial and ethnic groups
	Unaware of the ethical practices established to ensure cultural competency	Exploring specific knowledge and information about a particular group or individual	Demonstrates skill and knowledge in the ethical practices of cultural competency	Reflects diversity in one's scholastic endeavors
Accepts unreasonable assumptions without proof or ignores the proof that might disconfirm one's assumptions	Actively participates in reading and activities designed to develop cultural awareness and works toward eliminating racism and prejudice (Sue et al., 1992)	Knowledgeable and demonstrates efficiency in the practice of culturally competent ethical standards	Consistently practices cultural sensitivity and the ethical practices of cultural competency at an exemplary level	

Affective Behaviors	Becomes culturally encapsulated (Pedersen, 2002)	Possesses a general awareness of the ethical standards for cultural competency Assisted by a supervisor in learning to engage in a variety of verbal and non-verbal helping responses	Able to implement more than one method or approach to helping but recognizes that helping styles and approaches may be culture bound	Demonstrates knowledge of the potential bias in assessment instruments, use of procedures, and interprets findings keeping in mind the cultural and linguistic characteristics of clients
	Defines reality according to a universal, monocultural perspective	Able to send and receive both verbal and non-verbal messages accurately and appropriately	Refers to good sources when linguistic skills are insufficient	Serves as an advocate for culturally appropriate services and utilizes professional skills and leadership to affect change
	Insensitive to cultural variations	Working to gain a proficient level of comfort with the differences of race, ethnicity, culture, and beliefs		Educates clients of service alternatives available and their personal and legal rights for effective cultural intervention
	Fails to evaluate others' viewpoints			

The CCDM utilizes a four by four matrix, which offers a personal/individual, culture-specific approach that can recognize the interrelationship and interaction in multiple dimensions. The four domains of the CCDM, disposition, cognitive understanding, therapeutic skills, and affective behaviors, reflect the literature's sentiment of cultural competency skills of awareness, knowledge, and skills. The categorical levels of novice, apprentice, proficient, and distinguished provide criteria for assessment.

The novice is described as having little or no knowledge of diverse cultures and may deny the importance of cultural variables in counseling. Culture is viewed according to a universal, monocultural perspective. This group lacks experiences of exploration and discussion of cultural differences and, therefore, demonstrates inadequacy in working with a diverse population. The novice exhibits a lack of understanding cultural stereotypes and biases and holds preconceived notions about others who are different. Therapeutic skills present an unawareness of ethical practices and the acceptance of unreasonable assumptions.

At the apprentice level, there appears to be an emerging awareness of cultural biases and assumptions. A professional at this level actively engages in a continuous process of challenging personal attitudes and beliefs that do not support respecting and valuing differences. The apprentice explores the community for appropriate services. There exists a limited awareness of assessment models and knowledge of the affect of oppression, racism, discrimination, and stereotyping. At this level, there is an awareness of the need for cultural competence and, therefore, the apprentice works to develop an understanding of how culture influences interventions with clients. The counselor possesses a general awareness of ethical standards for cultural competency, yet, still needs to work to gain a greater level of comfort with differences of race, culture, and beliefs.

As a professional become more proficient, he/she demonstrate a greater level of involvement and comfort. There is evidence that at this level the practitioner exhibits an awareness and sensitivity to personal cultural heritage. This professional interacts from a level of comfort toward those of different racial, ethnic, and cultural beliefs. Proficient level practitioners understand how an Eurocentric approach conflicts with the cultural values of other traditions. Recognizing limitations, there is an effort to enrich understanding through educational, consultative, and training experiences. The therapeutic skills of a proficient professional include a knowledge of how race, gender, or disability affect personality formation, vocational choices, the manifestation of mental health disorders, and the appropriateness of selective competent approaches. Proficiency is demonstrated through a variety of helping approaches and by promoting client self advocacy.

At the distinguished level, professionals immerse themselves using holistic approaches and accept new roles that impact system change. There is intention in their work as it is evident that cultural competency is ongoing and long-term. Distinguished level professionals establish a working relationship with providers of various cultures within the community. There is an awareness of discriminatory practices at the social and community level and knowledge of appropriate culturally relevant assessments are utilized. Practitioners serve as an advocate for culturally appropriate services, client self advocacy is promoted and ethical practices of cultural competency are practiced at an exemplary level.

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