THE HEALTHCARE ACT OF 2010

REMEDY AND REACTION by Paul Starr Yale University Press, 2011 Excerpts and comments by Toni Sullivan, Feb. 2012 EXCERPTS from Chapter 4.

"The Clinton health plan and other alternative approaches to comprephensive reform attempted to escape from what I referred to as the American health policy trap: a costly and complicated system that has left a growing minority of Americans without financial protection in sickness but has nonetheless satisfied enough people to make it difficult to change. The key elements of the trap are a system of employer-provided insurance that conceals its true costs from those who benefit from it; targeted government programs that protect groups such as the elderly and veterans, who are well organized and enjoy wide public sympathy and believe that, unlike other claimants, they have earned their benefits; and a financing system that has expanded and enriched the health care industry, creating powerful interests averse to change." pp.122-123 (Also see p237 for a discussion of barriers to single payer.)

"The Clinton plan sought to enlist the elements of society unhappy about rising costs and deteriorating coverage without antagonizing the protected public or the interest groups in the industry." p.123

The Clinton plan failed to pass. "If business was an inherently unreliable political ally, should Clinton have never sought to win it over? Some on the left believed that if only Clinton had endorsed single-payer or an expansion of Medicare {he would have had a chance to pass health care} But a single payer plan never had a chance. Paul Wellstone, single-payers leading advocate only had 04 co-sponsors for his bill; reaching 50 votes, much less 60, was inconceivable."p. 126

EXCERPTS from Chapter 5

In 1994 newt Gingrich became Speaker of the House and vowed war on the Welfare State. "Much of the struggle over national policy....focused on the federal budget, but the issues were deeper that spending levels. The Republicans wanted to change the framework of policy by adopting a constitutional amendment requiring a balanced budget and by enacting legislation to eliminate or restrict the individual entitlement to benefits under the major health programs. Medicaid they wanted to devolve upon the states; Medicare they wanted ultimately to turn into a voucher, which the elderly could use to buy private insurance . The aim was to reduce the liability and scope of government and the demands on taxpayers on the grounds that individuals would make better decisions about health care if they had to bear more of the cost."p.130

The 1980s began the transition from New Deal/progressive policy which had pretty much held through the 70s including the Nixon administration. By the 90s government was far more conservative. Any health care reform would have to be include cost efficiency/containment/reduction and preferably entitlement "reforms" Yet the federal commitment and actions contradicted this dictum from time to time + with the passage in 1997 of the new health care program for children + SCHIP. Yet another + and bigger- Republican action created the new Medicare prescription drug benefit (Medicare part D) which provided an

unfunded subsidy to the insurance companies to offer Medicare plans to seniors which became known as Medicare Advantage. The funding (14% subsidy) went entirely to the private insurance companies at a cost of several billion dollars. The ACA will secure a percentage of its funding from rolling back the Medicare Advantage option (5 Billion dollars over 10 years.) Medicare, through the ACA, will provide these services to seniors, ie drug coverage, preventive care services, home care.

"Americans rights to health care, insofar as they have any, depend on statute, and as of 1999, the two health care entitlement programs, Medicare and Medicaid , were the primary sources of those rights."pp.131-132 In 1996 following arduous and rancorous negotiations between the Clinton White House and the Republican Congress, President Clinton succeeded in severing the connection between Medicaid and welfare reform. The president signed the welfare reform bill while preserving the federal entitlement of Medicaid, preserving the food stamps program, and Medicaid eligibility for those who had previously qualified for welfare.

..."Clinton's defense of the entitlement for Medicaid but not for welfare was a critical turning point in the relationship of the two programs. Medicaid had begun largely as an offshoot of welfare; eligibility for welfare had meant eligibility for Medicaid. Now the connection was completely severed, and Medicaid could include more low-income two-parent families and single individuals. As one federal analyst argued, the welfare reform legislation was an opportunity for states to recast and market Medicaid as a freestanding health insurance program for low income families without the stigma of welfare."pp.136-137

"When the battle of the budget began in 1995, Republicans seemed likely to terminate the federal guarantee of health coverage that Medicaid provided. Instead, Medicaid emerged in some respects stronger than it had been before. Many who had previously denigrated the program came to appreciate its value. The benefits were broad, including a wider range of preventive services for children than private insurance typically covered. No longer tied to welfare, Medicaid had the potential to serve as a general basis of health insurance for low-income Americans. Instead of expecting to abolish Medicaid, liberal reformers would now think about how to incorporate it into a system of universal coverage." pp.137-138

CHAPTER 6 2006-2008

These two years were momentous with respect to health care reform. The accomplishment of near-universal health care in Massachusetts under the leadership of Governor Romney and the Democratic legislature, incorporating public subsidies to assist with purchase of private insurance policies, employing an individual mandate, is proving to be successful. Continued assessments and modifications are leading to further success with this model. The election of Barack Obama as President with a strong commitment to health care reform culminated in 2009 with the passage of the PPACA. The legislation models many of the same components of the Massachusetts Plan.

CHAPTER 7 2009-2010

"The fall of 2008 brought two developments that heightened the emotional intensity of American politics and created an unanticipated context for the national debate about health care . In rapid succession , the financial system and economy went into free fall and the nation elected barack Obama, elevating anxiety and hope at the same time." p.195

"Going into the election, Democrats had already decided to settle for reforms that would be minimally disruptive. But the concessions made by Democrats were of little interest to most Republicans....who from their standpoint, regardless of what Democrats said, the proposed changes amounted to a government take-over, because in the final analysis, government would take responsibility for seeing that everyone had health care."p.195

"It was in this context that health-care reform took on a significance for both sides that transcended the specifics of the legislation. For the republicans it would be all about what they saw as overreaching federal government. For the Democrats it would also be about government; it would become a test of whether after so many failures, government could finally deal with a problems as complex, costly, and emotional as health care. And because the prognosis for their other priorities would suffer if the democrats failed on health-care reform, it would become a test of nothing less than their ability to govern." p.196

"Eight days after the election Max Baucus (Chair of Senate Finance Committee)...issued a white paper...It is the duty of the next Congress to reform America's health care system. The paper then set out a plan that reflected what was now the standard Democratic model for reform: a nationwide insurance pool called the heaslth Insurance Exchange to ensure access to affordable, guaranteed coverage, with no pre-exisiting conditions exclusions, an expansion of medicaid to cover all of the poor, tax credits to subsidize premiums for qualifying families and small businesses, and a requirement for individuals to obtain coverage once the exchange was established. The proposal was basically the same as President Obama had campaigned for except for two points: Baucus included an individual mandate, and as a short-term measure before the exchanges were established, proposed to allow 55 to 64 year olds to buy into Medicare." p197

By August of 2009, following brutal rancor: "Inside the White House Obama was hearing the bad news about the trends (gross understatement), and Rahm Emanuel and Vice president Joe Biden were urging him to give up on comprehensive reform and call for a more modest program. But Obama not only resolved to go ahead ; in September and again in the new year, the President took charge of the effort to steady the health-care initiative and prevent it from careening off the tracks."p.220

"In the Senate, the Majority leader Harry Reid had the parallel responsibility of merging committee bills ands assembling the votes necessary for passage. Reid generally deferred to the committees and in the health care legislation that meant the Finance and HELP Committees insofar as they did not conflict with one another. That deference resulted, for example, in HELP'S liberal public health proposal becoming part of the final Senate Bill."p.225 (This magnificent provision was then carefully protected as the bill moved through the final stages of approval.)

CHAPTER 8 The ACA as PUBLIC PHILOSOPHY

"The Affordable Care Act introduces new rules for insurers as well as new requirements and subsidies for individuals. The new rules require insurers to issue policy's and renew them for all legal applicants, and they prohibit companies from refusing to cover preexisting conditions or charging according to an individual's health. While insurers can vary premiums by age and by tobacco use, they can do so only within limits. To prevent people from taking advantage of the system by purchasing insurance only when they get sick, the law requires individuals to maintain a minimum level of coverage. And to increase the number with insurance and enable low-income people to comply with the mandate, the law extends eligibility for Medicaid to all citizens with incomes under or near the federal poverty line and subsidizes private insurance for both citizens and legal immigrants earning up to four times the poverty level. according to the CBO, the law will extend coverage to about 32 million people, roughly half through Medicaid and half through added private insurance, raising the insured share of the population to about 94%."p.240 (I believe the covered number will reach about 98% because of the addition of the Public Health programs, FQHCs and SBHCs.)

RE Immigrants- legal and illegal: "Hospitals have an obligation to provide emergency care to all persons, but neither Clinton in 1993 nor Obama 16 years later proposed extending a right to subsidized coverage to illegal immigrants. Illegal immigrants are eligible for neither Medicaid nor any subsidies for private insurance. They can not even make unsubsidized use of Insurance Exchanges. In fact, some illegal immigrant workers who now receive insurance directly from their employers will lose that coverage if their employers shift coverage to the exchange. To the disappointment of immigrant groups, the law does not change the exclusion from Medicaid of legal immigrants with less than 05 years of residency in the U.S."p.246

"The ACA does, however, extend premium and cost-sharing subsidies in the exchanges to legal immigrants regardless of years of residency. In addition all immigrants, legal and illegal, WILL BENEFIT FROM THE EXPANSION OF COMMUNITY HEALTH CENTERS, WHICH ARE PROJECTED TO DOUBLE IN CAPACITY WITH THE ADDITIONAL FUNDS AUTHORIZED UNDER THE LAW. In sum, while new immigrants continue to be barred fro getting free care under medicaid, all legal immigrants acquire the same rights as citizens in the purchase of subsidized private insurance. And though illegal immigrants receive no rights to insurance coverage, the law provides support to the clinics that provide them charity care. By reducing the number of uninsured, the law should also improve the financing of hospitals in low-income areas, including immigrant communities. The presence in the U.S. of 12 million people with no legal rights is...an untenable situation, which only general reforms of immigration can address. In the absence of that legislation, the ACA strikes a reasonable compromise."p.246

Differing conceptions of health insurance: "Conservatives tend to see health insurance as being the same as other forms of insurance and therefore appropriate only for large and unexpected costs, not for costs that are small or routine and can be paid out-of-pocket as ordinary expenses. In this view insurance inherently creates moral hazard (that is, invites additional spending),so coverage-particularly government mandated-should be limited to high cost services."p.259

" The opposite view, usually upheld by liberals, conceives of health insurance as being a form of prepayment for medical care and insists that limiting coverage to catastrophic costs creates perverse incentives favoring technologically intensive services to the neglect of primary care and

prevention. One of the aims of reform, in this view, should be to promote primary and preventive services precisely to lessen the reliance on high-tech care that accounts for the largest costs in the system."p.259

..".But though the health insurers, drug companies, and other interests profit from the health system, they are not alone responsible for maintaining it. The bias against change also comes from members of the protected public.....The resistance to reform didn't arise because Americans were such determined individualists that they rejected all government help ;much of the resistance has come from members of an entitled majority with a privileged position in the public-subsidy system. The potency of these entitlements lies in the psychology of self-exemption they instill; the beneficiaries do not understand themselves as benefiting from government assistance or as sharing a common condition with the excluded. The tax subsidies are nearly invisible to those who receive them; medicare invites the elderly to believe that they have earned its benefits, whereas other claimants have not. Morally armed, they can reject helping others in need as a matter of high principle; after all Americans shouldn't look to the government for help."p280 ..."Perhaps America will simply get used to the idea that although other countries can provide health care to all their people, the U.S. is too poor to afford it."p281

"The difficulties in the search for remedy in health policy were not inevitable: at times alternatives were in reach that could have provided insurance protection to all and kept costs closer to the levels of other advanced nations. In 2010 Congress finally overcame the usual drumbeat of fear by the opponents of reform with moderate legislation that could help create a more just and efficient system. Repealing the law would not just mean denying insurance to more than 30 million people. It would be a confession of universal helplessness in the face of a problem that has nagged at the national conscience for a century. The search for remedy would continue, but it would proceed under a shadow of uncertainty about whether Americans will ever b able to hold their fears in check and summon the elementary decency toward the sick that characterizes other democracies."p.281

PATIENT PROTECTION AND AFFORDABLE CARE ACT & THE HEALTH CARE AND EDUCATION RECONCILIATION ACTS 0F 2010 SUMMARY OF COVERAGE: BENEFITS AND COSTS Prepared and Presented by Toni J Sullivan SOCDC, September, 2010 Reviewed and updated, December, 2011

MEDICARE: Changes in Benefits and Costs Beginning 2010: Prevention Services:
--Deductibles and co-payments are eliminated for annual checkups including many screening tests. Prescription Drug Coverage:
--If you reach the gap in prescription drug coverage aka the donut hole you'll receive a $250 subsidy. In 2011 All with prescription drug coverage will receive 50% discounts on brand-name drugs. From 2012 to2019 additional discounts will apply to name-brand and generic drugs each year. By 2020 the donut hole will be completely closed. After 2020 seniors will pay 25% of drug costs to a catastrophic limit, then 5% thereafter.

Beginning 2011: Physician Shortage Areas:
--From 2011 through 2115, Medicare will pay a 10% increase to doctors who practice in underserved areas, like inner cities and rural communities.

Beginning 2012 Medicare Advantage:
--These are private insurance alternatives funded through Medicare that typically offer more generous benefits than standard (original) Medicare. These plans cost the Govt. more than original Medicare,14% on average. These subsidies will begin to be cut in 2012 which could limit the availability of these plans, and\or raise premiums, and\or modify benefits. Advantage plans would also be required to spend at least 85% of their revenue from premiums and subsidies on medical claims. (As original Medicare modifies to provide preventive services, prescription drug coverage, and more community-based services the need for Medicare Advantage will decrease.) Note: In 2012, the Medicare payroll tax will increase from the current 1.45% for individuals/couples to 2.35% for those making more than $200/$250 K and a 3.8% tax on unearned income for those over $500 K.

MEDICAID: Changes in benefits and costs: Beginning immediately: Medicaid and SCHIP (States Children Health Insurance Program) eligibility:
--Because of the economic downturn, many states are currently making substantial cuts in Medicaid. However, beginning immediately states cannot reduce eligibility for Medicaid until 2014 for adults and 2019 for children. So coverage can be kept, but some benefits, such as dental care and vision care, will likely be lost.

Beginning 2011: States will receive federal subsidies to provide preventive services in the communities, recommended by the National Prevention, Health Promotion and Public Health Council, chaired by the US Surgeon General. (These services will also be available in settings where all persons can receive them, such as vision screenings in schools.)

States will also receive incentives to offer home and community-based services recommended by the Public Health Council without additional costs to the states. Beginning 2013 + 2014: Medicaid's reimbursements to doctors will be increased to the same level as Medicare, so more doctors may be willing to participate in the program. (In 2008 Medicaid reimbursements averaged only 72% of the rates paid by Medicare, according to a recent Urban Institute study.)

Beginning 2014: Medicaid and SCHIP insurance would be available to all individuals and/or families earning up to 133% of poverty-- $14,404 for an individual or $29,327 for a family. (Earned income for SCHIP may be higher in some states than 133% of poverty, but these are all families who earn too much to qualify for Medicaid, but too little to afford private insurance.)

The estimated number of people who would be newly eligible for Medicaid, including children who would join SCHIP is 15 million!

UNINSURED (who are not eligible for Medicare or Medicaid, including those who are employed but unable to obtain or keep coverage at work):

Beginning 2010: Coverage for adult children:
--Children under the age of 26 can be covered as dependents on their parents' plan, unless he\she gets a job providing employer-sponsored health insurance. Adult children, under age 26, can not

be denied coverage on parents' plans due to illness or preexisting conditions. The rates can be increased, however.

Coverage for pre-existing conditions:

--If you have a pre-existing medical condition and have been uninsured for more than 06 months, you can get subsidized coverage through a new high-risk insurance pool until 2014, when insurers can no longer refuse applicants with pre-existing conditions. The premiums for the program will be "established for a standard population." The Kaiser Family Foundation reports that out-of-pocket costs will be capped at $5.950 for individuals and $11,900 for families.

--If a family seeks to purchase private insurance, insurers cannot refuse coverage because of a pre-existing medical condition of one of the family members..

Beginning 2013:
--After 2013 insurers cannot charge higher premiums or deny coverage because of a pre-existing medical condition. Plans could be excluded from exchanges for unjustified premium increases.

Beginning 2014: Subsidies for purchasing private insurance
--If you are an individual on the `bubble" you may qualify for Medicaid or
--If you are an individual who makes between $14, 404 and 43,320 or if you have a family of 04 with income between $29,327 and $88,200, you will qualify for govt. subsidies to help you buy insurance. With subsidies individuals would pay from $444 annually (salary of $14,512) to $4,115 annually (salary of $43,200). Families with subsidies would pay $904 to $8,379 with salaries from $29,547 to $88,200. The estimated number of people who will be affected is 25 million! They will pay out-of-pocket between 2% and 9.5% of their income for premiums. The estimated number of people who will be affected is 25 million!

Insurance exchanges:
--Insurance exchanges are marketplaces where you can compare benefits and prices and choose the policy that best fits your needs and your pocketbook. If your employer does not cover you and you earn too much to qualify for Medicaid you qualify for purchasing on the exchanges. Depending on your salary you may be eligible for subsidies (up to $88,200 salary for family of 4). Persons whose income exceeds the maximum for a family of 04 can still use the exchanges, but wouldn't be eligible for a subsidy.

--Employed low salary worker ($14,000) can be eligible for Medicaid or employer-sponsored private insurance. The worker can buy insurance through an exchange if the premiums of the offered plan are too high relative to income. (Premiums greater than 9.5%) Persons who still can not afford to buy insurance could apply for a hardship waiver.

INSURED who are employed in small or large companies and usually have small group or large group policies. Beginning 2010: --The plans in place will have to stop some practices within 06 months, like setting life time limits on coverage, but don't have to meet the new coverage

standards required of all policies in 2014. The plans, therefore, may not be viable for long because insurers can not add benefits or enroll more people in noncompliant policies.

Beginning 2013:
--You may pay higher taxes. Top earners will pay increased Medicare payroll tax on wages and investments. The income threshold for claiming tax deductions on medical costs will be higher.

--Flexible spending accounts--which typically allow employees to shelter as much $4,000 or $5,000 from taxes--will be reduced to$2,500, and they will not pay for over the counter drugs

-- If you have a high value plan: In 2018, the most expensive insurance policies will be subject to a new tax, which means beneficiaries could face higher out-of-pocket costs or reduced benefits.

Beginning 2014:
--All insurance plans, including your "old" plans will meet a required set of standards including: no annual or lifetime limits on coverage; no rescission, and no premium increases due to illnesses.

--You can buy coverage through the exchanges: if your employer's plan covers less than 60% of the costs, or you're paying more than 9.5% of your income to get it, you can buy in the exchange.

if your income is below four times the poverty level, and your premiums cost more than 8% of your income, but less than 9.8%, you can get a voucher from your employer to buy in the exchange.

OTHER EXCELLENT BENEFITS

1. The new health care reform legislation creates a dedicated Prevention and Public Health Fund that will provide $15B over 10 years to support community prevention and research activities as well as strengthen state and local public health capacity. These funds represent the largest commitment to prevention and wellness in U.S. history. The law also establishes the (afore-mentioned) National Prevention, Health Promotion and Public health Council to be chaired by the Surgeon General. it will be tasked with developing a national prevention strategy.

2.. The new law expands mental health care parity to a much wider pool, making it possible for millions more people to get the same coverage for substance abuse and illnesses like bipolar disorder, major depression and schizophrenia as they would for, let's say diabetes or cancer. Parity means that deductibles, co-payments, and limits on the number of days of coverage must be no more restrictive for coverage of mental illness and substance abuse than for coverage of medical and surgical treatments.)

3. The new health care reform law containing one benefit for a special group of consumers (the 55-64 year olds) starts June 1. The Early Retiree Reinsurance Program, is a 05 billion federal subsidy to employers to help them pay for healthcare coverage for their retired workers who don't yet qualify for Medicare.

The percentage of large firms offering retiree coverage dropped from 66% in 1998 to 31% in 2008. It is hoped that this new subsidy will encourage employers to continue retiree health coverage rather than cancel it for 2012. It is hoped that this subsidy will last until 2014 when retired workers who don't qualify for Medicare would be eligible to buy affordable health coverage through insurance exchanges.

ADDITIONAL COSTS & BENEFITS INDIVIDUAL MANDATE: All individuals will be required to have health insurance, with some exception, beginning in2014. Those without coverage will be required to pay a yearly penalty of the greater of $695 per person (up to a max of $2,085 per family), or 2.5% of household income, which will be phased-in from 2014-2016. Exceptions will be made for financial hardship or religious objections, and for persons uninsured for less than 03 months; and those for whom the lowest cost health plan exceeds 8% of income, and if the individual has income below the tax filing threshold ($9,350 for individual and $18,700 for a married couple. ($17B revenue over 10 yrs.)

EFFECT ON LARGE EMPLOYERS (at least 50 FT employees): Employers that don't offer health benefits and that have at least one employee who receives subsidized insurance will be charged a $2K per + employee fee. If the employer offers coverage but employee(s) instead purchase subsidized insurance, the fee is $3K for each employee receiving a subsidy, or $750 for each employee in the company, whichever amount is smaller. (52B revenue over 10 years.)

EFFECT ON SMALL EMPLOYERS: 2010-2013 Small businesses will receive tax credits to offer coverage to their employees. If an employer pays at least half of its employee's premiums, it can receive a tax credit up to 35% of the contribution.

2014 and after:-- businesses can buy insurance through the exchanges and get a tax credit up to 50% of employees' premiums for 02 years. An employer with more than 50 workers will pay a penalty if it does not offer health insurance and any of its full-time workers get subsidized coverage in the exchanges.

PPACA Update & Overview with a Focus on Public Health and Prevention Prepared by Toni J Sullivan EdD RN FAAN, December 2011 Dr. Sullivan is Professor and Dean Emeritus of the Sinclair School of Nursing, University of Missouri, Columbia, Missouri; and was Professor and Chairperson of the Dept. of Nursing at USC. She is a nurse scientist and a public health scientist, & author of the award winning Collaboration: A Health Care Imperative. McGraw Hill, 1998

INTRODUCTION The Patient Protection & Affordable Care Act (PPACA) was signed by Pres. Obama, March 23, 2010. This broad, sweeping landmark law is attempting to do huge things; it is the single most important piece of legislation ever passed promoting health and wellness + both individual and community-based + and the costs are covered. It is transformative:

-in overcoming racial inequities and disparities in health care, which by themselves increase health care costs by at least 17B annually!

-by its' focus on health promotion and disease prevention, as opposed to main focus on illness and treatment of disease.

-by making huge strides toward health care as a right rather than a privilege for those who can afford to pay,

-by making huge strides toward universal health care. The CBO and the DHHS estimate that 94-95% of citizens will be covered for health insurance by 2019. (My own estimate is higher-- 97-98% will have a `health care home.')

-by dramatically increasing government funding of health care, primarily through Medicaid, as well as subsidies to private insurers.

-in greatly increased team work and collaboration between and among providers and patients, multidisciplinary teams, and health care organizations, and

-in the major increases in public health services in inner cities and rural hard-to-reach areas. It is conceivable that these major increases will lead to near universal health care coverage!

-in reducing income inequities, as more benefits and breaks are provided to low income persons than are provided to those in higher income brackets.

The Congressional Budget Office (CBO) estimates that the ACA will reduce the number of uninsured by 32M in 2019 at a net cost of 938B over 10 years, while reducing the deficit by 124B during this time. (This figure does not take into account the numbers who will achieve a `health care home' through various Public Health programs.)

POLITICS AND PROCESS

During the year of negotiating and processing the design and development of the ACA, opposition to the coming legislation was ferocious, as was opposition to the idea of President Obama achieving the success of accomplishment that a historic HCR bill will signify.

Now we're in the midst of the largest assault on the ACA and on Public Health in our history due to an assault on the role of government in our country. Government is bad + particularly the federal govt. goes the meme. There is assault on govt. at state, county, and local levels, as well. Public health, public safety, education, social services are all under siege in state houses all over the U.S.

In one House Bill Congress proposed repeal of the Affordable Care Act (defeated). The only item excepted from a total repeal was the 450B for Medicare Advantage--the $$$ going to private insurers, passed by the Bush Administration to subsidize the drug benefit and give other incentives to enrich private insurers.

Almost immediately after passage of the PPACA law suits began against 1) the mandate to purchase health insurance; 2) penalties on employers who do not provide health insurance when they meet the law's requirements to do so, and 3) the requirement after 2016 that states cover their lawful share of expansion of Medicaid to provide health insurance to a substantially higher income level. Rulings by Appeals Courts have split about evenly.

Both sides, the Administration and the opposition, requested the Supreme Court to rule on these issues. The Court has agreed to do so in January, and has allocated an unprecedented 05 and one/half hours for hearings. The justices will hear 02 hours of argument on whether Congress overstepped its constitutional authority by imposing a mandate, 90 minutes on whether the mandate may be severed from the balance of the law if Congress did go too far, and an hour each on the Medicaid and Anti-Injunction Act questions. (The latter refers to an earlier Supreme Court decision that basically says you can't make judgments on tax issues in advance, but only after they are already levied.)

Despite funding cuts and threats of more funding cuts, and the tremendous challenges, both in offense and defense of funding streams, much has been accomplished in moving the ACA along; public health providers and advocates are passionately committed to it's success!

INSURANCE EXCHANGES AND START UP

Although all of the states have much the same tasks to accomplish, there is variability in the progress to date, with the vast majority of the states actively preparing for full implementation by January 1, 2014. Also most of the states, with a few holdouts in the south and southwest, have fully implemented having children remain on their parents policies, of not dumping people from their insurance when they develop a serious illness, of not refusing to cover people with preexisting conditions, and of removing or not imposing lifetime limits on insurance coverage.

Illinois is one of the states that impressively is on target. Governor Pat Quinn (D) and his point man for development, Michael Gelder, view the bill as a major component of economic recovery in Illinois, and of achieving universal health care for all Illinois' citizens. Illinois has the insurance exchanges in place; the pre-existing conditions piece is in place with over 1,000 covered under this provision as of June 2011; Illinois will be fully implemented + on time + in 2014.

Another state, Maryland, is also well along in the process of preparation for implementation, including the Insurance Exchange Governor Martin O'Malley signed legislation in April establishing a framework for the state's exchange, making Md. one of the 1st states to have a legislative structure guiding the Insurance Exchange. Md anticipates insuring up to 400 thousand additional people, mainly through the Exchange. Peter Bielenson, MD and Director of the Howard County HD, has designed a model Maryland Nonprofit Health insurance Co-OP which will likely join the Exchange. This model has a special mission to reach families who will still not be able to afford insurance.

The Co-Op is based on three pillars: establishing primary medical homes for patients; eliminating fee-for-service practices, which enable providers to order tests and procedures that

are often unnecessary; and using evidence-based practice. The Co-Op will be open to all to join through the Exchange.

The Maryland example is representative of the creativity and commitment to reform occurring in many of the states as they develop their criteria for insurers to meet in the policies they will endeavor to have accepted in the Exchanges. The President recently strongly encouraged creativity by the states as long as they meet core requirements for basic, but comprehensive services. (The Centers for Medicare and Medicaid Services, Dept. of HHS have a proposed rule for Establishment of Exchanges and Qualified Health Plans under review.)

Two states, Louisiana and Oklahoma, have refused federal assistance in the start-up process; Louisiana is not planning to have an Insurance Exchange. The PPACA has legal authority for the DHHS to develop the Exchanges for any state that does not comply with the requirement. It is believed that all states will comply, however.

One notable transformative piece in Illinois is that over 700,000 Illinoisans will join Medicaid due to the ACA. Note that Md expects to insure an additional 400 thousand people, many thousands of whom will be Medicaid recipients. The CBO estimates that an additional 15 million U.S. citizens will receive Medicaid as a result of the PPACA. Medicaid, of necessity, will be of much higher quality than it currently is because clients will move back and forth from Medicaid to other insurance coverage as their financial and work status change. Also, Medicaid reimbursement to providers will be equal to the Medicare reimbursement by 2014. (Medicaid has been largely the bottom tier of a two tier system of health care.)

PUBLIC HEALTH: ROLES, PROGRAMS, & LEADERSHIP

The Public Health establishment in the U.S. will play a major leadership role in the PPACA, in the actual provision of programs, in the transformation of illness care to health care, and the integration of community health or population health with individual health and illness care. The Public Health presence in the U.S. is vast at the county, state, and federal levels; the history of Public Health in this country dates to the very beginning of our country when health depts. were formed to provide services to merchant seamen.

The expansion of PH presence and services mirrors the growth of our nation. Public health services focused on community environments: such as services to individuals and families largely focused around communicable diseases, such as Tbc, -- in order to protect the community as well as treating the diseased person. Immunizations have historically been a major disease prevention activity of health depts.

Public health services have always been publicly funded. Public health has never been a wealthy part of U.S. health care. Public health services are traditionally respected and trusted by the citizenry. In the 1980s, when increased access to primary care was focused sharply in health reform efforts, and Medicaid funding was available for low income persons, and Nurse Practitioner education came into being, and these new providers were able to achieve practice privileges in most states, Public Health Depts. began to offer Primary Care Clinics to low income

people, with reimbursement usually through Medicaid. Now the stage is set for Public Health to be a major + and welcome player-- in the PPACA.

Public health components account for about 40% of the ACA legislation. Through these new or continuing and expanded public health programs: illness prevention, health promotion, and primary care services are provided to individuals, families, and communities, often without requirements for direct payment for services. These programs do/will include Medicaid funding (which will increase dramatically under the ACA) and continuing (improved) Medicare funding, and private insurance funding, and federal and private grant funding, and no funding-- or free care. No one is turned away because of inability to pay! Millions + who are within the framework of the remaining uninsured + will receive high quality health care from these programs; they are the vehicles that will move the U.S. substantially closer to universal health care + that is publicly funded!

It is irresistible to speculate about how much of health and illness care will be covered by federal funding (and state funding) once the PPACA is fully and successfully implemented. It will be huge! Medicare, Medicaid, SCHIP, Veterans Administration, Department of Defense, Federal DHHS, inc. HRSA, NIH, USPHS, and State Depts. of Health are the major payers. Opponents of the PPACA will be shouting `socialized health care', I'm sure. My best estimate is at least 80% of health care will be publicly funded. Some of these component parts represent actual `public health care systems', such as the VA.

The National Prevention Strategy: The PPACA legislation required within the law establishing a national prevention strategy under the leadership of the Surgeon General, Regina Benjamin. Working with a team representing most of the federal agencies plus an Advisory Board on Prevention, Health Promotion, and Integrative Services and Public Health, a gorgeous document was developed, published, and released June 16, 2011. (An excerpt from the National Prevention Strategy is appended as Handout 1.) This document represents the first ever nationwide effort to prioritize prevention by issuing a set of goals and recommendations that will empower Americans to live longer, healthier lives; eliminate health disparities; and control rising health care costs. The document's vision states: Working together to improve the health and quality of life for individuals, families and communities by moving the nation from a focus on sickness and disease to one based on prevention and wellness.

The PPACA legislation allocated 15 Billion over 10 years, as mandated funding, to support the implementation of the National Prevention Strategy. This is the first time in our history that prevention is funded + and it is a hefty amount of money. The amount allocated, however, is substantially lesser. Nevertheless, it is still an exciting and historic document that is giving great direction to the PPACA!

Safety Net Providers: Providers such as community health centers, public hospitals, free clinics and Health Depts. serve as safety nets for uninsured people. These programs are needed now more than ever, as there are still sizable numbers of persons who will not be able to afford any of the coverage options. These public health programs are best equipped to meet the health care needs of vulnerable, uninsured populations. Federally Qualified Community Health Centers and School-Based Health Centers are two of the most comprehensive and most responsive to the

needs of underinsured persons. One of the key issues for safety net providers as reform is implemented is preparing for a surge in newly insured persons.

More than 20 million people, about 1/3 of them illegal immigrants, will remain uninsured even after all reforms take effect, according to Pamela Riley, MD, MPH, Officer for Vulnerable Populations, Commonwealth Fund.

Federally Qualified Community Health Centers (FQCHCs): These safety net centers were started in the 90s before the ACA, and grew to about 2,000 by year 2000. They now are a vital component of the ACA and their numbers have increased rapidly to over 10,000; they are projected to reach 12,000 by 2014. They are in every state and territory, and are the primary or only `medical/health care home' to 20 million Americans. (A map prepared in 2010, appended as Handout 2, shows the U.S. locations of the FQHCs.) These are comprehensive, high quality, multidisciplinary heath care centers; where necessary they are linked to larger service systems providing acute in-patient care and specialty services, and all necessary lab and x-ray services.

FQCHCs have always welcomed the insured in need of high quality care. At present about 60% of their funding comes from paid care funded by Medicaid or Medicare, or private insurance. Those who cannot pay are always welcomed; the range of services available is never limited due to inability to pay. Federal grants, private grants, and special allocations supplement funding. The challenge +which will be met-- is to smoothly integrate these centers into the ACA.

School-Based Health Centers (SBHCs): These centers began, in earlier forms, several decades ago when community-based services came into focus, and school nursing including the school nurse practitioner became recognized clinical specialty areas of practice + and school nurses were more readily available; many of the centers also include health care for family members- and even for nearby residents of the local neighborhoods. The PPACA recognizes SBHCs as crucial to providing services to uninsured children as well as children of the insured.

Two important provisions of the ACA for SBHCs are: an emergency 200M appropriation for establishing more sites and equipment needs, and an authorization for a grant program for operations. Today there are approximately 1700 SBHCs located in 45 states and the District of Columbia. Fifty-seven per cent are in urban communities, while 27% are rural.

Once the ACA is fully implemented (2014) we will need 5808 SBHCs to serve children 6-17 years of age who are without health insurance. Roughly 3900 additional SBHCs are needed. (Nat. Assoc. of SBHCs). Most SBHCs are on-site models of integration and cooperation within the schools where they provide a comprehensive range of services that meet the specific physical and behavioral health needs of the young people.

They employ multidisciplinary teams of providers including physicians, nurses, social workers, psychologists, alcohol and drug counselors, etc. They also, when and where necessary, provide clinical services through affiliations with hospitals, MD offices, Health depts. etc.

Parents are required to provide consent for services; a Community Advisory Board consisting of parents, students, family organizations, etc. serves as an oversight and consultative body. SBHCs

bill Medicaid, CHIP, Tri-Care, private insurers, and families directly. SBHCs assist children and their families with navigating the complexities of payment . Support also comes from state and federal govt. and private foundations and school districts.

Study after study after study documents the excellence of services provided by SBHCs to their young clients and their families, and the powerful contribution they make to their clients and their communities' mental and physical health. Also well documented is the cost effectiveness of these centers. It will be important to do comparative effectiveness research as the centers increase in numbers and scope of services.

On November 30 the LA Times featured School-Based Health Centers with a large article-with pictures- beginning on the front page of the LAextra. The SBHC at Belmont High School near downtown Los Angeles is part of a rapidly expanding network of school-based centers around the country offering free or low cost medical\health care to students and their families.

In California there are 183 SBHCs, up from 121 in 2004. Twelve more are expected to open by next summer. (Ca School Health Centers Assoc.) Recently SBHCs got a fiscal boost from the PPACA + a $200 million fund to establish SBHCs + Ca received $14 million of the grant funds through a competitive grants program. But, as with all programs and services: the challenge going forward is adequate funding.

The LA Unified School District has 35 clinics on their campuses; the first opened more than two decades ago. The District plans to build 14 new centers using school construction bond money.

"Clinics on school grounds are uniquely placed and equipped to find and treat those health issues which keep students from succeeding in school. There may be a shortage of food in the house that causes stress and physical problems, or drug use that leads to frequent absences." . "You just cannot ignore the reality of the patients' lives," said Julia Lear, Senior Adviser for the Center for Health and Health Care in Schools at George Washington University.

Women, Infants, and Children (W.I.C.) Beginning in the 1980s the Special Supplemental Food Program for Women, Infants, and Children began addressing infant mortality. WIC certification and nutrition education were integrated into maternal and child health nursing services. Food is provided to low income pregnant and breast-feeding mothers and their children up to age 05. Women enrolled in WIC receive myriad other related services.

The WIC program is the single largest public health program funded directly to the states. Its base funding of almost 7B was cut $523M or 07% this current fiscal year. WIC, nevertheless, with it's outstanding contribution to improving infant mortality and maternal, infant, and child health will continue to be an important component of the ACA.

Workforce Provisions and Funding for Public Health and Clinical Workforce: The PPACA has devoted considerable expertise and funding allocations (either annually renewed or mandated) to creation of an adequate number of personnel who are well educated and prepared to provide high quality care to recipients of care and make major contributions as members and leaders in their respective provider teams. (APHA Issue Brief p.3)

The law creates an independent National Health Care Workforce Commission to review current and projected health workforce needs, including those of Public Health, and to make recommendations to Congress and the Administration on workforce policies. The law also provides support for workforce planning at the state level, and enhances support for the national, state, and regional health workforce analysis centers. (APHA Issue Brief p.3

The specific provisions can be divided into 05 sections: Health Workforce Training, Public Health Infrastructure, new Public health Programming, Health Workforce Analysis, and Planning and Funding. (APHA Issue Brief p.7) A handout from the Issue Brief is appended (Handout #3) to this paper that presents several workforce education initiatives as well as programmatic initiatives, along with their funding streams.

The workforce provisions in the ACA have the potential to substantially address the training, recruitment, retention, and worker supply needs etc....However, the promise of these provisions will only be fulfilled if they are fully funded. To date only 11 of 19 provisions described in the Issue Brief have received funding, and those funded have received smaller amounts of funding than authorized. Furthermore, a majority of their funding has gone toward the clinical workforce, as opposed to the public health workforce as a whole. Issue Brief p.3

COST CONTAINMENT & COST EFFECTIVENESS

The PPACA won't quickly bend the cost curve for health care or insurance premiums.....but the reform will make an important start . Some experts believe it will lay the structural framework to mount the most serious effort ever made to control health care\medical inflation. The competitive insurance exchanges that should help lower premiums for individuals and small businesses by offering an array of private and/or public policies and rates. An excise tax will be imposed in 2018 designed to drive employers and employees away from the highest cost policies.....Health economists consider the excise tax a very strong cost control measure, because if workers have to pay more of the costs themselves, they and their doctors may think more carefully about whether they need a particular test or procedure. The impact of the excise tax gets stronger as the years pass.

The ACA creates and supports an array of pilot programs to test other innovative cost reduction strategies. They include encouraging new medical groups to better coordinate care of the chronically ill and paying doctors and medical institutions based on the quality, not quantity, of services they deliver. The reform measure will establish an independent board to push approaches that work into widespread use in Medicare and, eventually, in the private sector. Evidence-based practice and comparative effectiveness research are two very similar approaches to increase practice efficiency and quality. (NY Times Editorial: Health Care Reform, AT Last, March 22, 2010)

Additional examples are pilot programs to test new compensation models that get away from fee-for-service. Another example is Best Practices pilot programs; another example is to gather clinical data for cost benefit analysis from FQHCs and SBHCs and other community +based programs.