

Implementing the Affordable Care Act in North Carolina

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North Carolina Institute of Medicine

- Quasi-state agency chartered in 1983 by the NC General Assembly to:
 - Be concerned with the health of the people of North Carolina
 - Monitor and study health matters
 - Respond authoritatively when found advisable
 - Respond to requests from outside sources for analysis and advice when this will aid in forming a basis for health policy decisions

NCGS §90-470



National Health Reform Legislation

- Patient Protection and Affordable Care Act (HR 3590) (signed into law March 23, 2010)
- Health Care and Education Affordability Act of 2010 (HR 4872) (also referred to as “reconciliation”)
 - **The combined bills are often referred to as the Affordable Care Act (or ACA)**

NC Implementation Efforts

- Eight different workgroups examined different aspects of the ACA.
 - Health Benefits Exchange and Insurance Oversight; Medicaid; New Models of Care; Quality; Prevention; Fraud and Abuse; Health Professional Workforce; Safety Net.
- All the work of the separate workgroups were coordinated by an Overall Advisory group
 - Chaired by: Al Delia, Secretary, NC Department of Health and Human Services;* Wayne Goodwin, Commissioner, NC Department of Insurance.
 - Goal was to ensure that the decisions made in implementing health reform are in the best interest for the state as a whole.
 - More than 260 people from across the state involved.



*Lanier Cansler was co-chair when he was Secretary of NC Department of Health and Human Services

NC Foundations

- Health reform workgroups supported by generous grants from:
 - Kate B. Reynolds Charitable Trust
 - Blue Cross and Blue Shield of North Carolina Foundation
 - The Duke Endowment
 - John Rex Endowment
 - Cone Health Foundation
 - Reidsville Area Foundation

Four Key Health Challenges

- 1) Coverage and access problems
- 2) Overall population health status
- 3) Quality
- 4) Costs

How the ACA Responds to these Challenges

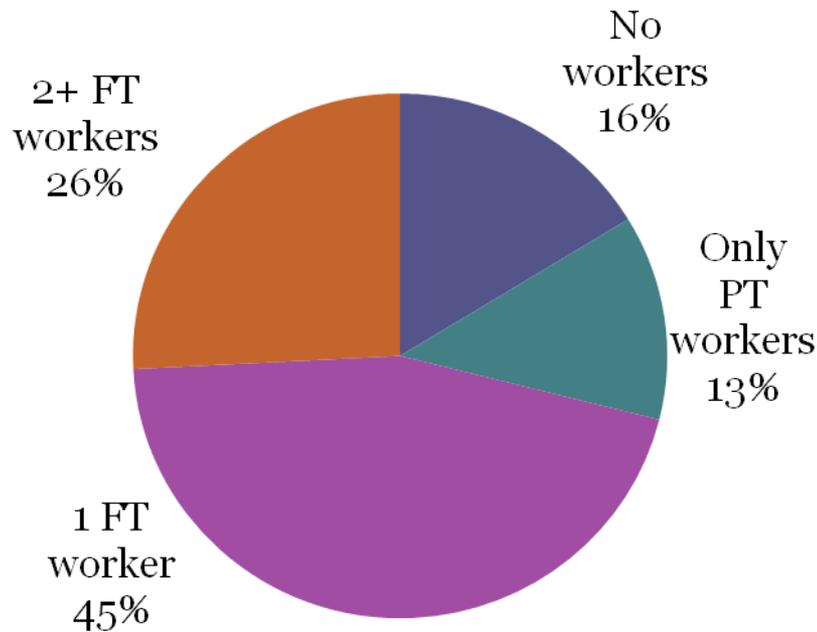
- **1) Coverage and access barriers**
- 2) Overall population health
- 3) Quality
- 4) Costs

Problem #1: Lack of Insurance Coverage

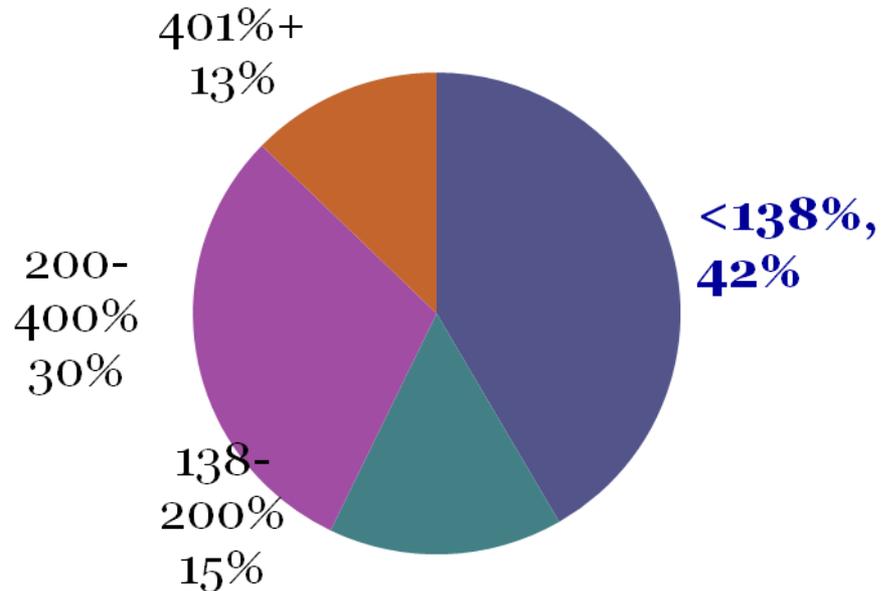
- Approximately 48 million nonelderly people (18%) who were uninsured in the US in 2011.
 - Approximately 1.5 million uninsured in North Carolina (19% of the nonelderly population).
- Being uninsured has a profound impact on health and financial wellbeing.

Uninsured in North Carolina

Most Uninsured in Household with Full-time Workers (2010-2011)



Most Uninsured Low or Moderate Income (2010-2011)

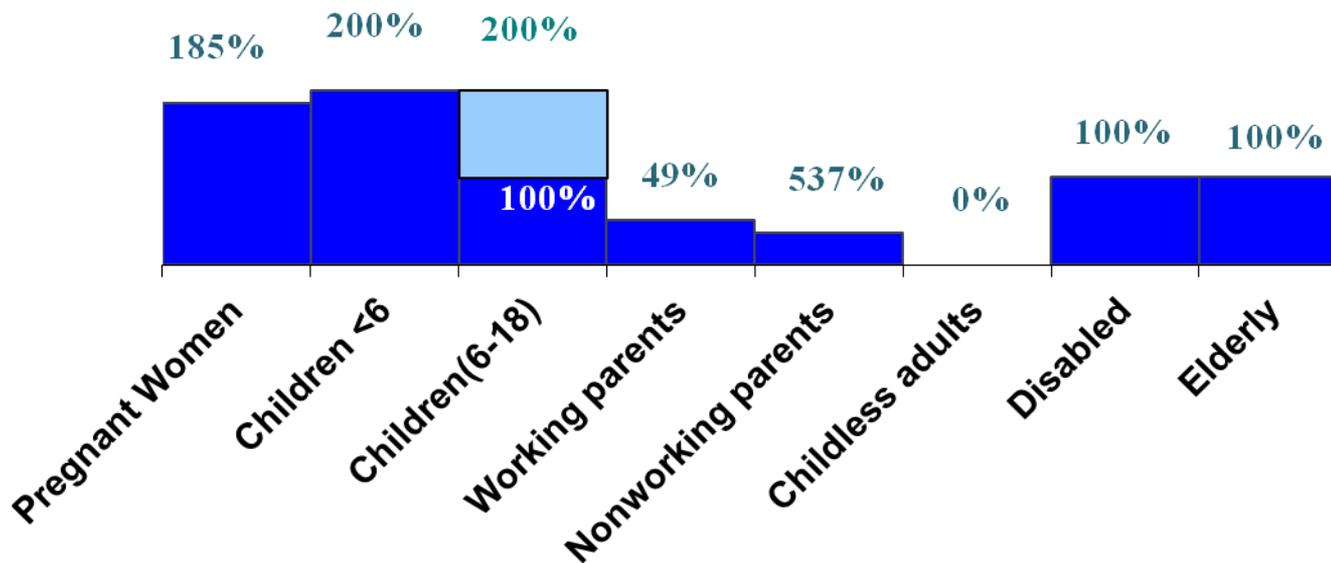


Coverage Provisions Pre-Supreme Court

- ACA would have required most people to have health insurance coverage or pay a penalty.
 - Most low income people with incomes <138% Federal Poverty Levels (FPL) would gain coverage through Medicaid.
 - Most other people would continue to get health insurance through their employer.
 - Some people would qualify for subsidies to purchase coverage on their own through the Health Benefits Exchange.

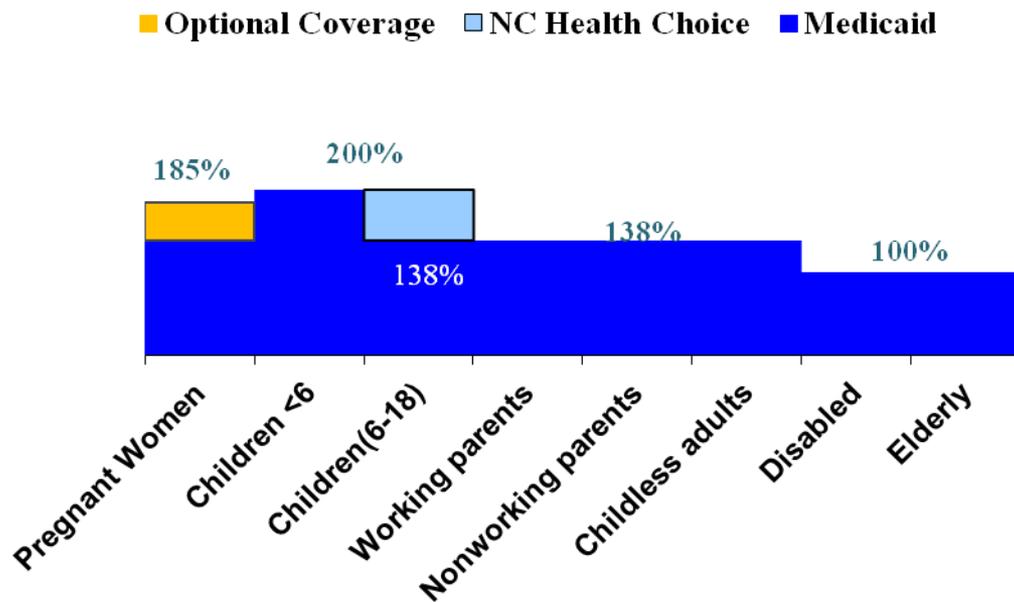
Existing NC Medicaid Income Eligibility (2012)

■ NC Health Choice ■ Medicaid



Currently, childless, non-disabled, non-elderly adults can not qualify for Medicaid

NC Medicaid Income Eligibility if Expanded (2014)



• *Beginning in 2014, adults can potentially qualify for Medicaid if their income is no greater than 138% FPL, or \$31,809 for a family of four (2012) if state expands Medicaid.*

Source: Affordable Care Act (Sec. 2001, 2002). 138% FPL (2012) = \$15,415 (\$1,285/mo) for one; \$20,879 (\$1,740) for two, \$26,344 (\$2,195/mo.) for three; \$31,809 (\$2,651/mo.) for four.

Medicaid Expansion

- Medicaid currently only covers certain categories of low-income populations.
 - Because of categorical restrictions, Medicaid only covered 30% of low-income adults in North Carolina (or 26% of adults <139% FPL) in 2010-2011.
- *ACA as enacted* would have expanded Medicaid to cover almost all low-income adults with incomes below 138% FPL.
 - No resource test for most categories of eligibles.
 - Simplified application.
 - ACA does not expand coverage to undocumented immigrants.



138% FPG is \$15,415 for an individual, and \$31,809 for a family of four in 2012.

Employer Mandate

- ACA provisions:
 - Employers with 50 or more full-time employees required to offer insurance or pay penalty (Sec. 1201, 1513, amended Sec. 1003 Reconciliation)
 - Employers with less than 50 full-time employees exempt from penalties. (Sec. 1513(d)(2))
 - Employers with 25 or fewer employees and average annual wages of less than \$50,000 can receive a tax credit. (Sec. 1421, Sec. 10105)

Individual Mandate

- Citizens and legal immigrants will be required to pay penalty if they do not have qualified health insurance, unless exempt. (Sec. 1312(d), 1501, amended Sec. 1002 in Reconciliation)
 - Penalties: Must pay the greater of: \$95/person or 1% taxable income (2014); \$325 or 2.0% (2015); or \$695 or 2.5% (2016), increased by cost-of living adjustment*
 - No individual or family will have to pay more in penalties than they would have paid for the lowest cost bronze plan.

Subsidies to Individuals

- Refundable, advanceable premium credits will be available to individuals with incomes between 100-400% FPL on a sliding scale basis, *if not eligible* for government coverage or affordable employer-sponsored insurance (Sec. 1401, as amended by Sec. 1001 of Reconciliation)
 - 400% is \$44,680/yr. for one person, \$60,520 for two, \$76,360 for three, \$92,200 for a family of four in 2012.*
 - North Carolina's median household income is well below 400% FPL.

*2012 Federal Poverty Levels are: \$11,170 for an individual, \$15,130 for a family of two, \$19,090 for a family of three, or \$23,050 for a family of four. US Census Bureau.

Health Benefits Exchange

- States (or the federal government) will create a Health Benefits Exchange for individuals and small businesses. (Sec. 1311, 1321)
- Exchanges will:
 - Provide standardized information (including quality, costs, and network providers) to help consumers and small businesses choose between qualified health plans.
 - Determine eligibility for the subsidy.
 - Facilitate enrollment for HBE, Medicaid and NC Health Choice through use of patient navigators.

State-based HBE

- To operate a state-based HBE in 2014 the state would need to show operational readiness by January 1, 2013.
- State could assume operation of the HBE in the future if it can show operational readiness one year before it assumes operations.
 - Federal funds are available to help with start-up costs, through 2014.*
 - HBE must be financially self-sufficient by 2015.



* <http://apply07.grants.gov/apply/opportunities/instructions/opplE-HBE-12-001-cidIE-HBE-12-001-015353-instructions.pdf>.

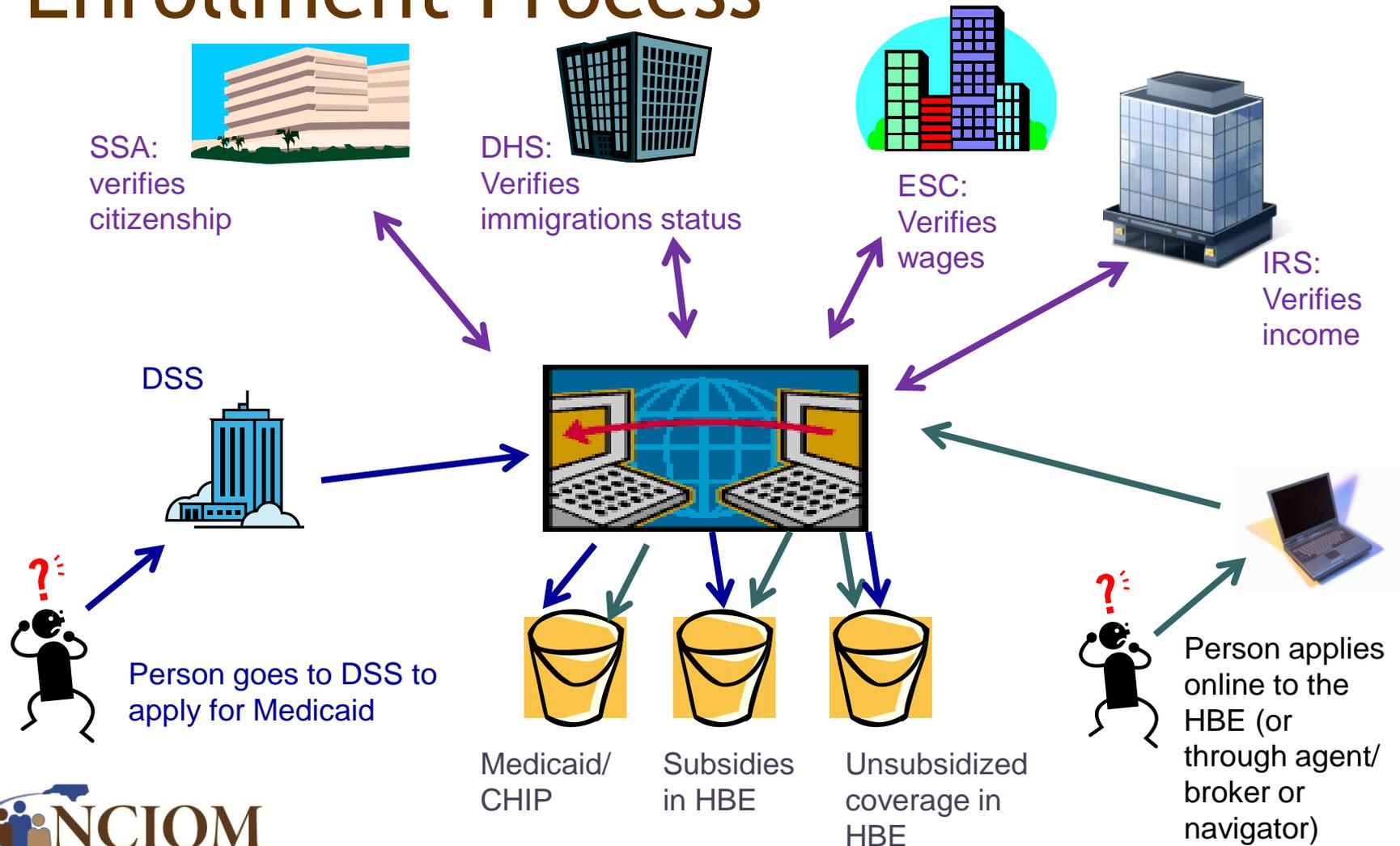
Partnership Arrangement

- North Carolina may be able to develop a partnership arrangement:
 - In partnership arrangement, states can assume responsibility for consumer assistance and/or plan management.
 - Federal government will select and train navigators, but states could select and train “in person assisters” (essentially the same as navigators).

No Wrong Door

- North Carolina has funding to create a “no wrong door” enrollment system so people can enroll in Medicaid, CHIP, or private coverage through the HBE.
- Also, separate requirements for outreach to vulnerable populations.
 - Medicaid must conduct outreach to vulnerable populations.
 - HBE must contract with patient navigators and state may contract with in person assisters to help with enrollment process.

Simplified Application and Enrollment Process



New Insurance Requirements

- Most insurers must cover with no cost sharing: *
 - Recommended preventive services with A or B recommendation from USPSTF and all recommended immunizations by ACIP, with no cost sharing. (Sec. 1001, 10406)
 - Preventive care and screenings identified as part of Bright Futures for infants, children, and adolescents (Sec. 1001)
 - Preventive care and screenings for women (Sec. 1001)
- Health plans must also cover mental health and substance abuse services in parity to other health services. (Note: Parity already applies to large group plans). (Sec. 1311(j))

Essential Benefits Package

- States are required to select an essential benefits package for qualified health plans offered in the *nongroup and small group market* that includes:* (Sec. 1302)
 - Ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitation and habilitative services; laboratory services; preventive and wellness services, and chronic disease management; pediatric services, including oral and vision care.



* With some exceptions, existing grandfathered plans not required to meet new benefit standards or essential health benefits. CCIIO. Essential health benefits bulletin. Dec. 16, 2011.
http://cciio.cms.gov/resources/files/Files2/12162011/essential_health_benefits_bulletin.pdf 23

Other Insurance Consumer Protections

- Currently, insurers:
 - Must allow parents to cover children on their health insurance plans until the child reaches age 26.
 - Government estimates that this has led to expansion of coverage to 2.5 million young adults.
 - May not deny coverage or impose preexisting condition exclusions on children under age 19 on the basis of their preexisting health status.

Other Insurance Consumer Protections

- Beginning in 2014, insurers may not deny coverage or charge people more because of their pre-existing health status. (Sec. 1201)
 - Premiums can only vary based on age (3:1 difference for adults), geography, family composition, and tobacco use (1.5:1 difference) for individual and small group plans.
- Cannot impose annual or lifetime limits in health plans. (Sec. 1001, 10101)

Supreme Court Challenge to ACA

- Chief Justice Roberts issued the opinion for the majority of the court (Breyer, Kagan, Ginsburg, Sotomayor)
 - Upheld the constitutionality of the individual mandate (under Congress' taxing authority).
 - **Struck down the government's enforcement mechanism for the Medicaid expansion, essentially creating a voluntary Medicaid expansion.**
 - Left the rest of the ACA intact.

Coverage Expansion: Impact on North Carolina

- State data originally suggested that 700,000 *uninsured* people could gain coverage in 2014. Of these:
 - 300,000 (~43%) would be eligible for subsidized coverage through a newly created Health Benefits Exchange. (Milliman report, 2011)
 - 400,000 (~57%) would gain coverage through the Medicaid expansion, if the state chooses to expand Medicaid. (Division of Medical Assistance, preliminary estimates, 2011)
- Because of the Supreme Court decision, Medicaid expansion is now optional to the state.

NC Cost of Medicaid Coverage

- The federal government pays a higher percentage of Medicaid costs for “newly eligibles” vs. “existing eligibles.”
 - The federal government pays 100% of the costs of the newly eligibles (2014-2016), then phases down to 90%.
 - The federal government pays 64% of the costs of the existing eligibles.
- DMA initially estimated that Medicaid expansion would cost the state \$830 million (2014-2019), but would draw down \$15.4 billion from the federal government.

Most Low-Income Uninsured are Ineligible for Subsidies

- The ACA envisioned that most low-income people would gain coverage through Medicaid.
- **If states chooses not to expand Medicaid, low income people (with incomes <100% FPL) will *not* be eligible for subsidies in the Health Benefits Exchange.**
 - The ACA limits subsidies to individuals with incomes that exceed 100% FPL (Sec. 1401, amending Sec. 36B(c)(1) of the Internal Revenue Code).

Other Provisions to Expand Access

- ACA includes new efforts to expand and promote better training for the health professional workforce.
- North Carolina received ACA funding to expand:
 - Primary care residency programs (UNC-CH, New Hanover)
 - PA programs (Duke, Methodist)
 - Public health workforce (UNC-CH)
 - Training for personal and home care aides (DHHS)
 - Nursing programs (Duke, UNC-CH, UNCC, NCCU, UNCG, ECU, UNCW, WSSU, WCU)
 - Graduate nursing education (Duke)
- Many other workforce provisions authorized but not yet funded.

ACA Includes Other Provisions to Expand Access to Services

- Expanded appropriations for National Health Service Corps (NHSC) by \$1.5 billion over 5 years.
 - Loan forgiveness and scholarships for primary care, dental, and mental health professionals for agreeing to serve in health professional shortage areas (HPSAs).
 - NHSC providers have almost tripled since 2008 (from 3,600 in 2008 to ~10,000 in 2012).
- However, Congress cut base appropriations in FY 2012 as part of the budget negotiations to avoid a possible government shutdown.

New Funding for Community and Migrant Health Centers

- ACA appropriated \$9.5 billion over 5 years to support federally qualified health centers, plus \$1.5 billion in new capital funds. (Sec. 10503, Sec. 2303 of Reconciliation)
 - North Carolina received ACA funding to create new access points in 11 centers, including Southside United Health Center in Winston-Salem.
 - North Carolina also received more than \$30 million in capital improvements.
 - Funding also available to help FQHCs transition to patient centered medical homes.
 - However, FQHC base funding cut by \$600,000/year as part of last year's deficit reduction legislation.

Maldistribution of Health Professionals (2014)

- North Carolina is likely to experience a health professional shortages in 2014 in some areas of the state.
- In 2012, there were:
 - 114 primary care health professional shortage areas in NC.
 - It would take 138 primary care practitioners to remove the HPSA designation based on a 3,500:1 population:practitioner ratio.
 - It would take 339 practitioners to achieve optimal population:provider ratio of 2,000:1.
 - Also existing shortage areas for dental care and behavioral health.

Four Major Challenges Facing North Carolina

- 1) Coverage and access barriers
- **2) Overall population health**
- 3) Quality
- 4) Costs

Problem #2: Population Health

- US ranks 26th out of 34 OECD countries on overall life expectancy at birth, and 30th in infant mortality rates.
- North Carolina ranks 32nd of the 50 states in population health measures in 2011. (America's Health Rankings, 2011)
 - Based on a composite of 22 measures including behaviors, community and environment, public and health policies, clinical care, and health outcomes.

Affordable Care Act

- Prevention and Public Health Fund to invest in prevention, wellness, and public health activities (Sec. 4002)
 - Appropriates \$1 billion in FY 2012 increasing to \$2 billion over time.
 - Priority areas for the national public health agenda includes health promotion and disease prevention to address lifestyle behavior modification (including smoking cessation, proper nutrition, exercise, mental health, behavioral health, substance use disorder, and domestic violence screenings). (Sec. 4001)

ACA Prevention Grants

- North Carolina received ACA funds to support greater investment in prevention and health promotion.
- NC received new prevention funding. Some of the funds include:
 - ~\$7.5 million to support multi-faceted interventions for tobacco free living, active living and healthy eating, and use of evidence-based clinical and other preventive services (Community Transformation Grant).

Selected Other ACA Prevention Grants

- \$3.7 million in Putting Communities to Work
 - Appalachian District and Pitt County Health Departments
- \$3.2 m/year in Maternal, Infant, and Early Childhood Home Visiting (MIECHV) grants (3 yrs.)
 - Funding used to support
- \$1.7 million to assist pregnant and parenting teens and women in high needs counties
- \$1.1 million for pregnancy prevention (APPNC)

Prevention: Impact on North Carolina

- More people will have coverage for clinical preventive services
- Greater funding for prevention programs that cover both primary and secondary prevention
- Greater emphasis on helping individuals understand how to manage their own health problems

Problem #3: Quality

- *To Err is Human* estimated that preventable medical errors in hospitals led to between 44,000-98,000 deaths in 1997. (Institute of Medicine, 1999)
- People only receive about half of all recommended ambulatory care treatments. (E. McGlynn, et. al. *NEJM*, 2003; Mangione-Smith, et. al. *NEJM*, 2007)

Improving Quality of Care

- The ACA directs the HHS Secretary to establish national strategy to improve health care quality. (Sec. 3011, 3012)
 - Funding to CMS to develop quality measures (Authorizes \$75M for each FY 2010-2014; Sec. 3013-3014)
 - Plan for the collection and public reporting of quality data. (Sec. 3015, 10305, 10331)
 - Move towards value based purchasing.
 - Funding to support comparative effectiveness research.
 - Funding for new models of care which change reimbursement to reward quality and health outcomes.

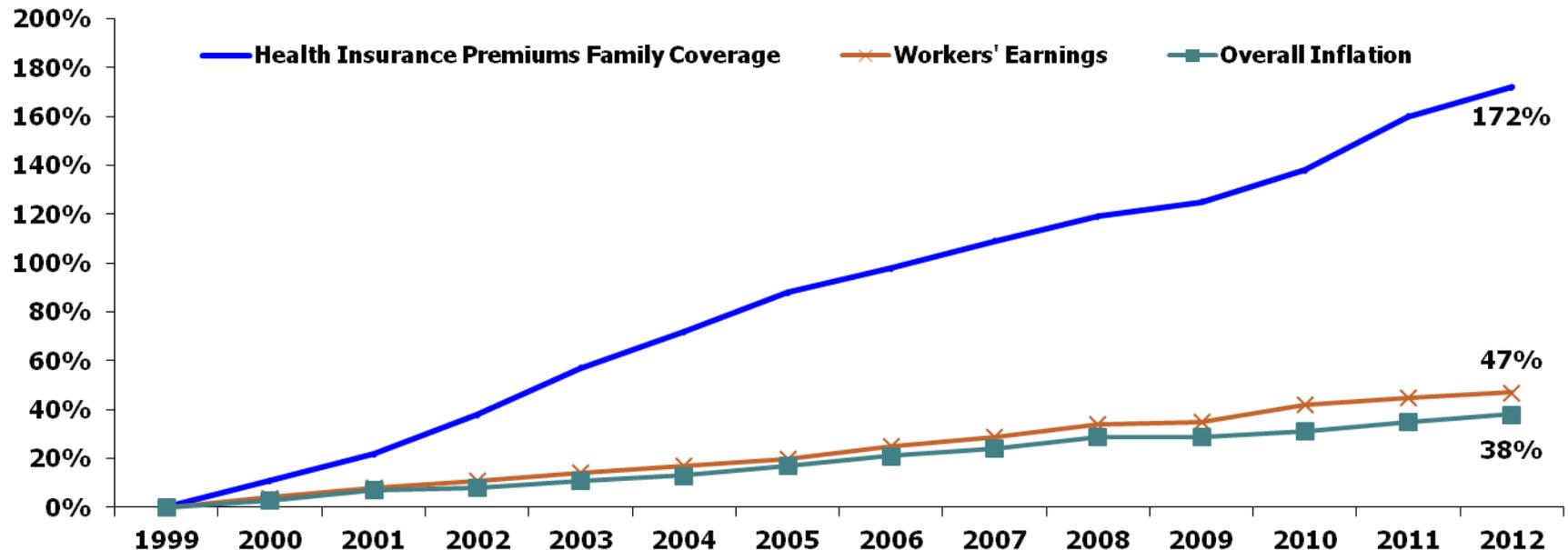
New Quality Initiatives

- North Carolina Hospital Association and Carolinas Healthcare System were 2 of 26 Hospital Engagement Networks that will develop learning collaboratives and trainings to enhance quality and improve patient quality.
- Community-based Care Transitions: Northwest Community Care Network received ACA funding to help reduce hospital readmissions.

Problem #4: Costs

- US spending on health care rising far more rapidly than other costs in our society.
 - US spends more on health care than any other industrialized nation.
- On average, health care spending increased 6% per year per capita between 1991-2010 (Kaiser Family Foundation State Health Facts).
 - Health care costs rising about 3 times the rate of inflation.

US Health Insurance Premiums Increasing More Rapidly Than Inflation or Earnings



Source: KFF. Employee Health Benefits Survey. Chartpack. 2012. Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2011. Bureau of Labor Statistics, Consumer Price Index, U.S. City Average of Annual Inflation (April to April), 1999-2012; Bureau of Labor Statistics, Seasonally Adjusted Data from the Current Employment Statistics Survey, 1999-2012 (April to April).

Reducing Rate of Increase in Health Care Spending: ACA

- No “magic bullets” to reduce rising health care costs
- ACA includes new opportunities to test new models of care delivery and payment models in Medicare and Medicaid to improve quality, health, and reduce unnecessary health care expenditures
- Once new models are shown to work in different communities and with different delivery systems, Secretary of HHS has the authority to implement broadly in other communities.

Affordable Care Act

- New models of care will reward health professionals and health care systems for:
 - 1) Improving population health
 - 2) Improving health care quality and health outcomes
 - 3) Reducing health care costs
- North Carolina testing several new models of care in Medicaid, Medicare, and commercial insurance.

North Carolina A Leader for Patient Centered Medical Homes (PCMH)

- Community Care of North Carolina (CCNC) is a nationally recognized PCMH model. Many of the PCMH initiatives through Medicaid:
 - Health homes.
 - Pediatric Accountable Care Collaborative (\$9.3 million over 3 years).
 - Demonstration to improve care for dual eligibles (Medicare and Medicaid) through CCNC.
- All are focusing on improving care for people with chronic illnesses.

Other Quality/Cost Innovations

- Other Medicare and Medicaid models being tested in North Carolina
 - Accountable Care Organization: Coastal Carolina Quality Care (New Bern), Cornerstone Health Care (High Point), Triad Healthcare Network (Greensboro)
 - Innovations at Home: Doctors Making Housecalls (Durham)
 - Medicaid Emergency Psychiatric Demonstration: Charter Northridge Behavioral Hospital, Wake County
 - Treatment of Chronic Pain: Mountain Area Health Education Center (\$1.2 million over three years)
 - Reducing death and disability for people with Type 2 diabetes: Duke and Univ. of Michigan (NC partnering with Durham health department and Cabarrus Health Alliance)

ACA: Outstanding Challenges

- The ACA presents many new challenges to the state.
 - If state chooses not to expand Medicaid, the poorest people will lack insurance coverage and they will be ineligible for subsidies.
 - May not be sufficient provider supply in 2014 to handle health care needs of newly insured, and will continue to be maldistribution issues.
 - Some providers and higher income individuals will pay more in taxes.
 - We do not yet have the “magic bullet” that will ensure better quality and reduced health care costs.

ACA: New Opportunities

- However, ACA offers many opportunities, including:
 - Expanding coverage to more of the uninsured.
 - Makes health insurance coverage more affordable to many (although some people may have to pay more for coverage).
 - Helping improve overall population health and expands coverage of preventive services.
 - Greater emphasis on quality of care.
 - Potential to reduce longer term cost escalation.

Questions



NCIOM Health Reform Resources

- Implementation of the Affordable Care Act in North Carolina. <http://www.nciom.org/wp-content/uploads/2011/03/HR-Interim-Report.pdf>
- Implementation of the Affordable Care Act in North Carolina. *NCMJ*, May/June 2011;72(2):155-159. <http://www.ncmedicaljournal.com/wp-content/uploads/2011/03/72218-web.pdf>
- What Does Health Reform Mean for North Carolina? *NCMJ*, May/June 2010;71:3 <http://www.ncmedicaljournal.com/archives/?what-does-health-reform-mean-for-north-carolina>
- NCIOM: North Carolina data on the uninsured <http://www.nciom.org/nc-health-data/uninsured-snapshots/>
- Other resources on health reform are available at: <http://www.nciom.org/task-forces-and-projects/?aca-info>

National Health Reform Resources

- Patient Protection and Affordable Care Act.
Consolidated Bill Text
<http://docs.house.gov/energycommerce/ppacacon.pdf>
- US Health Reform website
www.healthcare.gov
- National Federation of Independent Business v. Sebelius
<http://www.supremecourt.gov/opinions/11pdf/11-393c3a2.pdf>
- Congressional Budget Office. Selected CBO Publications Related to Health Care Legislation, 2009-2010.
<http://www.cbo.gov/ftpdocs/120xx/doc12033/12-23-SelectedHealthcarePublications.pdf>
- Kaiser Family Foundation
<http://healthreform.kff.org/>

For More Information

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2012 Federal Poverty Limits

Family Size	100% FPL/yr	138% FPL/yr	250% FPL/yr.	400% FPL/yr
1	\$11,170	\$15,415	\$27,925	\$44,680
2	\$15,130	\$20,879	\$37,825	\$60,520
3	\$19,090	\$26,344	\$47,725	\$76,360
4	\$23,050	\$31,809	\$57,625	\$92,200
Each add'l person	\$3,960	\$5,465	\$9,900	\$15,840

2012 Federal Poverty Guidelines available at:

<http://aspe.hhs.gov/poverty/12poverty.shtml>. Note: Federal poverty guidelines are updated each year.



Sliding Scale Subsidies

Individual or family income	Maximum premiums (Percent of family income)	Out-of-pocket cost sharing:*	Out-of-pocket cost sharing limits**
<133% FPL	2% of income	6%	\$2,017 (ind)/\$4,033 (family) (1/3 rd HSA limits)
133-150% FPL	3-4%	6%	\$2,017/ \$4,033
150-200% FPL	4-6.3%	13%	\$2,017/ \$4,033
200-250% FPL	6.3-8.05%	27%	\$3,025/ \$6,050 (1/2 HSA limit)
250-300% FPL	8.05-9.5%	30%	\$6,050/ \$12,100
300-400% FPL	9.5%	30%	\$6,050/ \$12,100
400% + FPL	No limit	30%	\$6,050/ \$12,100

*Out-of-pocket cost sharing includes deductibles, coinsurance, copays. **Out of pocket limits do not include premium costs. Annual cost sharing limited to: \$6,050 per individual and \$12,100 family in 2012 (HSA limits) (Sec. 1302(c), 1401, 1402, as amended by Sec. 1001 of Reconciliation). <http://cciio.cms.gov/resources/files/Files2/02242012/Av-csr-bulletin.pdf>. 57