EXAMINING THE IMPACT OF THE PATIENT PROTECTION AND AFFORDABLE CARE ACT IN NORTH CAROLINA

EXECUTIVE SUMMARY

In March 2010, Congress passed national health reform,[1] referred to throughout this report as the Affordable Care Act (ACA). The ACA was enacted to address certain fundamental problems with our current health care system, including the growing numbers of uninsured, poor overall population health, poor or uneven quality of care, and rapidly rising health care costs. The ACA expands coverage to the uninsured, focuses on prevention to improve population health, and places an increased emphasis on quality measurement and reporting. The ACA also has provisions to increase the supply of health professionals and strengthen the health care safety net.[2] The federal legislation also includes provisions aimed at reducing health care expenditures.

Health care accounts for a remarkably large portion of the United States' economy. In 2010, the United States spent $2.6 trillion on health care, an average of more than $8,000 per person (up from $1,110 in 1980).[3] The percentage of the gross domestic product (GDP) devoted to health care increased from 7.2% in 1970 to 17.9% in 2010. During this time, health care costs per person have grown an average of 2.4 percentage points faster than the GDP.[4] The increases in health care costs impact the ability for employers to offer insurance and for individuals to afford insurance. Rising health care costs also impact government programs such as Medicaid and Medicare, which are major parts of federal and state budgets. Increasing health care costs contribute to our federal deficit and reduce our ability to spend in other areas such as education, transportation, and economic development.

The ACA offers new opportunities to expand coverage, improve population health and quality of care, and reduce health care costs. At the same time, the legislation creates new challenges for the states as well as for families, businesses, health care professionals, and organizations.

NCIOM WORKGROUPS

In order to implement the new law, the North Carolina Department of Health and Human Services (NCDHHS) and North Carolina Department of Insurance (NCDOI) asked the North Carolina Institute of Medicine (NCIOM) to convene stakeholders and other interested people to examine the new law to ensure that the decisions the state makes in implementing the ACA serve the best interest of the state as a whole. The effort was led by an Overall Advisory Group, which was chaired by Lanier M. Cansler, CPA, Former Secretary, NCDHHS,[5] Albert Delia, Former Secretary, NCDHHS, and G. Wayne Goodwin, JD, Commissioner, NCDOI. The Overall Advisory Group included an additional 40 members, including legislators, agency officials, leaders of the state's academic health centers, and representatives of health care professional organizations, insurers, business, consumer groups, and philanthropic organizations. In addition to the Overall Advisory Group, eight other workgroups were charged with studying specific areas of the new act: Health Benefits Exchange; Medicaid; Safety Net; Health Professional

Workforce; Prevention; Quality; New Models of Care; and Fraud, Abuse, and Overutilization. (See Appendix A for a complete list of all Workgroup and Steering Committee members.)

Each workgroup was tasked with studying specific areas of the ACA and providing advice to the state about the best way to implement these provisions as well as examining federal funding opportunities in their area. The workgroups were guided by their co-chairs and the steering committee. The workgroups began meeting in August 2010 and met for 12-18 months. An interim report was published and is available online at http://www.nciom.org/wp-content/uploads/2011/03/HR-Interim-Report.pdf. Altogether, 260 people from across the state were members or steering committee members of one or more of the nine groups. In addition, the meetings were open to the public so that many others have participated in the meetings either in person or online.

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This document is a compilation of reports from each of the health reform workgroups. Each report contains information about the applicable ACA provisions, findings, and recommendations. The recommendations of each workgroup was reviewed by the Overall Advisory Committee, and then sent to the NCIOM Board of Directors for final review. What follows is a summary of the NCIOM recommendations based on the work of the different workgroups and Overall Advisory Committee. The complete recommendations can be found in each of the workgroup chapters.

EXPANDING HEALTH CARE ACCESS TO THE UNINSURED

In North Carolina, there were approximately 1.6 million uninsured nonelderly individuals in 2010 (19%).[6] People who are uninsured are more likely to delay care and less likely to receive preventive services, primary care, or chronic care management. As a result, they are more likely to end up in the hospital with preventable health problems and more likely to die prematurely.[7] When the uninsured do seek care, some of the costs of their care are shifted to the insured population.

By 2014 the ACA requires most people to have health insurance or pay a penalty. To meet this requirement, the ACA builds on our current system of employer-sponsored insurance, individual coverage, and public coverage. Large employers (50 or more full-time equivalent employees) are required to offer employees coverage or pay a penalty.[8] Small businesses are not required to offer coverage, but the ACA provides tax credits to some small businesses to help offset some of their premium costs. Many North Carolina families will be eligible for subsidies to help them purchase private coverage, if they do not have access to affordable employer based coverage, cannot qualify for public coverage, and have incomes between 100- 400% of the federal poverty level.[9,10] In addition, the ACA gives states the option to expand Medicaid to cover more low-income adults.[11] In the first year alone, close to 800,000 uninsured people could gain coverage, if

North Carolina expands Medicaid. Of these, 41% will gain coverage through the private market, and 59% could gain coverage through Medicaid.[12]

Health Benefit Exchange Workgroup

The ACA requires most people to have minimum essential health insurance coverage beginning in 2014 or pay a penalty. To help individuals who do not have access to affordable employer based coverage and small businesses, the ACA requires that each state have a Health Benefits Exchange (Exchange). Exchanges will offer information to help individuals and small businesses compare health plans based on costs, quality, and provider networks, and will help individuals and small businesses enroll in coverage. If a state chooses not to create its own Exchange, the federal government will create one to offer coverage to individuals and small groups in the state. The Exchange was created to make it easier for individuals and small businesses to purchase coverage that meets the minimum essential coverage requirements. The Exchange also can help promote competition on the basis of value, price, quality of care and customer service, and reduce competition based on risk avoidance, risk selection, and market segmentation. Qualified health plans (QHPs) offered through the Exchange must provide coverage of certain essential health benefits including ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorders services, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services, chronic disease management, and pediatric services (including oral and vision care).[13] North Carolina's essential health benefits plan will be based on the health plan that is most commonly purchased by small businesses in North Carolina: the Blue Cross and Blue Shield of North Carolina Blue Options PPO.[14] The ACA also creates a "patient navigator" or in-person assister role to provide information to the public about health plan choices and to help them enroll.

The North Carolina House of Representatives passed legislation in 2011 (HB 115), which would have created a state-based Exchange. This bill did not pass the Senate in the 2011 or 2012 Sessions. Although the legislature did not pass legislation creating an Exchange, it did pass legislation stating its intent to create an Exchange within the state, and directing the NCDOI and the NCDHHS to continue to develop a state-based exchange.[15]

Beginning in 2014, individuals and small businesses will be able to purchase health insurance coverage through a newly created Exchange. While the General Assembly indicated an interest to create a state-based exchange, it did not enact authorizing legislation in time to allow North Carolina to move forward with a state-based Exchange. North Carolina still has the option to create a state-based exchange in the future should it choose to do so; however, the state can only apply for federal funds to help build a state-based exchange through October 2014.

The effective and efficient operation of the Exchange will be critically important to the citizens of North Carolina. More than half a million individuals and numerous small employers are likely to seek coverage through the Exchange. The NCIOM believes that North Carolina has a better understanding of the needs of its citizens and of the small business market place than does the federal government. Therefore, the NCIOM recommended:

RECOMMENDATION 2.1: STATE AND FEDERAL HEALTH BENEFITS EXCHANGE OPERATIONAL RESPONSIBILITIES
The North Carolina General Assembly should create a state-based Health Benefits Exchange (Exchange). The state-based Exchange should be responsible for most of the operational aspects of the Exchange, including consumer assistance, plan management, eligibility, enrollment, and financial management.

Under the ACA, Exchanges have the authority to modify QHP participation requirements if necessary to enhance Exchange operations. For example, the Exchange Board could limit the number or type of plan designs or take other steps necessary to facilitate consumer choice of health plans. However, the discretion to limit the number or types of plan designs should only be exercised if consumers have a reasonable choice of plans in the Exchange. Further, the Exchange should not make health plan oversight so prescriptive that it fosters innovations in plan design. In other words, one of the overriding goals of the Exchange should be to ensure that consumers have meaningful choices among competing insurers. In addition, the ACA requires health plans to meet state network adequacy requirements. The NCGA, NCDOI, or the Exchange Board should establish network adequacy standards, if needed to meet federal requirements.

RECOMMENDATION 2.2. HEALTH BENEFITS EXCHANGE BOARD AUTHORITY FOR EXCHANGE CERTIFICATION
The North Carolina General Assembly should give the Health Benefits Exchange (Exchange) Board the authority, beginning in 2014, to standardize terminology, benefit designs, or limit the number of plan offerings if needed to facilitate meaningful choice and promote competition among insurers, but only if the Exchange Board determines there is a reasonable level of choice in the Exchange market. The Exchange Board should also have the authority, beginning in 2016, to require or incentivize insurers to meet state standards in addition to those required by the ACA or Secretary of the United States Department of Health and Human Services.

RECOMMENDATION 2.3. DEVELOP OBJECTIVE NETWORK ADEQUACY STANDARDS
If necessary to meet federal requirements, the North Carolina Department of Insurance (NCDOI) should develop objective network adequacy standards as may be required by the ACA that apply to all health insurers operating inside and outside the Exchange. The NCDOI should retain some flexibility in its regulations to allow insurers to test new and innovative delivery models.

In addition to the network adequacy standards, the ACA requires health plans to contract with essential community providers (ECP) in order to be certified.[16] ECPs are providers that serve predominantly low-income, medically underserved communities. The Exchange Board should monitor this provision to ensure that low-income and other vulnerable populations have access to all services without reasonable delay, and if necessary, further clarify how QHPs can meet this requirement.

RECOMMENDATION 2.4. MONITOR ESSENTIAL COMMUNITY PROVIDER PROVISIONS
The Health Benefits Exchange (Exchange) Board, in collaboration with the North Carolina Department of Insurance, should monitor insurers' contracts with essential community providers to ensure that low-income and other vulnerable populations have reasonable and timely access to a broad range of providers. If necessary, the Exchange Board should provide additional guidance to insurers about what constitutes a sufficient number or reasonable geographic distribution necessary to meet this requirement for qualified health plans offered in the Exchange.

Federal funding necessary to create and operate the Exchange is only available through 2014. Thereafter, the Exchange must be fully self-sufficient at the state-level. The ACA identifies certain methods of ensuring financial sustainability, including assessments or user fees on participating insurers, but does not limit states if they want to identify other financing mechanisms.[17]

RECOMMENDATION 2.5. ENSURE HEALTH BENEFITS EXCHANGE FINANCIAL SUSTAINABILITY
The North Carolina General Assembly should establish a Health Benefits Exchange (Exchange) Trust Fund. Any new premium tax revenues generated as a result of the implementation of the Patient Protection and Affordable Care Act (ACA) should be deposited into the Exchange Trust Fund to pay for reasonable Exchange operations. The North Carolina General Assembly (NCGA) should transfer any funds remaining in the Inclusive Health Trust Fund after payment of outstanding health bills to the Exchange Trust Fund. The NCGA should give the Exchange Board the authority to raise other revenues, within parameters established by the NCGA, if the premium tax revenues generated as a result of the implementation of the ACA are insufficient to pay for reasonable Exchange operations.

The ACA includes different mechanisms to inform and educate the public about new insurance options, and to help facilitate their enrollment into coverage. At the very general level, the Exchange and the Medicaid agency must engage in broad outreach efforts to educate the public and targeted populations about the availability of new insurance coverage options, insurance subsidies, and how to enroll.

RECOMMENDATION 2.6. HEALTH BENEFITS EXCHANGE OUTREACH AND EDUCATION
The Health Benefits Exchange (Exchange), in conjunction with the North Carolina Department of Insurance, and North Carolina Division of Medical Assistance should develop a standardized community outreach and education toolkit and provide workshops so that interested organizations and individuals can disseminate information about public and private insurance options, the Exchange website, subsidies available to individuals and small businesses, and appropriate referral sources where people can get individualized help with eligibility and enrollment and other insurance issues.

The ACA also requires that the Exchange contract with navigator or with in-person assister entities to help people understand their different insurance options and facilitate enrollment into plans. The NCDOI operates a similar program for Medicare recipients, called the Senior Health Insurance Information Program (SHIIP). The Exchange should contract with NCDOI to help establish navigator and in-person assister training, certification, and oversight requirements.

RECOMMENDATION 2.7. ROLE, TRAINING, CERTIFICATION, OVERSIGHT, AND COMPENSATION OF NAVIGATORS AND IN-PERSON ASSISTERS.
The Health Benefit Exchange (Exchange) should contract with the North Carolina Department of Insurance (NCDOI) to develop and oversee the navigator/in-person assister program. The NCDOI, in conjunction with the Exchange, should create a standardized training curriculum along with a competency exam to certify individual navigators and in-person assisters, and should create strong conflict of interest rules.

The state or Exchange can allow agents or brokers to enroll individuals, small businesses, or eligible employees into QHPs offered through the Exchange. Agents and brokers are in the best position to provide information and advice to small employers as employers need to weigh many factors in deciding whether to offer health insurance coverage and what type of coverage to offer. However, agents and brokers also need training to understand all the new public and private insurance options in order to provide the best information to individuals as well as small businesses and their employees. Additionally, the Exchange, in conjunction with the NCDOI, should examine current agent and broker commissions to reduce the financial incentives agents and brokers currently have to steer individuals and businesses to specific insurers.

RECOMMENDATION 2.8. REQUIREMENTS FOR AGENTS AND BROKERS SELLING COVERAGE IN THE HEALTH BENEFITS EXCHANGE
The Health Benefits Exchange (Exchange) Board should set policies allowing properly trained and certified agents and brokers to sell qualified health plans offered through the Exchange. The Exchange should contract with the North Carolina Department of Insurance (NCDOI) to create specialized training, certification, and continuing education requirements for agents and brokers. The NCDOI, in conjunction with the Exchange, should examine different ways to prevent conflicts of interest, reduce the incentive to steer individuals or businesses outside the Exchange, encourage agents and brokers to work with the smallest employers (with 10 or fewer employees), and encourage agents and brokers to reach out to small businesses that had not recently provided employer sponsored insurance coverage.

The ACA creates a "no wrong door" enrollment process. Individuals can apply directly to the Exchange, and if eligible for Medicaid or North Carolina Health Choice (NC Health Choice), North Carolina's Child Health Insurance Program, enroll directly into those programs. Conversely, people can apply for Medicaid or NC Health Choice first, and, if the person is

determined to be ineligible, he or she must be screened to enroll in a qualified health plan, and, if eligible, must be able to enroll "without delay." [18,19] Many of the low-income uninsured will first seek information about insurance options through their local Department of Social Services (DSS). DSS has a responsibility to provide assistance to anyone seeking to apply for or be recertified for Medicaid or North Carolina Health Choice.[20] Thus, the NCIOM recommended that DSS workers be trained and certified as navigators or in-person assisters so that DSS workers can assist people who are ineligible for Medicaid or NC Health Choice to enroll into a qualified health plan offered through the Exchange.

> **RECOMMENDATION 2.9. "NO WRONG DOOR" ELIGIBILITY AND ENROLLMENT**
> **Local departments of social services (DSS) should ensure that their Medicaid and North Carolina Health Choice eligibility workers are cross-trained and certified as navigators or in-person assisters so that DSS workers can assist people who are ineligible for Medicaid or NC Health Choice to enroll into a qualified health plan offered through the Health Benefits Exchange.**

Medicaid Workgroup

Beginning in 2014, the ACA allows states to expand Medicaid coverage to most uninsured adults with modified adjusted gross income (MAGI) no greater than 138% of the federal poverty limit.[21, 22] Children in families with incomes no greater than 200% FPL will continue to be eligible for Medicaid or NC Health Choice. Other people will gain coverage through private insurance offered through the Exchange. To qualify, a person must be a United States citizen or a lawfully present immigrant who has been in the United States for five years or more. Undocumented immigrants will not qualify for Medicaid coverage. If North Carolina elects to expand Medicaid eligibility, this change would be a major expansion to the North Carolina Medicaid program, especially for low-income adults.

A decision to participate in Medicaid expansion as put forth in the ACA would provide insurance coverage to approximately 500,000 North Carolinians, most of whom would remain uninsured without the expansion. Providing health insurance coverage will help people gain access to the care they need, which can help improve health outcomes. The gross service costs to the state would be $840.9 million and the new administrative costs would be $116.3 million between SFY 2014-2021. However, these new costs would be offset by pharmaceutical rebates ($60.9 million), redirecting existing state appropriations for other programs ($464.9 million), and the new tax revenues likely to be generated as a result of the increase in state domestic product from the infusion of $14.8 billion in new federal dollars ($496.9 million). Because of the high federal match rate, the offsets, and the new tax revenues, the state will actually experience a net savings of between $38 - $124 million/year from SFY 2014-2017. Beginning in SFY 2018, North Carolina will be required to contribute towards the costs of services to the newly eligibles. By, SFY 2021, the net new expenditure will be approximately $118.7 million to cover almost 540,000 people. Because of the large savings in the early years, North Carolina will be expected to save $65.4 million over the SFY 2014-2021 time period. Expanding Medicaid is also projected to create about 25,000 new jobs by 2016, which is expected to decline slightly to

18,000 sustained jobs (by 2021). The new federal funds would also help generate an additional $1.3-$1.7 billion in state domestic product per year.

RECOMMENDATION 3.1. EXPAND MEDICAID ELIGIBILITY UP TO 138% FPL
Based on North Carolina Division of Medical Assistance's projections of the number of people who may gain Medicaid coverage and the costs to the state, and the REMI analysis of jobs created, increase in the state's gross domestic product, and new tax revenues generated as a result of the expansion, the North Carolina Institute of Medicine recommends that North Carolina expand Medicaid eligibility up to 138% FPL.

Federal regulations prescribe most of the new eligibility and enrollment processes. States must implement the new eligibility and enrollment procedures for the existing Medicaid populations, even if the state does not choose to expand Medicaid. The state has some options which could further simplify the Medicaid eligibility and enrollment process.

RECOMMENDATION 3.2. SIMPLIFY MEDICAID ELIGIBILITY AND ENROLLMENT PROCESSES
The North Carolina Division of Medical Assistance (DMA) should simplify the eligibility and enrollment processes to reduce administrative burdens to applicants, Department of Social Services offices, and the state, and to help eligible applicants gain and maintain insurance coverage.

Further, it is likely that many individuals will move between Medicaid and the Exchange as their incomes fluctuate. Thus, the ACA includes provisions to streamline and coordinate the eligibility and enrollment processes between Medicaid, NC Health Choice, and the Exchange. Educating the public about these new requirements and the various health insurance options and insurance affordability programs is one of these provisions. Therefore, the NCIOM recommended:

RECOMMENDATION 3.3. DEVELOP A BROAD-BASED EDUCATION AND OUTREACH CAMPAIGN TO EDUCATE THE PUBLIC ABOUT NEW INSURANCE OPTIONS
The North Carolina Division of Medical Assistance, North Carolina Department of Insurance, and North Carolina Health Benefit Exchange should work together to develop a broad-based education and outreach campaign to educate the public about different health insurance options and insurance affordability programs.

Local DSS agencies will continue to play an important role in helping low-income people enroll in the appropriate health insurance coverage. Many people who have received assistance in the past through DSS are likely to continue to seek help there, regardless of whether they are eligible for Medicaid, NC Health Choice, or subsidized coverage through the Exchange. Thus, the NCIOM recommended:

RECOMMENDATION 3.4. RETRAIN DEPARTMENT OF SOCIAL SERVICES ELIGIBILITY WORKERS

The North Carolina Division of Medical Assistance, North Carolina Division of Social Services, and the North Carolina Association of County Directors of Social Services should provide training to county Department of Social Services (DSS) eligibility workers to help them understand the new eligibility and enrollment processes that will go into effect in the fall of 2013, and the new roles and responsibilities of DSS workers under the Affordable Care Act. Local DSS should ensure that there is at least one DSS eligibility worker who is trained and certified as a patient navigator or in-person assister in each DSS office.

In addition to expanding Medicaid coverage to more of the uninsured, the ACA gives states a number of options to expand home and community-based services (HCBS) to older adults or people with disabilities. Studies show that most people would prefer to remain in their homes or smaller community-based settings to receive services and supports rather than in a larger or institutional setting.[23,24] While supportive of expanding HCBS options for older adults or people with disabilities, the NCIOM was also cognizant of the state's fiscal constraints. Thus, the NCIOM recommended:

RECOMMENDATION 3.5. EXPLORE THE HOME AND COMMUNITY-BASED SERVICES MEDICAID EXPANSION OPTIONS
The North Carolina Division of Medical Assistance (DMA) should seek an actuarial estimate of the costs and benefits of options to expand home and community-based services (HCBS), and should explore options to use existing state dollars to leverage federal Medicaid funding to expand HCBS. DMA should give priority to support caregivers or otherwise provide services to help the frail elderly or people with disabilities to remain in their homes, and should give priority to those who have been identified as at-risk through the Adult Protective Services system. DMA should require the use of an independent assessment using standardized, validated assessment instruments so that the state can more appropriately target services to individuals based on their level of need and other supports.

Safety Net Workgroup

Many of the people who are expected to gain coverage under the ACA are already receiving some type of medical care from safety net organizations around the state. The safety net is composed of organizations that have a legal obligation or mission to provide health care and other related services to uninsured and underserved populations. Safety net organizations that have traditionally served underserved populations will be critical partners in meeting the health care needs of the newly insured. The ACA recognizes this and includes provisions to increase and strengthen the health care safety net.

In North Carolina, there is a wide array of safety net organizations. Primary care and preventive services are provided by federally qualified health centers, school-based or school-linked health centers, rural health centers, local health departments, free clinics, and private providers. Hospitals also provide significant amounts of care to the uninsured and other low-income populations.

Research shows that many individuals who present in the emergency department have needs that could be met by health care providers outside of the emergency department. The North Carolina College of Emergency Physicians formed an Access to Care Committee to respond to the ACA and to develop models to maintain access to care for underserved patients while reducing costs. A key recommendation from that group was to form alternative networks of health care for patients without an emergency medical condition or for patients whose emergency medical condition has been stabilized. The NCIOM concurred and recommended:

RECOMMENDATION 4.1. DEVELOP AN EMERGENCY TRANSITION OF CARE PILOT PROJECT
The North Carolina College of Emergency Physicians (NCCEP) and partners should develop an emergency care pilot project to address common conditions that present to the emergency departments but could be more effectively treated in other health care locations. The pilot project should focus on dental complaints, chronic conditions, and behavioral health issues. NCCEP and partners should seek funding for the emergency care diversion project through federal sources. If adequate funding is not received from the federal sources, the North Carolina General Assembly should fund the emergency care diversion pilot project.

The ACA also requires hospitals to conduct a community health needs assessment and take steps toward addressing those health needs. It also required "input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health".[25] Therefore, the NCIOM recommended:

RECOMMENDATION 4.2. INVOLVE SAFETY NET ORGANIZATIONS IN COMMUNITY HEALTH ASSESSMENTS
As part of the hospital and local health department community health assessments, these organizations should include input from safety net organizations and other community-based organizations that serve low-income, uninsured individuals within the hospital and public health service area. In implementing community health needs priorities, hospitals and local health departments should collaborate and partner with organizations that have a demonstrated track record in addressing the high priority needs.

The ACA also expands the 340B discount drug program to more hospitals. The 340B drug program provides deeply discounted prescription drugs for certain types of safety net providers. The savings the 340B program affords to safety net organizations could be used to reinvest those funds in other community benefits or services to the underinsured and uninsured patients they serve. To support the expansion of the 340B program in North Carolina, the NCIOM recommended:

RECOMMENDATION 4.3. EXPAND 340B DISCOUNT DRUG PROGRAM ENROLLMENT AMONG ELIGIBLE ORGANIZATIONS
The North Carolina Division of Medical Assistance, Office of Rural Health and Community Care, North Carolina Hospital Association, and North Carolina Community Health Center Association should continue their efforts to encourage eligible hospitals, rural referral centers, and federally qualified health centers to enroll in the 340B drug discount program, and to extend the capacity to provide discounted medications to more community residents who are patients of those 340B providers.

The ACA requires that the Exchange establish a program to award grants to entities that serve as navigator or in-person assister coordinating entities. The duties of a navigator or in-person assister include public education; distribution of fair and impartial information; facilitation of enrollment in QHPs; provision of referrals for grievance, complaint, or question about their health plan; and provision of information in a manner that is culturally and linguistically appropriate to the needs of the population being served. In order to receive a grant, an organization must demonstrate that it has, or could readily establish, relationships with employers and employees, consumers (including uninsured and underinsured consumers), or self-employed individuals likely to be qualified to enroll in a QHP. In addition, navigators and in-person assisters must meet standards to avoid conflicts of interest.

In North Carolina, safety net providers have established relationships with the diverse uninsured population that is traditionally hard to reach. These established relationships provide a unique opportunity for safety net providers to serve as navigators or in-person assisters for their patients.

RECOMMENDATION 4.4. ALLOW SAFETY NET ORGANIZATIONS TO FUNCTION AS PATIENT NAVIGATORS OR IN-PERSON ASSISTERS
The Health Benefits Exchange (Exchange) should train and certify staff at safety net organizations to serve as patient navigators or in-person assisters as long as these organizations meet the federal requirements for patient navigators or in-person assisters. As staff of safety net organizations, they should also educate consumers and patients about appropriate use and location of care.

The safety net will continue to play an important role in meeting the health care needs of both the newly insured and the people who remain uninsured. There is a continued need to coordinate the work of different safety net organizations to facilitate ongoing collaborations and communications. Therefore, the NCIOM recommended:

RECOMMENDATION 4.5. RECONVENE THE SAFETY NET ADVISORY COUNCIL
The Care Share Health Alliance should reconvene the Safety Net Advisory Council to identify communities with the greatest unmet needs; increase collaboration among safety net agencies; monitor safety net funding opportunities; make a recommendation and plan for integrating safety net tools including the North

Carolina Health Care Help website and the county level resources; and serve as a unified voice for the safety net.

Health Professional Workforce Workgroup

While the ACA includes provisions to increase the number of physical, behavioral, and oral health practitioners to address current and future workforce needs, and authorizes new programs to expand the number of health care providers, it does not include new appropriations to fund all of these provisions. Given limited federal funding for workforce initiatives, North Carolina policy makers, academic health institutions, and health professional organizations should focus on the steps it can take to ensure an adequate workforce to meet the health care needs of North Carolinians.

The increase in the number of North Carolinians with health insurance will increase demands for health care, particularly primary care.[26] In addition to high demands for physical health care, changes in insurance rules and access to health insurance are expected to increase demands for other services, particularly behavioral and oral health care. Workforce shortages significantly limit access to care as well as prevention and treatment options, particularly in rural areas of North Carolina. To meet the health needs of the population, North Carolina will need to increase the number of health care practitioners in primary care, and behavioral and oral health, with a particular need for practitioners willing to practice in rural and underserved communities. Furthermore, the provision of health care in the field is changing; therefore, education and training models must also change. Therefore, the NCIOM recommended:

RECOMMENDATION 5.1. EDUCATE HEALTH WORKFORCE USING NEW TECHNOLOGIES AND STRATEGIES IN NEW MODELS OF CARE

The North Carolina Community College System, the University of North Carolina University System, the North Carolina Area Health Education Centers Program (AHEC), private colleges and universities with health professions degree programs, and other interested parties should work together to create targeted programs and admissions policies to increase the number of students with expressed interested in primary care, behavioral health, and dentistry. AHEC should educate the existing workforce on new core competencies needed by the health care workforce including interdisciplinary team-based care, patient safety, quality initiatives, cultural competency, health information technology, and others.

Health care practitioners from underrepresented minority, ethnic, and racial groups are more likely to serve patients of their own ethnicity or race, patients with poor health, and in underserved communities.[27] Increasing diversity so that the workforce is representative of the population it serves in North Carolina will enhance patient care and improve population health and may reduce costs. Existing successful models for recruiting, training, and placing diverse health practitioners in North Carolina should be identified and enhanced. Therefore, the NCIOM recommended:

RECOMMENDATION 5.2. SUPPORT AND EXPAND HEALTH PRACTITIONER PROGRAMS TO MORE CLOSELY REFLECT THE COMPOSITION OF THE POPULATION SERVED
The North Carolina Area Health Education Centers Program, the North Carolina Community College System, the University of North Carolina University System, private colleges and universities with health professions degree programs, and other interested parties, including the Alliance for Health Professions Diversity, should collaborate to create more intensive programs and coordinate efforts to expand and strengthen existing evidence-based health professions pipeline programs.

Workforce shortages significantly limit access to care as well as prevention and treatment options, particularly in rural areas of North Carolina. The capacity to recruit and retain health professionals in rural and underserved areas across the state is critical to meet the health needs of North Carolinians. As part of the ACA, the National Health Service Corps (NHSC), a federal program for certain types of health care practitioners who receive loan repayments in return for practicing in a health professional shortage area (HPSA), received $1.5 billion in funding. Many states are competing to attract health professionals using NHSC funding. The Office of Rural Health and Community Care (ORHCC) plays a critical role in helping recruit health professionals and match them with qualified HPSAs. Recruiting health care professionals to rural and underserved areas also has a positive economic impact on local economies. Therefore, the NCIOM recommended:

RECOMMENDATION 5.3. STRENGTHEN AND EXPAND RECRUITMENT OF HEALTH PROFESSIONALS TO UNDERSERVED AREAS OF THE STATE
In order to support and strengthen the ability of the North Carolina Office of Rural Health and Community Care (ORHCC) to recruit and retain health professionals to underserved and rural areas of the state, the North Carolina Department of Commerce should use $1 million annually of existing industry recruitment funds to support ORHCC in recruitment and retention of the health care industry and health care practitioners into North Carolina.

In addition to focusing on rural and underserved areas, there is a general need to strengthen the existing primary care, behavioral, and oral health workforces. To recruit more physicians, nurse practitioners, and physician assistants into primary care and to retain the workforce we currently have will require a rebalancing of how practitioners are paid, rewarding those health care professionals who practice in primary care. In order to encourage health care professionals to enter into primary care practices and to retain current practitioners, the NCIOM recommended:

RECOMMENDATION 5.4. INCREASE REIMBURSEMENT FOR PRIMARY CARE AND PSYCHIATRY SERVICES
Public and private payers should enhance their reimbursement to primary care practitioners and psychiatrists to more closely reflect the reimbursement provided to other specialty practitioners. For purposes of this recommendation, primary care practitioners include, but are not limited to: family physicians, general pediatricians, general internists, psychiatrists as well as nurse practitioners, physician assistants, and certified nurse midwives practicing in primary care.

Given the health care needs of the population, the role of the health care industry in North Carolina's economy, the amount of money the state invests in educating health care providers, and the state's role in financing the consumption of health care, there is a pressing need for North Carolina to identify workforce priorities and to create policies that ensure there are enough practitioners with the proper training to meet the health care needs of the population. Therefore, the NCIOM recommended:

> **RECOMMENDATION 5.5. SUPPORT COMPREHENSIVE WORKFORCE PLANNING AND ANALYSIS**
> **The North Carolina Health Professions Data System should be expanded into a Center for Health Workforce Research and Policy to proactively model and plan for North Carolina's future health workforce needs. The North Carolina General Assembly should provide $550,000 in recurring funding beginning in SFY 2013 to support the Center for Health Workforce Research and Policy.**

IMPROVING POPULATION HEALTH

Ultimately, the goal of any broad scale health system reform should be on improving population health. The ACA includes new funding to invest in prevention, wellness, and public health infrastructure. The ACA includes $500 million in FFY 2010, $750 million in FFY 2011, and $1 billion in FFY 2012 for a new Prevention and Public Health fund to invest in prevention, wellness, and public health infrastructure. This focus on improving population health is particularly important to North Carolina, which ranked 33 of the 50 states in 2012 based on a composite of 24 different measures affecting health including individual behaviors, community and environmental factors, public and health policies, clinical care, and health outcomes.[28]

Prevention Workgroup

The ACA included new requirements and options to cover clinical preventive services in public and private health insurance plans. In addition, the ACA includes new requirements, as well as new options for employers to promote employee wellness.

The ACA requires state Medicaid agencies to provide coverage for tobacco-cessation drugs and to provide Medicaid coverage for counseling and pharmacotherapy to pregnant women for cessation of tobacco use. The ACA also prohibits cost-sharing for these services. North Carolina's Medicaid program currently covers some tobacco cessation drugs and is already in compliance with the provision on pregnant women. However, barriers to treatment still exist. Therefore, the NCIOM recommended:

RECOMMENDATION 6.1. INCREASE TOBACCO CESSATION AMONG MEDICAID RECIPIENTS
The North Carolina Division of Medical Assistance should provide all Federal Drug Administration (FDA) approved over-the-counter nicotine replacement therapy without a physician prescription as part of comprehensive tobacco cessation services and work to reduce out-of-pocket costs for such therapies. Primary care providers and Medicaid recipients should be educated about covered tobacco cessation therapies.

The ACA includes a provision that requires employers with 50 or more employees to provide reasonable break time and a private place (other than a bathroom) for an employee to express breast milk for nursing children for one year after the child was born. Employers with less than 50 employees must apply for and prove undue hardship if they have difficulty complying with the new provisions.

RECOMMENDATION 6.2. SUPPORT NURSING MOTHERS IN THE WORK ENVIRONMENT
The North Carolina Department of Labor and the Office of State Personnel (OSP) should partner to educate employers and employees on the requirement for reasonable break time for working mothers, and, as appropriate, the OSP policy. Small businesses should be encouraged to provide similar support to working mothers.

The ACA requires new employer-sponsored group health plans and private health insurance policies to provide coverage, without cost sharing, for certain preventive services and immunizations. The state and partners will need to monitor health plans to ensure that coverage is provided, educate providers and patients on the covered services, and provide mechanisms in electronic medical record systems to promote the provision of these services.

RECOMMENDATION 6.3. PROMOTE AND MONITOR UTILIZATION OF PREVENTIVE CARE SERVICES
North Carolina should provide the same coverage of preventive services for Medicaid enrollees as is provided to people with private coverage. The North Carolina Department of Insurance should monitor health plans to ensure compliance with the requirement that new employer-sponsored group health plans and private health insurance policies provide coverage, without cost sharing, for preventive services. Electronic medical record systems offered in North Carolina should provide clinical decision support tools to identify and promote prevention services. Outreach should be done to educate providers and individuals about covered preventive services.

The ACA includes provisions that aim to improve population health through benefits provided by employers. The ACA also includes worksite wellness provisions which allow employers to include wellness programs as part of their insurance coverage, if the programs promote health or

prevent disease. There is a need for education of employers and employees on these provisions, thus, the NCIOM recommended:

RECOMMENDATION 6.4. PROMOTE WORKSITE WELLNESS PROGRAMS IN NORTH CAROLINA BUSINESSES
The Center for Healthy North Carolina and the North Carolina Division of Public Health should provide information to businesses on evidence-based wellness programs, encourage leaders within businesses and worksites to develop a culture of wellness, and provide education to employers and insurers on the specific requirements of the Affordable Care Act for employer worksite wellness programs.

The ACA also provided new funding opportunities to expand prevention efforts, prevent or reduce overweight and obesity, reduce tobacco use, improve maternal and infant health, and strengthen the public health infrastructure. The North Carolina Division of Public Health has been successful in competing for these funds. Most of the funding has been used to implement or strengthen programs at the local level.

While much of the initial ACA funding has been targeted to states, some funding opportunities are also available to local public health agencies. Larger public health agencies generally have the capacity to compete for these funds. However, smaller and/or poorer counties may lack the personnel or infrastructure to apply for grants or to implement new initiatives. These are often the counties with the greatest health needs. Therefore, the NCIOM recommended:

RECOMMENDATION 6.5. BUILD CAPACITY OF COMMUNITIES TO RESPOND TO FUNDING OPPORTUNITIES
The Center for Healthy North Carolina and the Office of Minority Health and Health Disparities should develop the infrastructure needed to allow communities of greatest need to respond to prevention-related funding opportunities.

As with other areas of the ACA, many of the provisions that include grant funding opportunities were authorized, but not appropriated. Therefore, the NCIOM recommended:

RECOMMENDATION 6.6. MONITOR FUNDING OPPORTUNITIES FOR PREVENTION PROVISIONS
The state should monitor the federal appropriations process, as well as funding made available as part of the Public Health and Prevention Trust Fund, to identify additional funding of prevention provisions.

IMPROVING THE QUALITY OF CARE

The current health care payment system is structured to reward health professionals and providers based on the volume of services provided rather than based on the quality of care or health outcomes. The ACA begins to change the way that health care professionals and providers are reimbursed to emphasize the quality and value of the services provided.

Quality Workgroup
The ACA includes new provisions aimed at improving the quality of care provided by different types of health care professionals and providers. For example, the ACA requires the Secretary of the USDHHS to develop quality measures to assess health care outcomes, functional status, transitions of care, consumer decision-making, meaningful use of health information technology, safety, efficiency, equity and health disparities, and patient experience.[29] Health care professionals and providers will be required to report data on these new measures to CMS. Ultimately, these data will be made available to the public. In addition, the ACA changes the Medicare (and in some cases, Medicaid) reimbursement structure to reward providers and health care professionals, in part, on the quality of services provided.

Health care professionals and providers need to be educated about these changes, so that these groups can understand and be prepared to meet the new Medicare reporting and quality standards. In addition, consumers need to understand how to interpret the quality comparison data when they become available. Thus, the NCIOM made many recommendations about the need for education, including:

RECOMMENDATION 7.1. EDUCATE PRIMARY AND SPECIALTY CARE PROVIDERS ON QUALITY MEASURE REPORTING REQUIREMENTS
The Division of Medical Assistance and partners should educate primary care and specialty physicians on the requirement to report adult health quality measures on all Medicaid eligible adults.

RECOMMENDATION 7.4. EDUCATE PROVIDERS ON ACA ISSUES
The North Carolina Area Health Education Centers and partners should educate physicians on new ACA requirements and provisions aimed at improving quality.

RECOMMENDATION 7.5. EDUCATE HOSPITALS ON ACA ISSUES
The North Carolina Hospital Association should provide education to hospitals on new ACA requirements and provisions aimed at improving quality of care in hospitals.

RECOMMENDATION 7.6. EDUCATE HOME AND HOSPICE CARE PROVIDERS ON ACA ISSUES
The Association for Home and Hospice Care of North Carolina and the Carolinas Center for Hospice and End of Life Care should provide education to North Carolina hospice providers on quality reporting requirements, pay for performance, and the implications of the ACA value-based purchasing provisions.

RECOMMENDATION 7.7. EDUCATE FACILITY PERSONNEL ON ACA ISSUES
The North Carolina Division of Health Service Regulation and partners should educate their constituencies (ambulatory surgery centers, home health, and skilled nursing facilities) on the implications of value-based purchasing.

RECOMMENDATION 7.8. EDUCATE CONSUMERS ON AVAILABILITY AND INTERPRETATION OF PROVIDER QUALITY MEASURES
The North Carolina Healthcare Quality Alliance and partners should convene a broad representation of consumer stakeholders in an effort to construct an initial effort to affect consumer participation as these new resources become available.

Over time, health care professionals and institutions will be reimbursed, in part on the value of the services they provide. This will be measured by quality of care indicators or health outcomes. The ACA requires health care professionals and providers to report certain quality and outcome data to the federal government. In addition, many insurers are adopting similar reporting requirements. These new reporting requirements may become burdensome to health care professionals, if they are required to report the same, or similar data to multiple state and federal agencies and private insurers. Reductions in the reporting burden could be achieved through alignment of the state quality measure requirements (e.g., CCNC, DMA) with the federal measures. To reduce this reporting burden on providers and ensure that the state has access to information to drive state for state level quality improvement initiatives, the NCIOM recommended:

RECOMMENDATION 7.2. EXPLORE CENTRALIZED REPORTING
The North Carolina Health Information Exchange (NC HIE) Board should facilitate mechanisms to reduce the administrative burden of the Medicaid eligible adult quality reporting requirement through centralized reporting through the NC HIE and alignment of North Carolina quality measures with federal requirements.

RECOMMENDATION 7.3. INVESTIGATE OPTIONS FOR DATA STORAGE
The North Carolina Department of Health and Human Services, working with the NC HIE and other stakeholder groups, should examine options to capture data automatically from electronic health records and then coordinate submission of data to the appropriate entities. Data should be made available at the state level for research and quality and readmission reduction initiatives. These data should contain unique identifiers to foster linkage of datasets across provider types and time.

The ACA includes provisions to reduce payments to hospitals paid under the Medicare inpatient prospective payment system for certain preventable Medicare readmissions. The goal of this focus is to improve quality and efficiency of care by improving transitions in care. Transitions in care refer to movement of patients between health care providers and health care settings. Problems with transition can occur when information about a patient’s care or situation is not communicated adequately to other providers or to the patient. In order to improve transitions of care, the NCIOM recommended:

RECOMMENDATION 7.9. IMPROVE TRANSITIONS OF CARE
The North Carolina Healthcare Quality Alliance should partner with the North Carolina Hospital Association, provider groups, and Community Care of North Carolina to improve transition in care, including forging of relationships between providers of care, developing mechanisms of communication including a uniform transition form, identifying, and working with the North Carolina Health Information Exchange Board to facilitate information technology requirements, and developing mechanisms to evaluate outcomes. Solutions utilizing transition principles should be applied to all patients regardless of payer.

RECOMMENDATION 7.10. REIMBURSE NURSE PRACTITIONERS IN SKILLED NURSING FACILITIES
The North Carolina Health Care Facilities Association and Community Care of North Carolina should collaborate with the Division of Medical Assistance to provide reimbursement for nurse practitioner services in skilled nursing facilities.

COST CONTAINMENT

The United States spends more on health care that any other developed nation (17% of the gross domestic product, or $7,960 per capita in 2009). Spending on health care is rising far more rapidly than other costs in our society. The ACA attempts to reign in health care costs by encouraging the development of new models of care that promote better patient outcomes and reduces unnecessary utilization, reducing payments to certain providers, streamlining administrative costs, and reducing fraud and abuse.

New Models of Care Workgroup

New models of care are essential to improve the value delivered by our health care system. The ACA includes provisions aimed at testing new models of delivering and paying for health services with the goals of reducing unnecessary utilization and health care expenditures, while improving individual health outcomes and overall population health. The ACA gives CMS authority to test new models of care that expand access to needed services; incentivize providers to improve quality and individual and community health outcomes; involve patients more directly in their own care; reduce redundant, ineffective and inefficient utilization; and moderate rising health care costs.

North Carolina has many different pilots or demonstrations under development, both in the public and private sector, including, but not limited, to multipayer patient-centered medical homes, new payment models, value-based insurance designs, and broader population health interventions. Ongoing efforts are needed to catalogue the different initiatives and to disseminate information about successful efforts across the state. Therefore, the NCIOM recommended:

RECOMMENDATION 8.1. DEVELOP A CENTRALIZED NEW MODELS OF CARE TRACKING SYSTEM
North Carolina state government and North Carolina foundations should provide funding to the North Carolina Foundation for Advanced Health Programs (NCFAHP) to create and maintain a centralized tracking system to monitor and disseminate new models of payment and delivery reform across the state.

North Carolina needs to continually examine the way we provide and pay for health care services, to ensure that models being used are achieving optimal individual and population health outcomes, while providing care in the most efficient manner possible. Strong, independent evaluations that examine common quality, outcome, and cost metric—so that different models of care can be compared to one another—are needed to identify what works, for whom, and in what environment. Further, evaluation data should be shared publicly among insurers, other health systems, and the public. Thus the NCIOM recommended:

RECOMMENDATION 8.2. EVALUATE NEW PAYMENT AND DELIVERY MODELS
Any health system, group of health care providers, payers, insurers, or communities that pilot a new delivery or payment model should include a strong evaluation component. Evaluation data should be made public and shared with other health system, group of health care providers, payers, insurers, or communities so that others can learn from these new demonstrations. North Carolina foundations, payers, insurers, or government agencies that fund pilot or demonstration programs to test new payment or delivery models should pay for and require the collection of evaluation data and make this data available to others as a condition of funding or other support for new models of care.

There is a need for enhanced data to improve the functioning of the current health care system. State government, public and private payers, health systems, health care professionals, employers and consumers need information about diagnosis, utilization, costs, and outcomes in order to evaluate new delivery or payment models. To ensure that necessary data is captured in a way that allows for such evaluation, the NCIOM recommended:

RECOMMENDATION 8.3. CAPTURE DATA TO SUPPORT NEW MODELS OF CARE
The North Carolina Department of Health and Human Services should take the lead in working with the North Carolina Department of Insurance and various stakeholder groups to identify options to capture health care data necessary to improve patient safety and health outcomes, improve community and population health, reduce health care expenditure trends, and support the stabilization and viability of the health insurance market.

While public and private health care organizations in North Carolina have sought to take advantage of federal funding opportunities that could lead to improved outcomes and reduced cost escalation, public and private payers, health care systems, and health care professionals have experienced certain barriers which prevent them from being more innovative. A broader group of

stakeholders need to be involved in discussions to address potential barriers as well as solutions to overcome those barriers, including licensure boards, the North Carolina Department of Insurance, health professional associations, and health care systems.

> **RECOMMENDATION 8.4. EXAMINE BARRIERS THAT PREVENT TESTING OF NEW PAYMENT AND DELIVERY MODELS**
> **The North Carolina Institute of Medicine (NCIOM) should seek funding to convene a task force to examine state legal or other barriers which prevent public and private payers and other health care organizations from testing or implementing new payment and delivery models. The NCIOM Task Force should examine other health-related policies and regulations that impede implementation of new models of care or the otherwise effectively use of electronic health records. The NCIOM should present the potential recommendations to the North Carolina General Assembly, licensure boards, or appropriate groups within two years of initiation of this effort.**

Fraud and Abuse Workgroup

The ACA includes funding to support more aggressive efforts to eliminate fraud and abuse, and to recover overpayments in Medicare, Medicaid, and CHIP. These new efforts are expected to yield $6 billion in savings to the federal government over the next 10 years (and a corresponding reduction in costs to the state for the Medicaid and CHIP programs).

Unlike many of the other ACA provisions, most of the fraud and abuse provisions went in to effect in 2010 or 2011. Many requirements of the ACA provisions were already being addressed in North Carolina, including implementation of vendor enrollment and oversight software, provision of compliance programs, provider education, and prepayment review. However, the state needed to enact new laws to implement other mandatory ACA requirements. The North Carolina General Assembly enacted these new laws in 2011 as Session Law 2011-399.

CONCLUSION

North Carolina currently faces significant health challenges, including the growing numbers of uninsured, poor overall population health, rising health care costs, and the need to increase access to care and improve quality. The ACA begins to address some of these problems. Greater emphasis will be placed on improving overall population health and the quality of health care services. Further, the ACA includes provisions aimed at lowering the rate of increase in health care expenditures.

The ACA does not address—or solve—all of the state's health care problems. For example, while the ACA includes provisions to expand the health professional workforce, the Act included little new funding. Thus there is likely to be workforce shortages to address the pent-up demand for health services in 2014 when many of the uninsured gain coverage. The ACA includes new provisions to change the way we deliver and pay for health care with the goal of improving quality and health outcomes while reducing escalating health care costs but, as of yet, most of these efforts are untested.

Further, there are still unanswered questions. The ACA directed the Secretary of USDHHS to implement many of the provisions of the new law. The Secretary has issued both proposed and final regulations implementing many of the sections of the law, but further guidance on other sections will be forthcoming.

While the ACA imposes significant new challenges, it also offers opportunities to increase affordable coverage to more North Carolinians, improve population health, and improve quality of care. Over the longer term, we may also gain new strategies to reign in escalating health costs. The recommendations included in this report are intended to help North Carolina implement the Affordable Care Act so as to best serve the state as a whole.

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[1] The ACA is actually a combination of two separate pieces of legislation. The Patient Protection and Affordable Care Act (HR 3590) was signed into law on March 23, 2010. This law was quickly followed by the Health Care and Education Reconciliation Act (HCERA) (HR4872), which was signed into law on March 30, 2010.

[2] A more complete description of the ACA is available in the May/June 2010 issue of the NCMJ. Silberman P, Liao C, Ricketts TC. Understanding health reform: a work in progress. *NC Med J*. 2010;71(3):215-231. http://www.ncmedicaljournal.com/archives/?issue-brief-understanding-health-reform-a-work-in-progress-3733. Accessed January 18, 2011. A review of the steps the state has taken to implement the ACA is available in the March/April 2011 issue of the NCMJ. Silberman P, Cansler LM, Goodwin W, Yorkery B, Alexander-Bratcher K, Schiro S. Implementation of the Affordable Care Act in North Carolina. *NC Med J*. 2011;72(2):156-160. http:// http://www.ncmedicaljournal.com/wp-content/uploads/2011/03/72218-web.pdf. Accessed February 14, 2012.

[3] Kaiser Family Foundation. Health Care Costs: A Primer. http://www.kff.org/insurance/upload/7670-03.pdf. Published May 2012. Accessed January 29, 2013.

[4] Kaiser Family Foundation. Health Care Costs: A Primer. http://www.kff.org/insurance/upload/7670-03.pdf. Published May 2012. Accessed January 29, 2013.

[5] Secretary Cansler served as co-chair during his tenure as Secretary of the North Carolina Department of Health and Human Services. Secretary Delia became co-chair when he was appointed as Acting Secretary.

[6] United States Census Bureau. Current Population Survey, Annual Social and Economic Supplements. Table HIB-6. Health Insurance Coverage Status and Type of Coverage by State—Persons Under 65: 1999 to 2010. http://www.census.gov/hhes/www/hlthins/data/historical/HIB_tables.html. Accessed February 15, 2012.

[7] The Kaiser Commission on Medicaid and the Uninsured. The Uninsured: A Primer. Washington, DC: The Henry J. Kaiser Family Foundation.; 2010. http://www.kff.org/uninsured/upload/7451-06.pdf. Accessed February 8, 2011.

[8] Patient Protection and Affordable Care Act, Pub L No. 111-148, § 1513.

[9] The penalty is $95/year or 1% of income (whichever is greater) in 2014. The penalty amount increases to $695/year or 2.5% of income by 2016. Certain individuals are exempt from the mandate, including but not limited to those who are not required to pay taxes because their incomes are less than 100% of the federal poverty line (FPL), those who qualify for a religious exemption, American Indians, and those for whom the lowest cost plan would exceed 8% of their income.

[10] The constitutionality of the individual mandate along with the Medicaid expansion is being challenged in the United States Supreme Court. The Supreme Court accepted two cases to consider the constitutionality of different provisions of the ACA, *National Federation of Independent Business v. Sebelius*, and *Florida v. Department of Health and Human Services*. The different challenges will be considered in late March. A decision is expected before the close of the Supreme Courts current term in June, 2012. Kaiser Family Foundation. A Guide to the Supreme Court's Review of the 2010 Health Care Reform Law. http://www.kff.org/healthreform/upload/8270-2.pdf. Published January 2012. Accessed February 23, 2012.

[11] As originally passed, the ACA required states to expand Medicaid to all individuals with family incomes below 138% of the federal poverty guidelines, or lose federal funding. In June 2012, the Supreme Court ruled this was unduly coercive to the states and changed it to an optional expansion of Medicaid.

[12] Milliman I. North Carolina Health Benefit Exchange Study. Table 1.2. http://www.nciom.org/wp-content/uploads/2010/10/NCDOI-Health-Benefit-Exchanges-Report-Version-37_2012-12-9.pdf. Published December 9, 2011. Accessed February 14, 2012.

[13] Patient Protection and Affordable Care Act, Pub L No. 111-148, § 1302(a).

[14] The Center for Consumer Information and Insurance Oversight prepared a summary of the proposed North Carolina essential health benefit benchmark plan. The summary is available at: http://cciio.cms.gov/resources/EHBBenchmark/proposed-ehb-benchmark-plan-north-carolina.pdf. Accessed December 10, 2012.

[15] Sec. 49 of NCGA Session Law 2011-391.

[16] Patient Protection and Affordable Care Act, Pub L No. 111-148, §1311(c)(1)(C), 42 USC 13031.

[17] Patient Protection and Affordable Care Act, Pub L No. 111-148, § 1311(d)(5).

[18] Patient Protection and Affordable Care Act, Pub L No. 111-148, §2201, enacting §1943(b)(1)(C) of the Social Security Act, 42 USC 1396w-3(b)(1)(C).

[19] United States Department of Health and Human Services. Proposed Rule. *Fed Regist.* 76(159):51148-51199. To be codified at 42 CFR §435.1200(g).

[20] United States Department of Health and Human Services. Proposed Rule. *Fed Regist.* 76(159):51148-51199. To be codified at 42 CFR §435.908.

[21] The ACA requires states to expand Medicaid to cover nonelderly individuals with modified adjusted gross income of no more than 133% FPL, however the legislation also provides a 5% income disregard. Because of this disregard, individuals will be able to qualify for Medicaid if their income is not more than 138% FPL, assuming they meet other program rules.

[22] The federal poverty levels, established by the federal government, is based on family size. It is usually updated annually based on the changes in the Consumer Price Index. In 2012, the federal poverty levels for a family of one was $11,170; for a family of two ($15,130), family of three ($19,090), and family of four ($23,050). The federal poverty levels increase by $3,960 for each additional family member. United States Department of Health and Human Services. http://aspe.hhs.gov/poverty/12poverty.shtml. Accessed February 14, 2012. Because the federal poverty levels are updated annually, it is likely to be higher by 2014.

[23] National Institute of Mental Health. United States Department of Health and Human Services. Mental Health: A Report of the Surgeon General. Rockville, MD: National Institute of Mental Health; 1999. http://www.surgeongeneral.gov/library/mentalhealth/home.html. Published 1999. Accessed September 22, 2010.

[24] Bayer A.H., Harper L. American Association of Retired Persons. Fixing to Stay: A National Survey of Housing and Home Modification Issues. Washington, DC: AARP Independent Living Program; 1995, 2000. http://assets.aarp.org/rgcenter/il/home_mod.pdf. Accessed February 8, 2011.

[25] Patient Protection and Affordable Care Act, Pub L No. 111-148, § 9007(a), enacting Sec. 501(r)(3)(B)(i) of the Internal Revenue Code of 1986, 26 USC 501(r)(3)(B)(i).

[26] Hofer AN, Abraham JM, Moscovice I. Expansion of coverage under the patient protection and Affordable Care Act and primary care utilization. *Milbank Q.* 2011;89(1):69-89.

[27] North Carolina Institute of Medicine Primary Care and Specialty Supply Task Force. Providers in Demand: North Carolina's Primary Care and Specialty Supply. Morrisville, NC: North Carolina Institute of Medicine; 2007. http://www.nciom.org/projects/supply/provider_supply_report.pdf. Accessed December 10, 2008.

[28] United Health Foundation. America's Health Rankings 2012: North Carolina. http://www.americashealthrankings.org/NC/2012. Accessed January 31, 2013.

[29] Patient Protection and Affordable Care Act, Pub L No. 111-148, §§ 3013-3014.