

The ACA: What It Is and How It Will Look in North Carolina

County Commissioners Assoc.

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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



NC Implementation Efforts

- **Nine different workgroups examined different aspects of the ACA.**
 - More than 260 people from across the state involved.
- **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

Agenda

- 1) Current challenges facing North Carolina's health system
 - Coverage and access barriers
 - Overall population health
 - Quality
 - Costs
- 2) Impact counties
 - Employers
 - Service providers
- 3) Conclusion

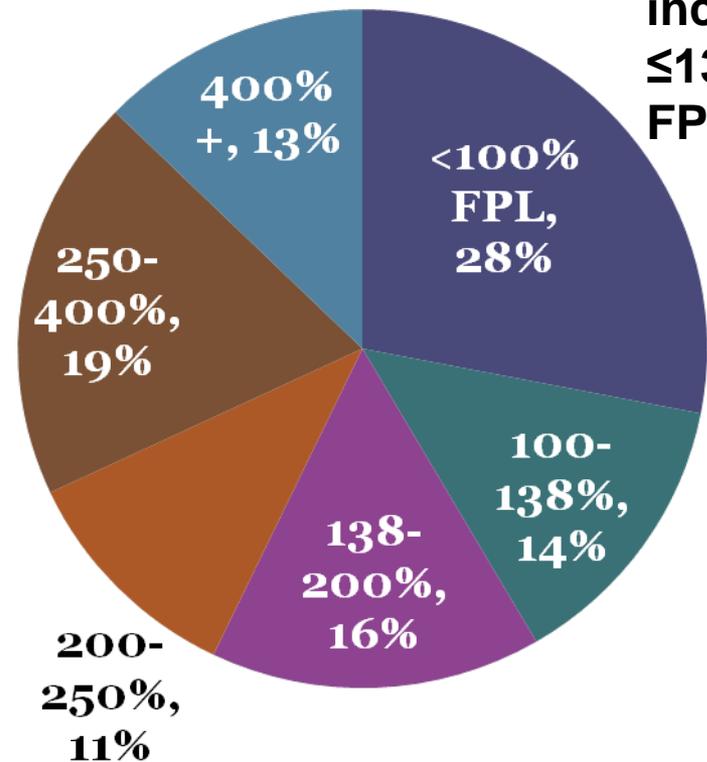
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Problem #1: Uninsured in North Carolina

- 1.5 million nonelderly people were uninsured in North Carolina (2010-2011).
- Being uninsured has a profound impact on health and financial wellbeing

Percent Uninsured by Family Income



42% have incomes \leq 138% FPL

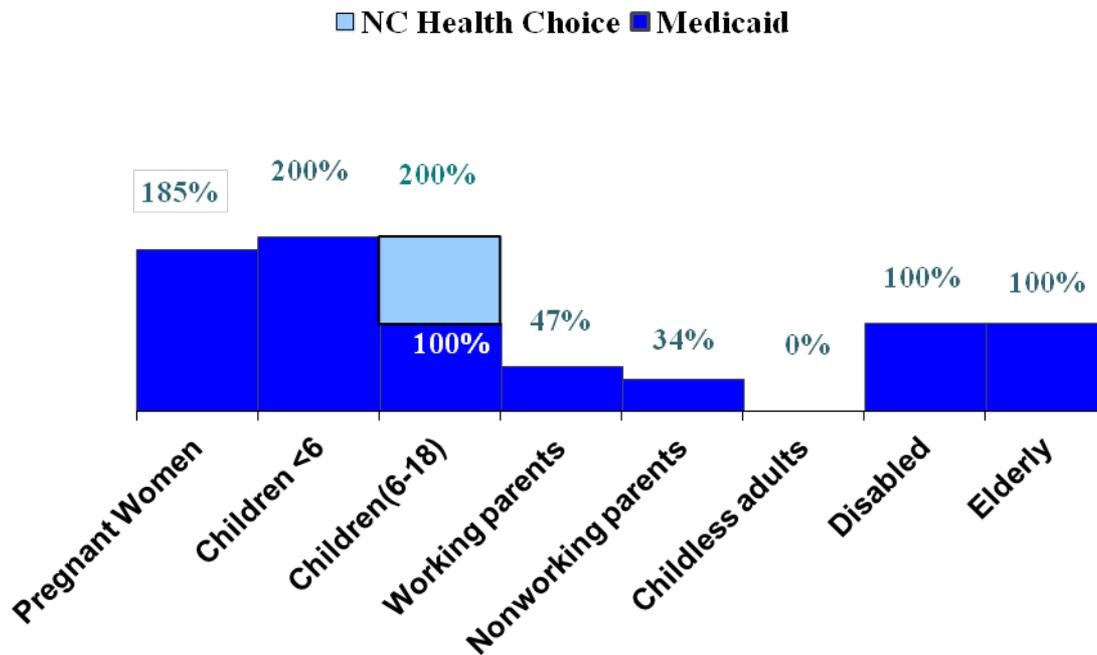
Coverage Provisions Pre-Supreme Court

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

Supreme Court Challenge to ACA

- Supreme Court, in *National Federation of Independent Businesses vs. Sebelius*:
 - 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.

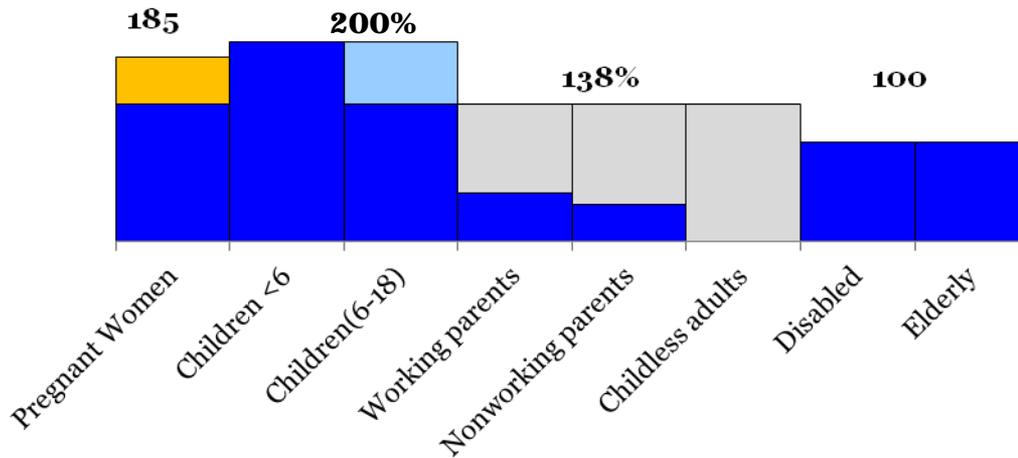
Existing NC Medicaid Income Eligibility (2013) (Percent of Federal Poverty Level)



- Currently, childless, non-disabled, non-elderly adults can not qualify for Medicaid
- Because of categorical restrictions, Medicaid only covers 30% of low-income adults in North Carolina

NC Medicaid Income Eligibility *if Expanded* (2014)

■ Existing Medicaid Eligibles ■ Newly Medicaid Eligibles
■ Existing NCHC ■ Optional Coverage



- If NC chose to expand Medicaid, approximately 500,000 adults with incomes up to 138% FPL would qualify for Medicaid (\$32,499 for a family of four (2013)).
- Even without expansion, Medicaid will cover 70,000-80,000 new people who are already eligible but not enrolled.

Note: 138% FPL (2013) = \$15,856/yr (1 person), \$21,404 (2 people), \$26,951 (3 people), \$32,499 (4 people).

Employer Responsibilities

- **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)
- **Employer mandate has been delayed for one year (until 2015).**

Individual Mandate (2014)

- Beginning January 2014, 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
 - The maximum penalty is equal to the amount the individual or family would have paid for the lowest cost bronze plan (minus any allowable subsidy).

Subsidies to Individuals

- Refundable, advanceable premium credits will be available to individuals to purchase coverage through the Exchange.
- Eligible individuals include those with incomes between 100-400% FPL on a sliding scale basis, if not eligible for government coverage or affordable employer-sponsored insurance (Sec. 1401)
- If states do not expand Medicaid, most poor people (<100% FPL) not eligible for subsidies to purchase coverage in the Exchange

Essential Benefits Package

- Insurance offered in the nongroup or small group market must offer an essential health benefits package:* (Sec. 1302)
 - Hospital services; professional services; prescription drugs; rehabilitation and habilitative services; mental health and substance use disorders; and maternity care, oral health and vision services for children
- Most insurance must also cover: *
 - Well-baby, well-child care, for children under age 21 (Sec. 1001, 1302)
 - Recommended preventive services and immunizations with no cost-sharing (Sec. 1001, 10406)
 - Mental health and substance abuse parity law applies to qualified health plans (Sec. 1311(j))



* With some exceptions, existing grandfathered plans not required to meet new benefit standards or essential health benefits.

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)

Federally Facilitated Marketplace

- In North Carolina, the federal government will create one Health Insurance Marketplace for individuals and another for small businesses. (Sec. 1311, 1321)
- Marketplaces will:
 - Provide standardized information (including quality and costs) to help consumers and small businesses choose between qualified health plans.
 - Links to provider directories.
 - Determine eligibility for the subsidy.
 - Facilitate enrollment for HBE, Medicaid and NC Health Choice through use of patient navigators or certified application counselors.

Outreach, Enrollment Assistance

- Four navigator organizations received a grant from the federal government to assist with education and enrollment:
 - Randolph Hospital – 3 counties
 - Mountain Projects – 7 western counties
 - NC Navigator Consortium – statewide
 - Alcohol and Drug Council of North Carolina – statewide
- Community health centers funded to help with education, outreach, and enrollment assistance.
- Other individuals/organizations can be trained to serve as “Certified Application Counselors (CACs).”
 - Many hospitals or safety net organizations will apply as CACs
- Agents and brokers can also help people enroll.

No Wrong Door

- ACA creates a “no wrong door” enrollment system so people can enroll in Medicaid, NC Health Choice, or private coverage through the Marketplace.
 - Same application used for all programs.
- Initial enrollment period will run from October 1, 2013 through March 31, 2014.

North Carolina Expansion Estimates

- Medicaid likely to grow by 70,000-87,000 people (woodwork group)
- Initial state estimates were that ~660,000 people* would purchase individual (non-group) coverage in the Marketplace (2014). Of these:
 - ~300,000 would have been previously uninsured and may qualify for subsidies
 - ~300,000 would have previously had coverage they purchased in the non-group market.
 - ~70,000 may switch from employer based coverage to the Marketplace.
- Another ~180,000 of the potential Medicaid expansion group may be *income eligible* for the Marketplace (incomes between 100-138% FPG)

Other Provisions to Expand Access

- ACA includes new efforts to expand and promote better training for the health professional workforce.
- Expanded appropriations for National Health Service Corps by \$1.5 billion over 5 years.
 - Loan forgiveness for agreeing to serve in health professional shortage areas (HPSAs).
- New funding to expand community and migrant health centers.

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Problem #2: Population Health

- North Carolina ranks 33rd of the 50 states and DC in population health measures in 2012. (America's Health Rankings, 2012)
 - North Carolina ranked 31st in determinants of health (eg, smoking, binge drinking, obesity, poverty, preventable hospitalizations).
 - North Carolina ranked 38th in health outcomes (eg, diabetes, poor physical and mental health days, cancer and cardiovascular deaths, infant mortality rate, premature deaths).

Affordable Care Act

- **Prevention and Public Health Trust Fund to invest in prevention, wellness, and public health activities** (Sec. 4002)
 - ACA initially appropriated \$750 million in FY 2011 increasing to \$2 billion in FY 2022 and each fiscal year thereafter.
 - Creates a national prevention, health promotion, and public health council (Sec. 4001)

ACA Prevention Grants

- North Carolina has received ACA funds to support greater investment in prevention and health promotion. For example:
 - ~\$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.
 - ~\$1.8 million to assist pregnant and parenting teens and women in high needs counties.
 - ~\$5.5 million to implement evidence-based maternal, infant, and early childhood home visiting programs.
 - ~\$3.0 million to support personal responsibility education for teens (\$1.5 million to DHHS, \$1.5 million to DPI).

New Requirements for Charitable Hospitals

- **New requirements for charitable 501(c)(3) hospitals:**
(Sec. 9007, 10903)
 - **Must conduct a community needs assessment once every three years, and must adopt an implementation strategy to meet the community health needs identified through the assessment.**
 - **In conducting the community health needs assessment, the hospital must take into account input from persons who represent the broad interests of the community, “including those with special knowledge of or expertise in public health.”**
 - **Must report how the hospital is meeting the community needs in its tax reporting.**

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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)

Affordable Care Act

- **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 (i.e., health outcomes, functional status, transitions, consumer decision making, meaningful use of HIT, safety, efficiency, equity and health disparities, patient experience). (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.**

Example of New Quality-Related Payment Policies: Excess Readmissions

- **Hospitals with excess readmissions (risk-adjusted 30-day readmission rates) are receiving lower Medicare payments** (Sec. 3025)
 - Initially, CMS will track readmissions for pneumonia, heart failure, and heart attacks. Additional health conditions will be added in 2015.
 - DRGs reduced by up to 1% (FFY 2013), 2% (FFY 2014), and 3% (FFY 2015)
 - In NC, 59 hospitals were subject to a penalty (average reduction in DRG payments: 0.25%) (2013).

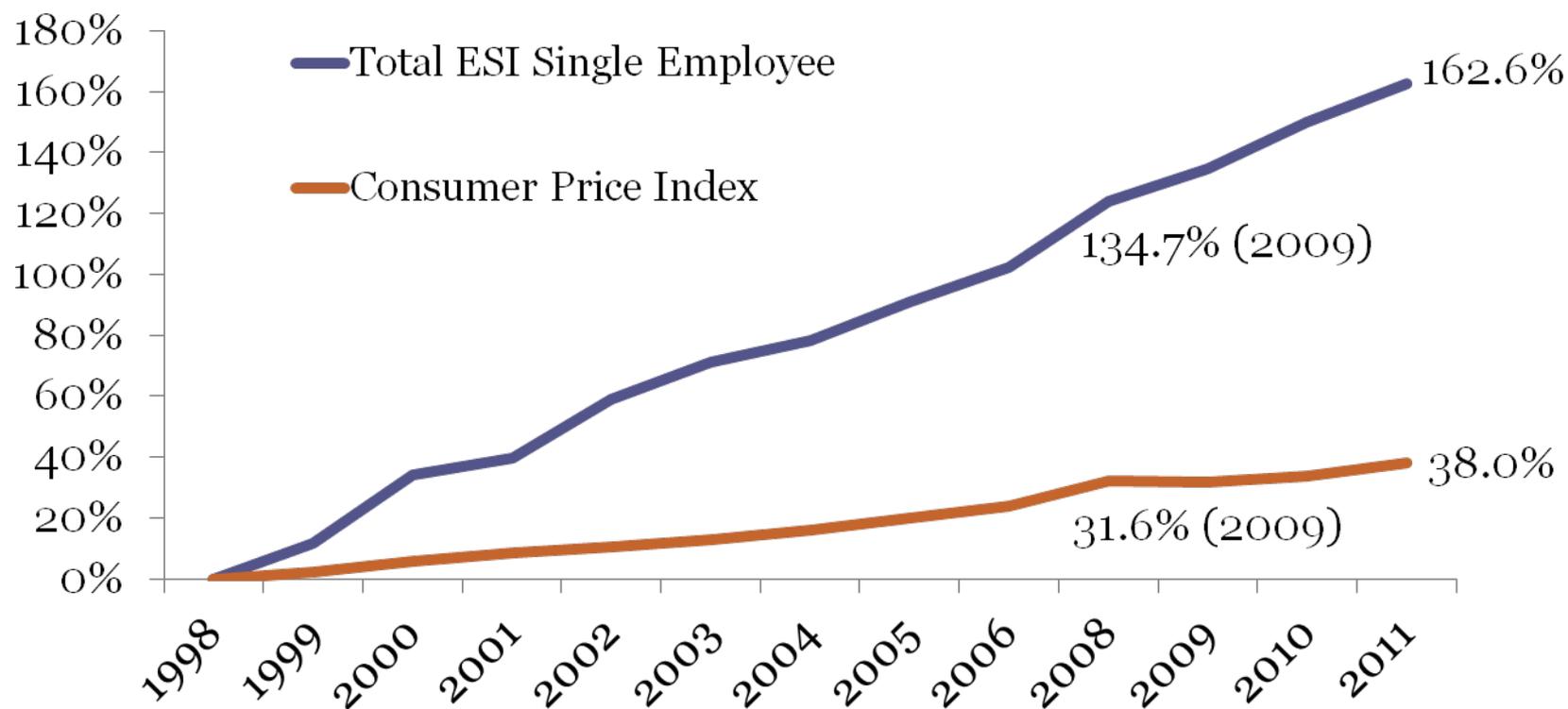
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Problem #4: Costs

- 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.
 - Health care costs rising about 3 times the rate of inflation.

Employer-Sponsored Premiums Rising Much Faster than Inflation (NC, 1998-2011)



Sources: ESI: Medical Expenditure Panel Survey, US Agency for Healthcare Quality and Research. Insurance Component. CPI: Bureau of Labor Statistics.

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 health care quality and health outcomes
 - 2) Improving population health
 - 3) Reducing health care costs
- North Carolina testing several new models of care in Medicaid, Medicare, and commercial insurance.

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Employer Responsibilities

- Employers with 50 or more full-time equivalent employees required to offer insurance or pay penalty (effective 1-1-2015) (Sec. 1201, 1513, amended Sec. 1003 Reconciliation)
 - Must *offer* coverage to employee *and* dependents, but not required to pay any share of premiums
 - However, subject to a penalty if:
 - Employer does not offer coverage that meets essential coverage requirements (premium covers 60% of the actuarial costs of the plan) or
 - Employer offers coverage, but it is not considered affordable to the employee (defined as the employee having to pay more than 9.5% of the family income for self-only coverage), and
 - Employees qualify for and receive a subsidy in the health insurance exchange

Employer Responsibilities

- **Potential penalties for employers with more than 50 employees** (Sec. 1513, amended by Sec. 1003 Reconciliation)
 - If employer *does not offer* coverage and at least one employee qualifies for and receives a subsidy, the employer must pay \$2,000 per *full-time* employee (excluding first 30 employees).
 - If an employer *does offer* coverage, but at least one full-time employee qualifies for and receives a subsidy, then the employer must pay \$3,000 for any full-time employee who receives a subsidy (but in no event more than \$2,000 per FT employee, excluding the first 30 employees).
 - Penalty determined on monthly basis.
- **Employers with 50 or fewer employees exempt from penalties.** (Sec. 1513(d)(2))

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Departments of Social Services

- **Implementation of NC FAST (automated electronic application and eligibility system) to go online August-September**
 - **Training universal workers on NC FAST**
 - **Transition to new system at same time as expected increase in applications**
 - **Between 70,000-90,000 new Medicaid eligibles expected who are currently eligible but not enrolled (“Woodwork”)**
 - **Others likely to apply for marketplace at DSS (“No wrong door”)**
 - **Eventually, NC FAST should help streamline eligibility and enrollment**

Public Health

- **Greater emphasis, at federal level, on improving population health**
 - Federal funding opportunities available to expand public health and prevention (Example: community transformation grant)
 - Greater partnership between hospitals and health departments on addressing community health needs
 - New models of care focused on improving population health outcomes, may be greater role for local health departments in the future
 - Health departments may need to serve as safety net primary care providers in some communities as we expand coverage to more uninsured

LME/MCOs

- Greater commercial coverage of mental health and substance abuse coverage as part of the essential health benefits
- New models of care require greater collaboration between providers—this may be difficult to achieve with MH/SA “carve out”

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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.**
 - **Employers may incur new costs**
 - **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:
 - Expands coverage to more of the uninsured.
 - Makes health insurance coverage more affordable to many.
 - Helps 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
- **Congressional Budget Office. Recent CBO reports post
Supreme Court decision.**
<http://www.healthcare.gov/prevention/nphpphc/strategy/report.pdf>
<http://www.cbo.gov/sites/default/files/cbofiles/attachments/43471-hr6079.pdf>
- **Kaiser Family Foundation**
<http://healthreform.kff.org/>

For More Information

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2013 Federal Poverty Levels/Year

| Family Size | 100% | 138% | 200% | 400% |
|--------------------|-------------|-------------|-------------|-------------|
| 1 | \$11,490 | \$15,856 | \$22,980 | \$45,960 |
| 2 | \$15,510 | \$21,404 | \$31,020 | \$62,040 |
| 3 | \$19,530 | \$26,951 | \$39,060 | \$78,120 |
| 4 | \$23,550 | \$32,499 | \$47,100 | \$94,200 |
| Each add'l person: | \$ 4,020 | \$ 5,548 | \$ 8,040 | \$16,080 |



Sliding Scale Subsidies

| Individual or family income | Maximum premiums (Percent of family income) | Out-of-pocket cost sharing:* | Out-of-pocket cost sharing limits (2014)** |
|------------------------------------|--|-------------------------------------|---|
| 100-133% FPL | 2% of income | 6% | \$2,250(ind)/\$4,500 (more than one person) |
| 133-150% FPL | 3-4% | 6% | \$2,250 / \$4,500 |
| 150-200% FPL | 4-6.3% | 13% | \$2,250 / \$4,500 |
| 200-250% FPL | 6.3-8.05% | 27% | \$5,200 / \$10,400 |
| 250-300% FPL | 8.05-9.5% | 30% | \$6,400/ \$12,800 |
| 300-400% FPL | 9.5% | 30% | \$6,400/ \$12,800 |
| 400% + FPL | No limit | 30% | \$6,400 / \$12,800 |

*Out-of-pocket cost sharing includes deductibles, coinsurance, and copays, but does not include premiums, noncovered services, or services obtained out of network. **Out-of-pocket costs limits in final rules:

<http://www.gpo.gov/fdsys/pkg/FR-2013-03-11/pdf/2013-04902.pdf>.

Subsidies to Individuals and Families: Example

- **How do premium subsidies work?**
 - Assume the Smith family has four people and a family income that equals \$47,150/year (slightly in excess of 200% FPL in 2013).
 - They want to purchase the second lowest cost silver plan with a premium cost of \$15,000/year.
 - They would pay \$2,970/year (or ~\$248/month) for the second lowest cost silver plan in the marketplace for their four family members (6.3% of their income).
 - The federal government would contribute \$12,030/year for their insurance, and would make the payments directly to the insurer.

Subsidies to Individuals and Families: Example

- How does the out-of-pocket cost sharing work?
 - Instead of paying for 30% of the costs out of pocket, the Smiths would pay 27% of the costs of medical care out of pocket (in deductibles, co-insurance, or co-payments).
 - Once the Smiths pay \$5,200 (per individual) or \$10,400 (per family) in deductibles, co-insurance and co-payments, the insurance company would pay 100% of the costs of covered services for the rest of the insurance year.

DMA Estimates: Net Costs for New and Existing Eligibles (2014-2021)*

| | Woodwork (Existing Eligibles) (2014-2021) | New Eligibles (2014-2021) |
|------------------|--|--|
| Eligibles | ~70,000-87,000 | ~494,000-536,000 |
| State | \$912 million total (\$99m to \$203m/yr) | \$-65 million total (-\$124m to +\$119m/yr) |
| Federal | \$2,636 million total | \$14.8billion total |
| Total | \$3,548 million total | \$15.7 billion total |

* Includes service costs, all the offsets (CHIP enhancement, ADAP, mental health, corrections), administrative costs, and new tax revenues (expansion only).

* North Carolina must pay its share of the cost of covering “woodwork” regardless of whether the state expands Medicaid to cover newly eligibles.

Simplified Application and Enrollment Process

Step 2: Verify identify, income, citizenship, and immigration status through online data from federal databases

Step 3: Screen to determine if potentially eligible for Medicaid/CHIP

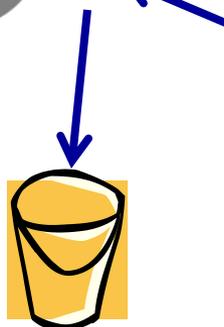
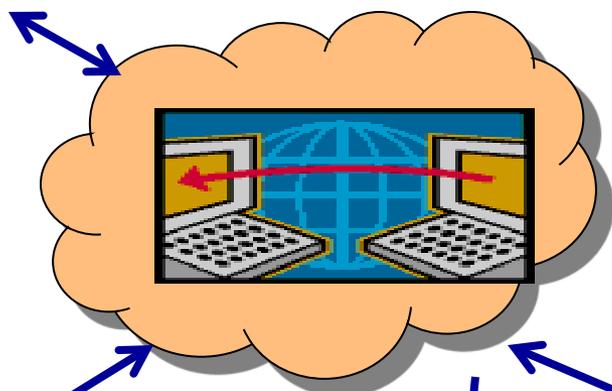
Step 4a: **If yes,** application sent to **NC DHHS**. Use federal and state administrative databases to determine eligibility. If eligible, enroll in Medicaid/ NC Health Choice

Step 4 b: **If no,** determine eligibility for subsidies, and pick an insurance plan

Federal Marketplace



Step 1: Person can apply by phone, online, or with personal help



Same process can work in reverse if person first applies at DSS