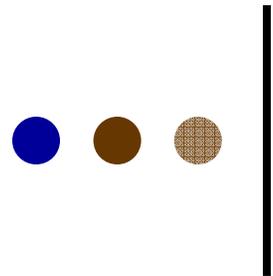




North Carolina: Implementing Health Reform

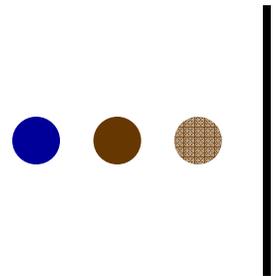
Background Information about the Patient
Protection and Affordable Care Act and
Charge to Workgroups





Overview

- Overview of the Affordable Care Act (ACA)
- Charge to the Workgroups



Overview

- **Overview of the Affordable Care Act (ACA)**
- Charge to the Workgroups

● ● ● | Background

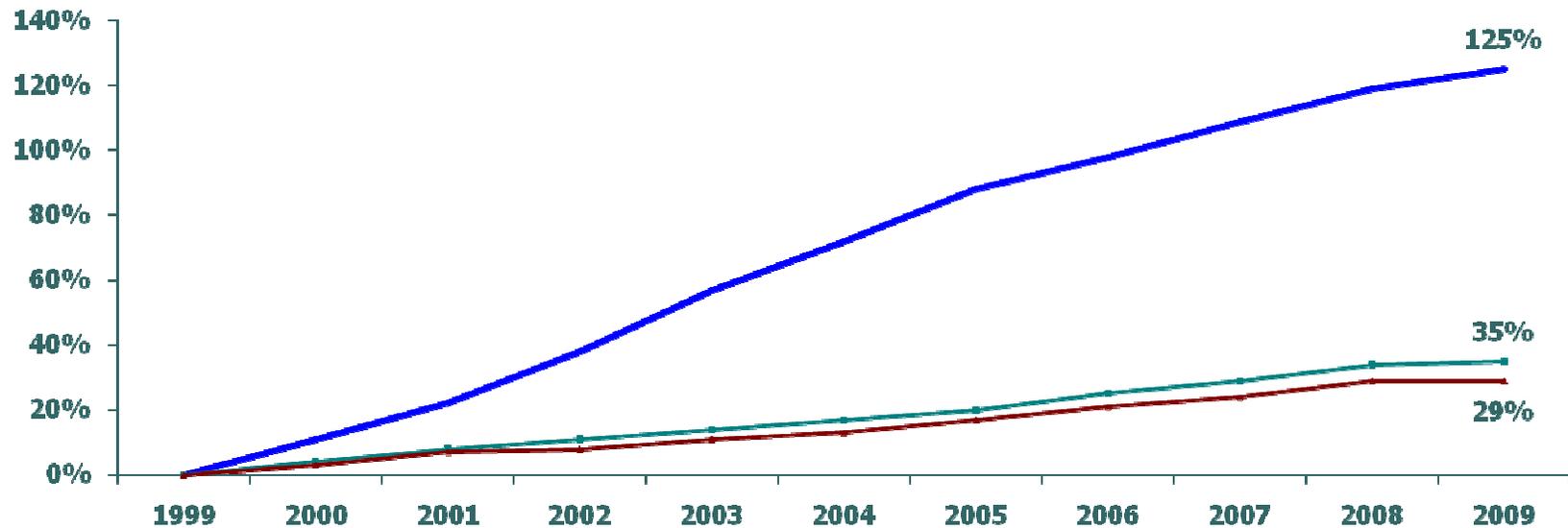
- Estimates of the uninsured (2008-2009):
 - 2008 US Census estimates: 1.4 million non-elderly uninsured in North Carolina (17%)
 - 2009 NCIOM estimate after downturn in the economy: 1.75 million non-elderly uninsured (21%)
- Average annual per capita personal health care spending (1998-2004):
 - Rising rapidly nationally and in North Carolina
 - North Carolina: 7.2% average annual increase



Source: NCIOM. Health Care Costs and Insurance Coverage in Five Southern States. Data Snapshot. 2009-3. North Carolina's Increase in the Uninsured: 2007-2009; US Census, Historical Health Insurance Tables. HI6.



US Health Insurance Premiums Increasing More Rapidly Than Inflation or Earnings (1999-2009)



Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2000-2008. Bureau of Labor Statistics, Consumer Price Index, U.S. City Average of Annual Inflation (April to April), 2000-2008; Bureau of Labor Statistics, Seasonally Adjusted Data from the Current Employment Statistics Survey, 2000-2008 (April to April). Claxton G. et. al. Job-Based Health Insurance: Costs Climb at a Moderate Rate. Health Affairs. Sept. 15, 2009.



Legislation

- The Patient Protection and Affordable Care Act (HR 3590), commonly referred to as the Affordable Care Act (ACA), was signed into law on March 23, 2010.
- The Health Care and Education Reconciliation Act of 2010 (HR 4872), commonly referred to as Reconciliation, was signed into law on March 30, 2010.

● ● ● | Overview of Health Reform

- By 2014, the ACA requires most people to have health insurance and larger employers to provide health insurance--or pay a penalty.
 - Most low-income people under 133% Federal Poverty Level (FPL) eligible for Medicaid
 - Most individuals/families with incomes below 400% FPL are eligible for premium subsidies, unless they have employer or governmental insurance
 - Large employers (50+) required to offer affordable insurance coverage or pay penalty
 - Small employers exempt from mandates, but some eligible for tax credits if they offer insurance



Most People Eligible for “Essential Health Benefits”

- HHS Secretary will recommend an essential health care benefits package that includes a comprehensive set of services: (Sec. 1302)
 - Hospital services; professional services; prescription drugs; rehabilitation and habilitative services; mental health and substance use disorders; and maternity care
 - Well-baby, well-child care, oral health and vision services for children under age 21 (Sec. 1001, 1302)
 - Recommended preventive services with no cost-sharing and all recommended immunizations (Sec. 1001, 10406)
 - Mental health parity law applies to qualified health plans (Sec. 1311(j))

● ● ● | Health Benefit Exchange

- States will create Health Benefit Exchanges (HBE) to help individuals and small business purchase health insurance
 - Limited to citizens and lawful residents who do not have access to employer- or government-supported health insurance and to small businesses with 100 or fewer employees (states can allow larger employers to enroll beginning 2017).
- Exchanges will:
 - Provide standardized information (including quality and costs) to help consumers choose between plans
 - Determine eligibility for the subsidy
- “No wrong door approach” between Medicaid and HBE



Insurance Reform

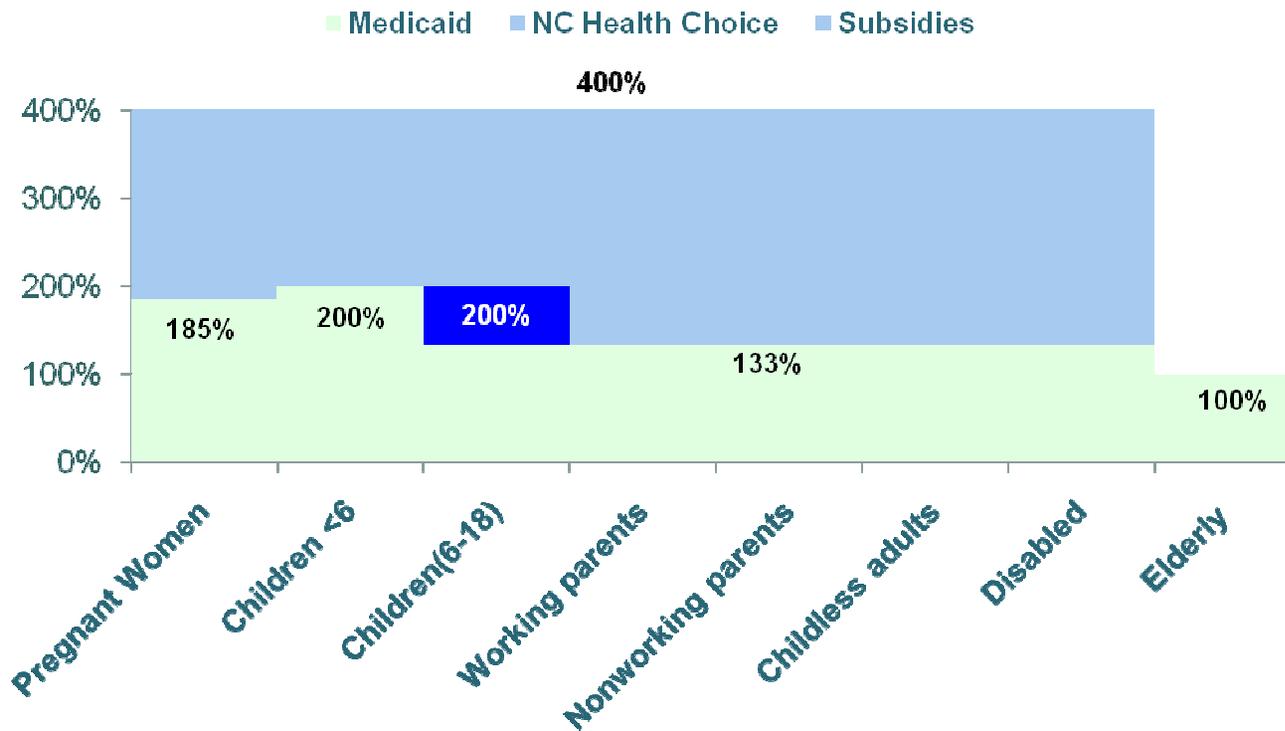
○ Insurers are required to:

- Enroll any individual or group, and cannot exclude, charge people more, or rescind policies because of preexisting conditions or use of health services (guarantee issue) (Effective 2014; Sec. 1201)
- Limit age adjustment to 3:1, geographic rating area, family composition, and tobacco use (limited to 1.5:1 ratio) in individual and small group market and exchange (Effective 2014; Sec. 1201)
- Extension of dependent coverage until the child reaches age 26
- Submit premium rate increases to regulators for review and/or approval if allowed under state law (Effective 2010; Sec. 1003)

○ Insurers are prohibited from:

- Including annual or lifetime limits for essential benefits (Sec. 1001, 10101)
- Imposing a waiting period of more than 90 days (Effective Jan, 1, 2014; Sec. 1201)

After Health Reform Fully Implemented (Beginning 2014)



Beginning 2014, most people with incomes $\leq 400\%$ FPL who do not have Medicaid, Medicare, Health Choice, TRICARE, or access to employer-based coverage can qualify for subsidies to purchase insurance in the Exchange



Estimated Take-Up of Uninsured (2011, 2014)

Provision	2011	2014
“Woodwork” Medicaid	52,000	167,000
Medicaid expansion	*	259,000
Dependent coverage under ESI	173,000	137,000
Federal high risk pool	7,000	*
Exchange subsidy	*	106,000
Full tax credit	7,000	5,000
Partial tax credit	19,000	14,000
Uninsured	1,337,000	1,013,000
Uninsured under status quo	1,596,000	1,701,000
Percent non-elderly uninsured (without health reform)	18.8%	19.2%
Percent non-elderly uninsured (with health reform)	15.7%	11.4%

* Source: Holmes M. Projected Changes in North Carolina Health Insurance Coverage due to Health Reform. Running the Numbers. *NCMJ*. May/June 2010;71(3):306-308. Note: these estimates do not include total take-up in programs, only that of the uninsured. We expect more of the uninsured to be covered in subsequent years, as the penalty for not having coverage increases.





Medicare

- Enhances preventive services, beginning Jan. 2011 (Sec. 4103-4105, 10402, 10406)
 - Covers preventive services with no cost-sharing (Sec. 4104)
 - Covers annual wellness visit as part of personalized prevention plan (Sec. 4103)
- Phases out the gap in the Part D “donut hole” by 2020 (Sec. 3315, as amended by 1101 Reconciliation)
 - \$250 rebate in 2010
 - Pharmaceutical companies required to provide 50% discount on brand-name prescription drugs beginning in 2011 (Sec. 3301)
- Strengthens the financial solvency of the Medicare program
 - Extends the life of the Medicare trust fund by 12 years



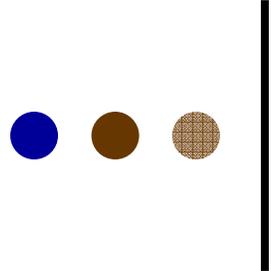
Prevention and Wellness: Overview

- Federal government providing more funding to support prevention efforts at national, state, and local levels
 - Grant funds will be made available for prevention, wellness, and public health activities
 - Some of the focus areas include: healthy lifestyle changes, reduction and control of chronic diseases, health disparities, public health infrastructure, obesity and tobacco reduction, improved oral health, immunizations, maternal and child health, worksite wellness



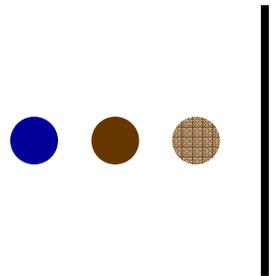
Prevention and Public Health Fund

- Prevention and Public Health Fund to invest in prevention, wellness, and public health activities (Sec. 4002)
 - Appropriates \$500 million in FY 2010, \$750 million in FY 2011, \$1 billion in FY 2012, \$1.25 billion in FY 2013, \$1.5 billion in FY 2014, and \$2 billion in FY 2015 and each fiscal year thereafter
 - May be used to fund programs authorized by the Public Health Service Act and for prevention, wellness, and public health activities
 - Half of this funding will be used for health professional workforce training



Workforce Overview

- Provisions aim to expand and promote better training for the health professional workforce
 - By enhancing training for quality, interdisciplinary and integrated care, and encouraging diversity
 - By increasing the supply of health professionals in underserved areas
 - By offering loan forgiveness, scholarships and funding to educational institutions to train primary care, nursing, long-term care, mental health/substance abuse, dental health, public health, allied health, and direct care workforce



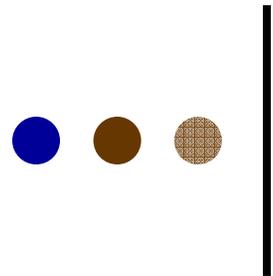
Quality

- HHS Secretary will establish national strategy to improve health care quality with Interagency Working Group on 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)
 - Secretary must develop health plan reporting standards within 2 years and develop methods to measure health plan value
(Sec. 1001, 10329)
 - Plan for the collection and public reporting of quality data
(Sec. 3015, 10305, 10331)
- Federal government will make significant investments in comparative effectiveness research



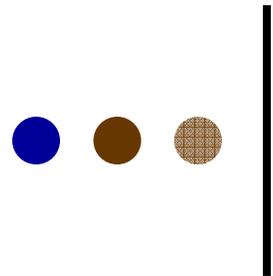
New Models Overview

- Efforts to test new models of care to improve quality and efficiency
- Center for Medicare and Medicaid Innovation
(Sec. 3021, 10306)
 - Some of the new models include: payment and practice reform in primary care (including medical home), geriatric interdisciplinary teams, care coordination and community-based teams for chronically ill individuals, integrating care for dual eligibles, improving post-acute care, Healthcare Innovation Zones, payment reform
 - Appropriates \$5 million (FY 2010) for design and implementation of models and \$10 billion to implement those models (FY 2011-2019)



Safety Net Overview

- New funding for safety net organizations
 - Includes new appropriations for community health centers and school-based health centers
 - Funding for National Health Service Corps to place providers in underserved communities
 - Regional emergency systems
- Funding authorized, but not appropriated for other safety net organizations
- New requirements for charitable 501(c)(3) hospitals:
(Sec. 9007, 10903)
 - Must conduct a community needs assessment and identify an implementation strategy; have a financial assistance policy; provide emergency services; and limit charges to people eligible for assistance to amounts generally billed



Long-Term Care

- Establishes a national voluntary insurance program to purchase community living assistance services and supports (CLASS) financed through payroll deduction.
(Sec. 8001-8002, 10801)
 - Plans provide for a 5-year vesting period and cash benefits of not less than an average of \$50/day to purchase non-medical services and supports
 - Financed through automatic payroll deduction (unless opt-out)
- New Medicaid options to expand home and community-based services



Cost Containment & Financing

- Reduction in existing health care costs through:
 - Increased emphasis on: reducing fraud & abuse, administrative simplification, reducing excess provider/insurance payments
- Increased revenues through:
 - Fees paid by individuals/employers for failure to have/offer insurance
 - Taxes/fees on insurers, pharmaceuticals, tanning salons, “Cadillac” insurance plans, wealthier individuals



*Cadillac plans defined as plans that exceed \$10,200 for individual coverage and \$27,500 for family coverage (effective 2018), with higher thresholds for people in high-risk professions or retirees.

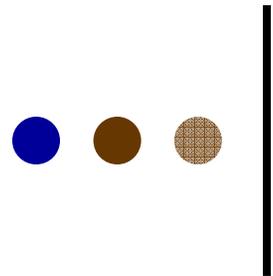


CBO Estimates of Coverage and Costs

- Covers 92% of all nonelderly residents (94% of legal, nonelderly residents)
 - Would cover an additional 32 million people (leaving 23 million nonelderly residents uninsured by 2019)
- Expansion of insurance coverage and new appropriations included in PPACA will cost \$938 billion over 10 years.
 - However, with new revenues and other spending cuts, PPACA is estimated to reduce the federal deficit by \$124 billion over 10 years.*



* More recent CBO estimate suggests that costs would increase by \$115 billion over 10 years *if* Congress funds all the provisions that are authorized at certain levels but not yet appropriated. Sources: CBO letter dated March 20, 2010, May 11, 2010.



Overview

- Overview of the Affordable Care Act (ACA)
- **Charge to the Workgroups**



Changes Will Impact North Carolina

- ACA will have significant impact on the way health care is delivered and financed in North Carolina.

The changes will affect:

- Patients (health care consumers)
- Providers
- Insurers
- Businesses
- Community groups
- State and local government



ACA Offers Unique Opportunities

- ACA provides new opportunities. For example, ACA:
 - Expands insurance coverage to the uninsured
 - Provides greater consumer protections and expanded coverage for people with insurance coverage
 - Increases funding for prevention and wellness
 - Invests in comparative effectiveness research, quality measurement and improvement, and provides funding to test new models of organizing and financing health care
 - Invests in health professional workforce development



ACA Offers New Challenges

- ACA also will create challenges, including but not limited to:
 - Costs of implementation
 - New health information technology challenges to collect data, enroll eligibles, process claims
 - Creation of a new health benefit exchange
 - Ensuring that insurers and providers can meet the new requirements of the Act
 - Outreach to help individuals and employers understand the new provisions and their different options



State Government Plays an Important Role

- State agencies are charged with implementing many of the critical components of ACA, including *but not limited to*:
 - Department of Insurance: regulatory oversight, development of the health benefit exchange (HBE)*
 - Department of Health and Human Services:
 - Division of Medical Assistance: Medicaid expansion for new eligibles, expansion of home and community based services
 - Division of Public Health: increased funding to support prevention and wellness at state and local levels
 - NC Office of Rural Health: provider recruitment with expanded National Health Service Corps funds
 - AHEC, UNC system, community colleges: health professional workforce training



*State option to develop HBE. If state does not develop, federal government will develop HBE for the state.



Other Groups Also Integrally Involved

- Private providers, insurers, businesses, non-profits and consumers are also involved, including *but not limited to*:
 - Insurers: must change insurance practices, develop new products, modify claims processing and data collection system
 - Health professionals: engage in efforts to measure, report, and improve quality, expand access, change the way health care services delivered
 - Businesses (50+ employees): provide insurance coverage to employees (or pay penalty), report coverage to IRS
 - Nonprofits/academic institutions: Funding opportunities for prevention, health professional training, patient navigators
 - Consumers: shop and purchase coverage (or pay penalty, unless exempt)



Structure of the Health Reform Workgroups

- The NC Department of Health and Human Services and the NC Department of Insurance, in collaboration with the NCIOM, has developed public-private workgroups to coordinate the state's efforts to implement ACA.
- The effort will be led by an overall advisory group, led by:
 - **Lanier Cansler, CPA**
Secretary
North Carolina Department of Health and Human Services
 - **Wayne Goodwin, JD**
Insurance Commissioner
North Carolina Department of Insurance



Health Benefit Exchange and Insurance Oversight

○ Co-Chairs:

- Louis Belo
Chief Deputy Commissioner
North Carolina Department of Insurance
- Allen Feezor
North Carolina Department of Health and Human Services

○ Charge:

- Development of the Health Benefit Exchange
- Provide guidance on insurance oversight
- Coordinate enrollment between Medicaid and the Exchange



Health Professional Workforce

○ Co-Chairs:

- Tom Bacon, DrPH
Director
North Carolina Area Health Education Centers Program
- Kennon Briggs
Executive Vice President and Chief of Staff
North Carolina Community College System
- Alan Mabe, PhD
Vice President for Academic Planning
UNC General Administration
- John Price
Director, NC Office of Rural Health and Community Care
NC Department of Health and Human Services



Health Professional Workforce

- Charge:
 - Examine funding opportunities for workforce development, including but not limited to: primary care, nursing, allied health, behavioral health, dentistry, public health, direct care workforce
 - Outreach about loan repayment opportunities
 - Identify best models for quality improvement and interdisciplinary training in workforce development programs
 - Fostering collaboration and coordinating implementation



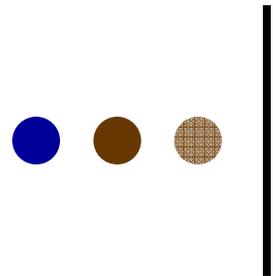
Medicaid and Elder Services

○ Co-Chairs:

- Craigan Gray, MD, JD, MBA
Director, NC Division of Medical Assistance
NC Department of Health and Human Services
- Steve Wegner, MD
President of NC Community Care Network, and Access Care, Inc.

○ Charge:

- Identify implementation steps for Medicaid expansion
- Coordinate enrollment between Medicaid and the Exchange
- Explore Medicaid state options to expand services, including but not limited to: prevention, home and community-based services
- Examine funding opportunities for Elder Justice Act



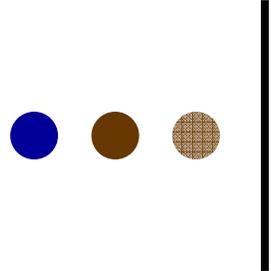
New Models of Care

- Co-Chairs:

- Allen Dobson, MD
Vice President, Clinical Practice Development
Carolinas HealthCare System
- Craigan Gray, MD, MBA, JD
Director, Division of Medical Assistance
NC Department of Health and Human Services

- Charge:

- Explore new methods of financing care, including accountable care organizations, bundled payment, global payment
- Explore new methods of delivering care, including patient centered medical home, coordinated care for chronic illness, medication management



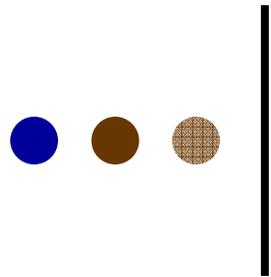
Prevention

- Co-Chairs:

- Jeffrey Engel, MD
State Health Director
Division of Public Health
NC Department of Health and Human Services
- Laura Gerald, MD, MPH
Executive Director
Health and Wellness Trust Fund

- Charge:

- Identify funding opportunities for prevention and wellness programs
- Identify communities of greatest need
- Encourage collaboration in funding opportunities



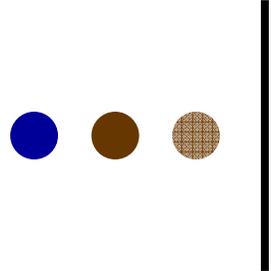
Quality

- Co-Chairs:

- Alan Hirsch, JD
Executive Director
NC Healthcare Quality Alliance
- Sam Cykert, MD
Associate Director for Medical Education
NC Area Health Education Centers Program

- Charge:

- Understand federal guidelines for patient outcome quality measures and reporting requirements
- Identify strategies to improve quality of care provided to meet the new quality requirements
- Build on existing state quality initiatives



Safety Net

- Co-Chairs:

- Chris Collins

Deputy Director, Office of Rural Health and Community Care
Assistant Director, NC Division of Medical Assistance
NC Department of Health and Human Services

- Ben Money, MPH

Executive Director
NC Community Health Center Association

- Charge:

- Explore new opportunities for community-based collaborative networks of care

- Examine new requirements for safety net providers

- Identify areas of the state with greatest unmet need, and encourage collaboration in funding opportunities



Fraud and Abuse

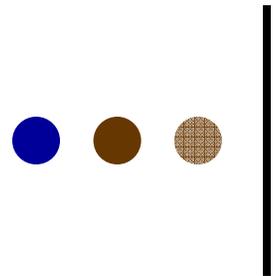
- Co-chairs:

- Al Koehler
Chief Investigator
NC Department of Insurance
- Tara Larson, MAEd
Chief Clinical Operations Officer
NC Division of Medical Assistance
NC Department of Health and Human Services

- Charge:

- Examine new program integrity provisions under Medicaid, Medicare (as it affects the state), and insurance
- Identify implementation steps to meet new federal requirements
- Understand and educate providers on financial integrity and fraud and abuse reporting requirements





Support for Workgroups

- Each workgroup will be:
 - Staffed by the NCIOM, who will help prepare background material for the workgroup
 - Be supported by a steering committee (state agency staff), who can help determine the order of workgroup's work (i.e., which sections of the bill will be considered first)
 - Work may be staged based on funding opportunities or when certain provisions of the bill are required to be implemented.



Goals of Broad-Based Effort

- **The overall goal of this initiative is to ensure that the decisions made in implementing ACA serve the best interests of the state as a whole.**
- To do this, partners must:
 - 1) Identify the decisions the state must make in implementing health reform
 - 2) Identify potential funding opportunities that will help us improve population health, access to care, and health care quality and reduce rising health care costs
 - 3) Build on North Carolina's existing strengths
 - 4) Coordinate the work among all the different groups involved in implementing health reform



Charge of the Different Workgroups

- Each workgroup will be charged with reviewing different sections of the bill, focusing on those provisions the state or partner groups must implement.
 - We generally will not review the sections that the federal government has sole responsibility to implement (e.g., Medicare provider payment policies).
- Develop a workplan, including *but not limited to*:
 - Identifying implementation requirements and needed state legislation (if any)
 - Identifying lead entity and partner groups
 - Identifying potential funding opportunities
 - Identifying NC's existing strengths and areas of greatest needs
 - Establishing proposed timeline for work
 - Make policy recommendations back to implementing entity (ie, state agency, legislature, or other partner groups)



Example of Workplan

Short Title	Req'd / Optional	Funding Opp.	MOE (Y/N)	Lead state agency	Other partners	Time	Implementation requirements
Medicaid expansion (Sec. 2001)	Req'd	NA	Yes	DMA	NA	2014	TBD
Pregnant & Parenting Teens	Opt.	Comp. (\$500K-\$2M/yr)	N	TBD	TBD	9/2/2010	TBD
HBE (Sec. 1311)	Opt. to state	NA	NA	DOI	TBD	No later than 3/2011	TBD



*TBD=Work groups will help fill in, NA=not available, Comp=competitive grants



Involvement of Broad Cross Section of the State

- Individuals with differing perspectives were selected to serve on the workgroups.
 - Many of the workgroup members represent stakeholder groups with financial interests in different aspects of health reform.
 - We want to hear everyone's perspective as we move forward implementing health reform. However, we also want to be cognizant of any potential or perceived conflicts of interest. Thus, if you have a specific conflict, please let the group know.
- The overall goal of this initiative is to ensure that the decisions made in implementing ACA serve the *best interests of the state as a whole*, rather than any specific interest group.



Recommendations of Workgroups Are Advisory

- The workgroups have been developed to provide advice to state agencies and the legislature and to help coordinate the state's implementation efforts.
 - The recommendations are not binding on state agencies or partner organizations.
 - However, implementation decisions will be improved through greater input; funding efforts can be strengthened through partnerships; and we can help avoid duplication of efforts.



Special Thanks to Our Supporters

- The Kate B. Reynolds Charitable Trust
- The Duke Endowment
- Blue Cross and Blue Shield of North Carolina Foundation
- The John Rex Endowment
- Moses Cone ~ Wesley Long Community Health
- Reidsville Area Foundation