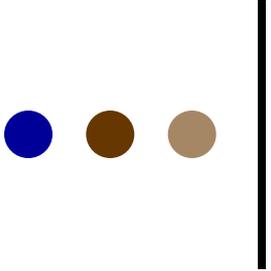


Patient Protection and Affordable Care Act: Focus on Health Benefit Exchanges

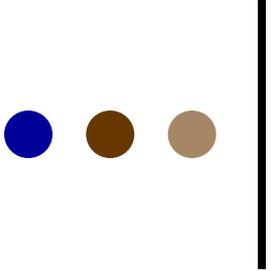
Health Benefit Exchange Pre-Meeting

Presentation by: Pam Silberman, JD, DrPH
President & CEO
North Carolina Institute of Medicine
August 22, 2011



Agenda

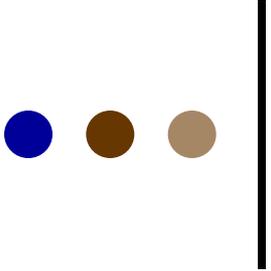
- Background
- Employer and individual coverage in the private market
- Insurance reform
- Medicaid expansion
- Other ACA provisions
- Potential impact on North Carolina



Agenda

- **Background**

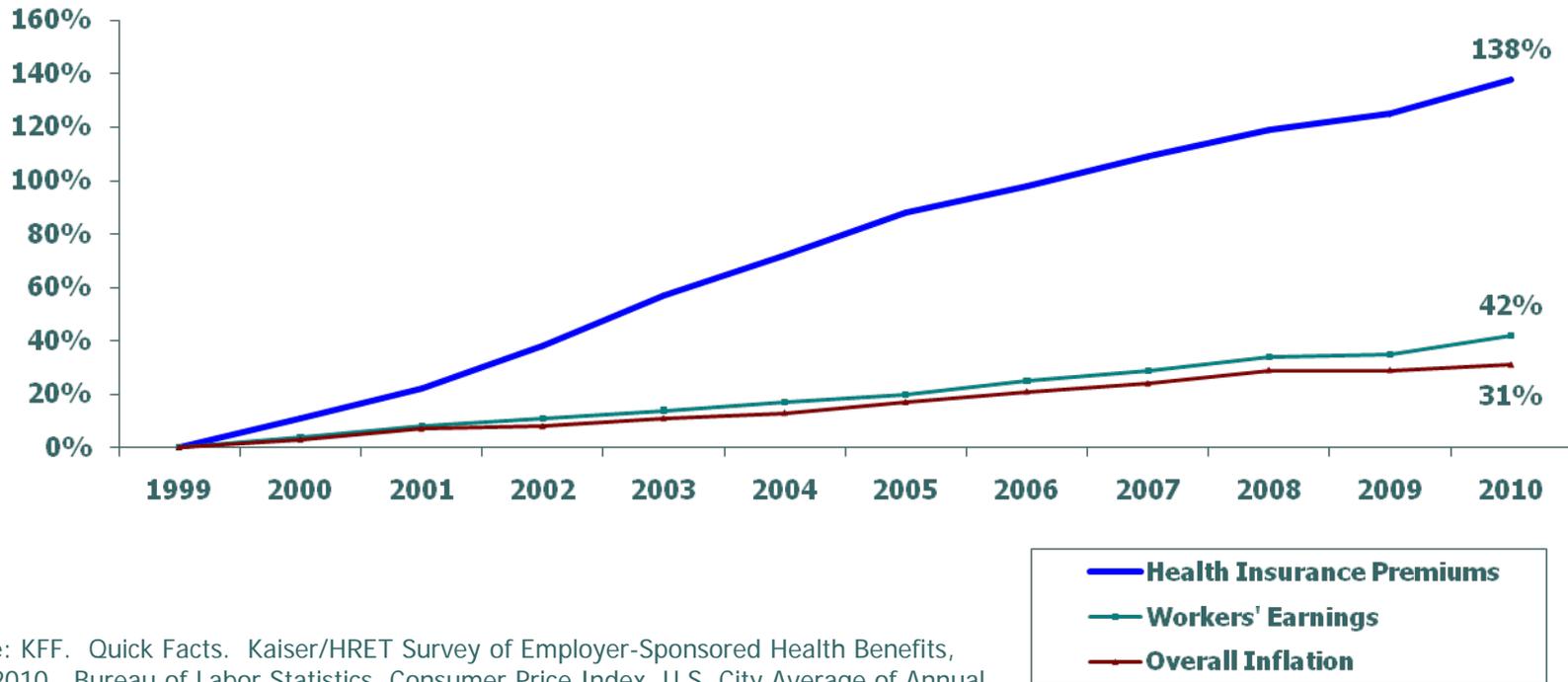
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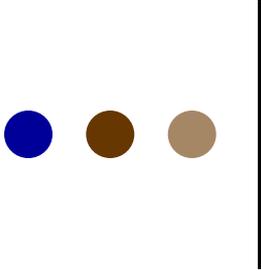
Background

- Estimates of the uninsured:
 - Recent Census numbers showed approximately 1.7 million non-elderly uninsured in NC (2009)
- Lack of health insurance impacts on a person's health
 - People who are uninsured are less likely to receive preventive services, more likely to end up in the hospital for preventable conditions or late stage cancer, and more likely to die prematurely
 - Lack of insurance coverage affects a family's financial security

US Health Insurance Premiums Increasing More Rapidly Than Inflation or Earnings (1999-2010)

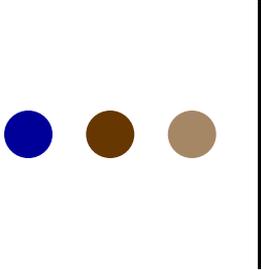


Source: KFF. Quick Facts. Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2010. Bureau of Labor Statistics, Consumer Price Index, U.S. City Average of Annual Inflation (April to April), 1999-2010; Bureau of Labor Statistics, Seasonally Adjusted Data from the Current Employment Statistics Survey, 1999-2010 (April to April).



National Health Reform Legislation

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

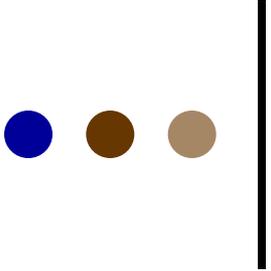


Overview of Health Reform

- By 2014, the bill requires most people to have health insurance and large employers (50+ employees) to provide health insurance--or pay a penalty.
 - Builds on our current system of public coverage, employer-sponsored insurance, and individual (non-group) coverage
- New funding for prevention, expansion of the health workforce, improving quality, testing new payment and delivery models, expand long-term care services, and increase the healthcare safety net

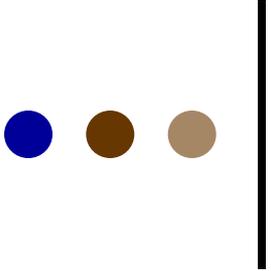
Health Reform Workgroups

- Public-private workgroups convened to how to best implement health reform in North Carolina
- *Overall Advisory Committee:*
Co-Chairs: Secretary Lanier Cansler, CPA; Insurance Commissioner Wayne Goodwin, JD
- *Eight work groups:*
Health Benefit Exchange and Insurance Oversight;
Health Professional Workforce; Medicaid Provisions and Elder Law; New Models of Care; Prevention; Quality; Safety Net; Fraud and Abuse



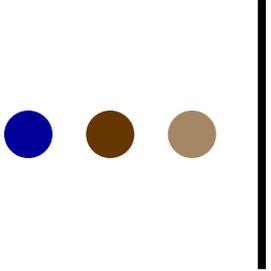
NC Foundations

- Health reform workgroups supported by generous grants from:
 - Kate B. Reynolds Charitable Trust
 - Blue Cross and Blue Shield of North Carolina Foundation
 - The Duke Endowment
 - John Rex Endowment
 - Cone Health Foundation
 - Reidsville Area Foundation
- North Carolina Network of Grantmakers created ACA grant tracking system: www.ncgrantmakers.org



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Employer Responsibilities

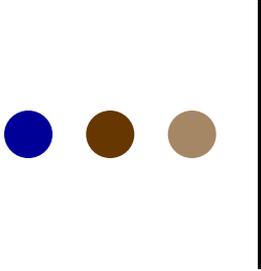
- Employers with more than 50 full-time equivalent employees are required to offer coverage or pay a **penalty** (Sec. 1513, amended by Sec. 1003 Reconciliation)
 - Full-time equivalent determined by counting number of monthly hours worked by part-time employees and dividing by 120.
- Employers with 50 or fewer employees exempt from **penalties** (Sec. 1513(d)(2))
 - Employers with 25 or fewer employees and average annual wages of less than \$50,000 can receive a tax **credit** (Sec. 1421, Sec. 10105)

Individual Mandate

- Citizens and legal immigrants will be required to pay penalty if they do not have qualified health insurance, unless exempt. (Sec. 1312(d), 1501, amended Sec. 1002 in Reconciliation)
 - Penalties: Must pay the greater of: \$95/person or 1% taxable income (2014); \$325 or 2.0% (2015); or \$695 or 2.5% (2016), increased by cost-of living adjustment*
 - Some of the exemptions include people who are not required to file taxes, and those for whom the lowest cost plan exceeds 8% of an individual's income (Sec. 1501(d)(2)-(4),(e))
- The question of the constitutionality of the individual mandate is being challenged in the courts.



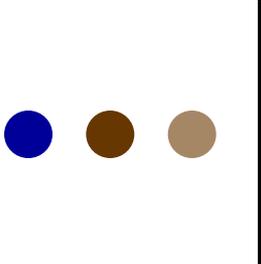
*Families of 3 or more will pay the greater of the percentage of income, or three times the individual penalty amount. The maximum penalty is equal to the amount the individual or family would have paid for the lowest cost bronze plan (minus any allowable subsidy).



Subsidies to Individuals

- Refundable, advanceable premium credits will be available to individuals with incomes up to 400% FPL on a sliding scale basis, if not eligible for government coverage or employer-sponsored insurance (Sec. 1401, as amended by Sec. 1001 of Reconciliation)
 - 400% is \$43,560/yr. for one person, \$58,840 for two, \$74,120 for three, \$89,400 for a family of four in 2011).*
 - 400% FPL is well below North Carolina's median household income

*2011 Federal Poverty Levels are: \$10,890 for an individual, \$14,710 for a family of two, \$18,530 for a family of three, or \$22,350 for a family of four. US Census Bureau. US Trustee Program. Census Bureau Median Family Income by Family Size. Oct. 31, 2010.

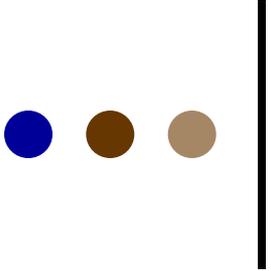


Health Benefits Exchange (HBE)

- States will create a Health Benefits Exchange for individuals and small businesses (Sec. 1311, 1321)
 - Limited to citizens and lawful residents who do not have access to employer-sponsored or governmental-supported health insurance and to small businesses with 100 or fewer employees. (Sec. 1312(f))
- Exchanges will:
 - Provide standardized information (including quality and costs) to help consumers choose between plans
 - Determine eligibility for the subsidy
 - Facilitate enrollment for HBE, Medicaid and NC Health Choice through use of patient navigators

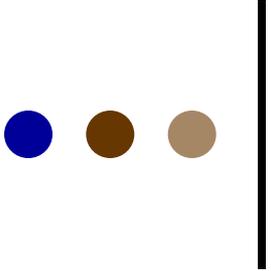
North Carolina Intent to Establish State-Based HBE

- If the state does not create an HBE, the federal government will do so
 - HB 115 would have created a state-based HBE. Passed the House, pending in the Senate.
 - The General Assembly did indicate its intent to “establish and operate a State-based health benefits Exchange that meets the requirements of the federal Patient Protection and Affordable Care Act.” (Sec. 49 of Session Law 2011-391.)



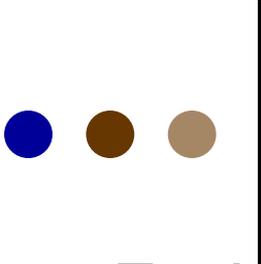
Health Benefits Exchange

- The following individuals or groups *must* obtain coverage through the HBE:
 - Individuals seeking premium and cost-sharing subsidies
 - Small businesses seeking employer tax credit
 - Individuals given a choice voucher
- The following individuals or groups *may* obtain coverage through the HBE:
 - Any other qualified individual (ie, a citizen or lawfully present immigrant)
 - Small business (as defined by the state)



HBE Requirements

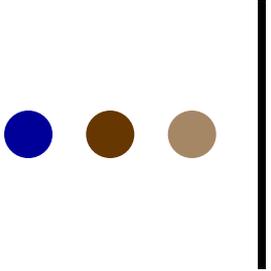
- Exchanges must:
 - Implement procedures for the certification, recertification, and decertification of qualified health plans and enroll co-op and federally approved multi-state plans (Secs. 1301, 10104, 1311 (d)(4)(A), 1321, 1322, 1334)
 - Provide for the operation of a toll-free telephone hotline to respond to requests for assistance (Sec. 1311(d)(4)(B))
 - Assign a quality rating to each qualified health plan offered through the HBE (Sec. 1311(d)(4)(D))
 - Maintain an internet website that uses standardized comparative information on plan options that includes costs and quality rating (Secs. 1311 (c), 1311(d)(4)(C), 1311(d)(4)(E))



HBE Requirements

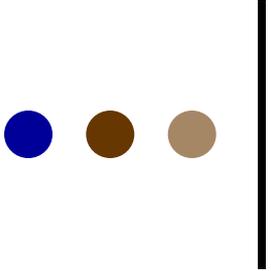
- Exchanges must:

- Determine eligibility for the premium subsidy and cost sharing reductions (Secs. 1411, 1401(f)(3), 1412, 10105; as amended by 1001, 1004 of Reconciliation)
- Inform people about eligibility for Medicaid and CHIP, and if eligible, enroll the individuals into these programs (Secs. 1311(d)(4)(F), 1411, 1413)
- Establish and make available an electronic calculator to determine the costs of coverage after applicable premium tax credits and cost sharing reduction (Sec. 1311(d)(4)(G))
- Certify individuals who are exempt from the mandate (Sec. 1311(d)(4)(H))
- Provide information to the Secretary of DHHS about anyone who is eligible for the premium tax credit or cost-sharing reductions, and the level of coverage (Sec. 1401(f)(3), as amended by 1004(c) of Reconciliation)



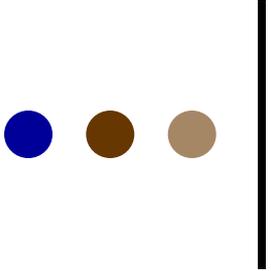
HBE Requirements

- Exchanges must:
 - Provide the Secretary of the Treasury information about anyone who is exempt; anyone who is receiving a subsidy who works for an employer required to offer insurance; and information about individuals who change employers and who cease coverage under a qualified health plan (Sec. 1311(d)(4)(I))
 - Provide information to employers of any employee who ceases coverage under a qualified health plan (Sec. 1311(d)(4)(J))
 - Establish a navigator program to provide information to the public about health plan choices and help them enroll (Sec. 1311(d)(4)(K), 1311 (i))



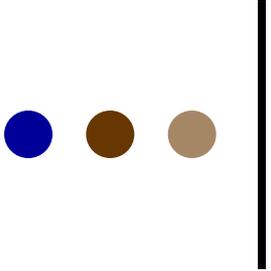
HBE Requirements

- Exchanges must:
 - Consult with stakeholders relevant to carrying out required activities (Sec. 1311(d)(6))
 - Publish average costs of licensing, regulatory fees and other payments to the HBE, and administrative costs (Sec. 1311(d)(7))
 - Report on all activities, receipts and expenditures annually to the Secretary of DHHS (Sec. 1313)
 - Credit the free choice voucher paid on behalf of qualified employees and consider information from employers contesting imposition of penalties (Secs. 10108(d)(2), 1411(f)(2))



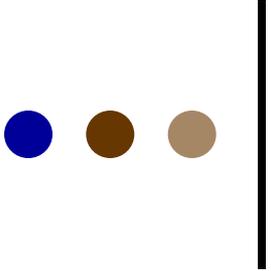
HBE Requirements

- Exchange must be self-sufficient beginning January 1, 2015. Exchange can charge assessments or user fees to participating health insurance issuers or otherwise generate funding (Sec. 1311(d)(5)(A))
- If states do not create qualifying HBE, then federal government will assume these responsibilities (Sec. 1321)



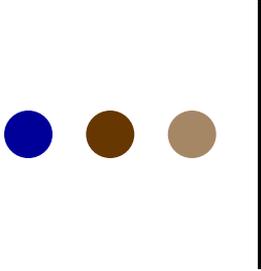
Qualified Health Plans

- To be certified, a qualified health plans must: (Sec. 1301, 1311, 10104)
 - Meet marketing requirements
 - Ensure sufficient choice of providers and provide information about in-network and out-of-network providers
 - Include essential community providers in the network
 - Be accredited on clinical quality measures and implement a quality improvement strategy
 - Utilize a uniform enrollment form
 - Provide standardized health plan information
 - Report pediatric quality reporting measures
 - Submit a justification for any premium rate increase prior to the increase



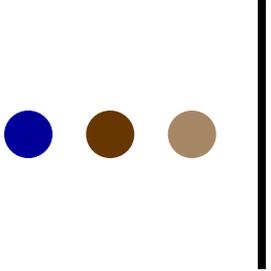
Qualified Health Plans

- To be certified, a qualified health plans must: (Sec. 1301, 1311, 10104)
 - Be accredited, report on clinical quality measures, and implement activities to reduce health disparities (including language services)
 - Provide specific plan-related information to enrollees, in plain language, including information on finances, enrollment and disenrollment, denied claims, out-of-network costs, claims payment policies and practices.
 - Provide timely information about the amount of cost-sharing (deductibles, copayments and coinsurance), and make this information available through the Internet



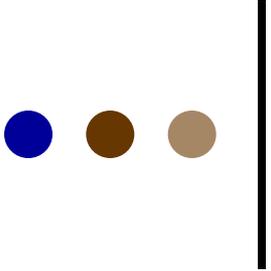
Essential Benefits Package

- 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))



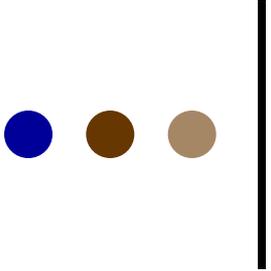
Four Levels of Coverage

- Four levels of plans, all must cover essential benefits package: (Sec. 1302(d))
 - Platinum: 90% of the benefit costs
 - Gold: 80% of the benefit costs
 - **Silver: 70% of the benefits costs***
 - Bronze (minimum creditable coverage): must cover 60% of the benefit costs of the plan
 - Catastrophic plan (only available to people up to age 30 or if exempt from coverage mandate) (Sec. 1302(e))



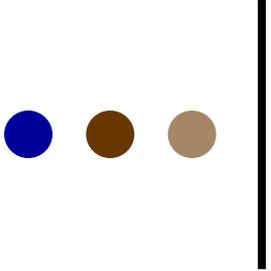
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Insurance Reform: 2014

- Insurers are prohibited from:
 - Discriminating against people or charge them more based on preexisting health problems (Effective 2014; Sec. 1201)
 - Including annual or lifetime limits for essential benefits (Sec. 1001, 10101)
- Insurers are required to:
 - Limit the differences in premiums charged to different people based on age (3:1 variation for adults allowed), and certain other rating factors (Effective 2014; Sec. 1201)



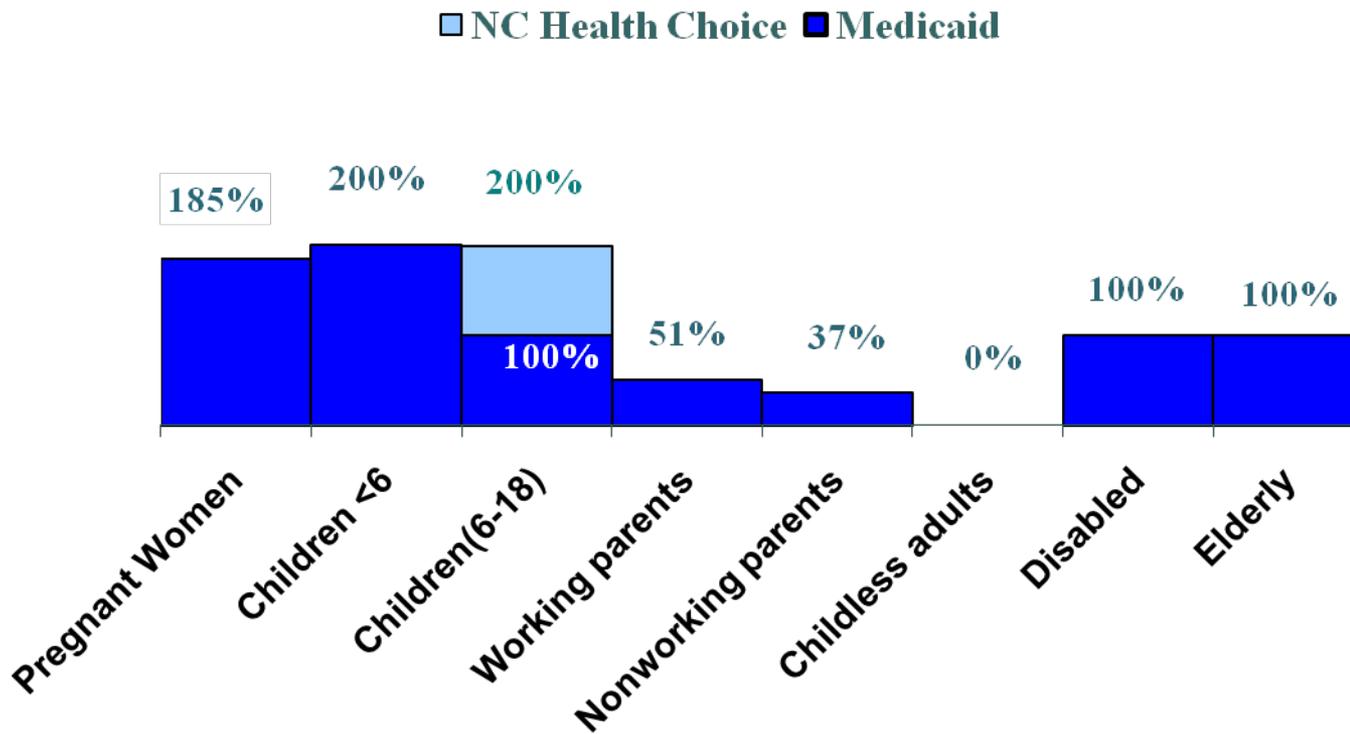
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Expansion of Public Coverage

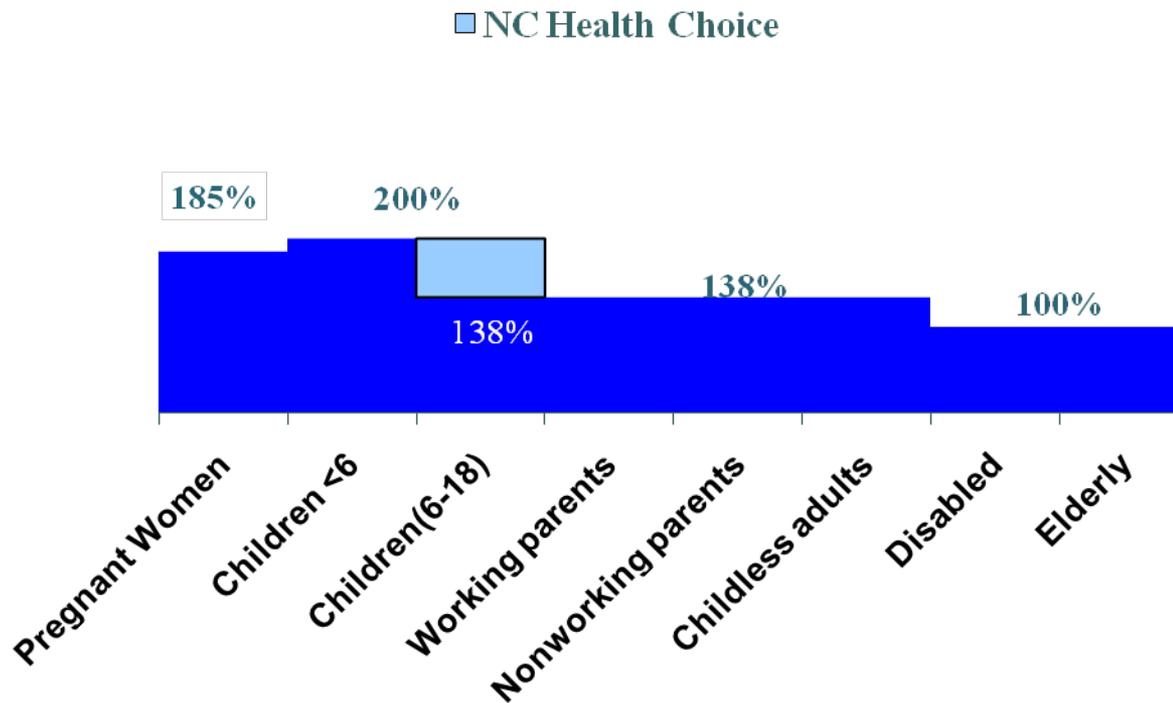
- Beginning in January 2014, adults will be able to qualify for Medicaid if their income is no greater than 138% of the federal poverty guidelines (FPL) (\$30,429/year for a family of four in 2010)*
 - Currently, childless adults who are not elderly or disabled can not qualify for Medicaid (regardless of their amount of income)
- Undocumented immigrants are not eligible for Medicaid or any other insurance coverage made available through this bill

Existing NC Medicaid Income Eligibility (2010)



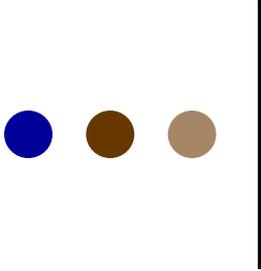
Currently, childless, non-disabled, non-elderly adults can not qualify for Medicaid

Existing NC Medicaid Income Eligibility (2014)



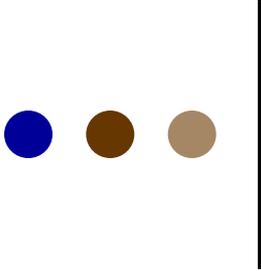
- *Beginning in 2014, adults can qualify for Medicaid if their income is no greater than 138% FPL, or \$30,843 for a family of four (2011)*
- *ACA requires greater outreach and enrollment simplification*

Source: Affordable Care Act (Sec. 2001, 2002). The ACA expands Medicaid for adults up to 133% FPL, but also includes a 5% income disregard. Effectively, this raised the income limits to 138% FPL.



Enrollment Simplification

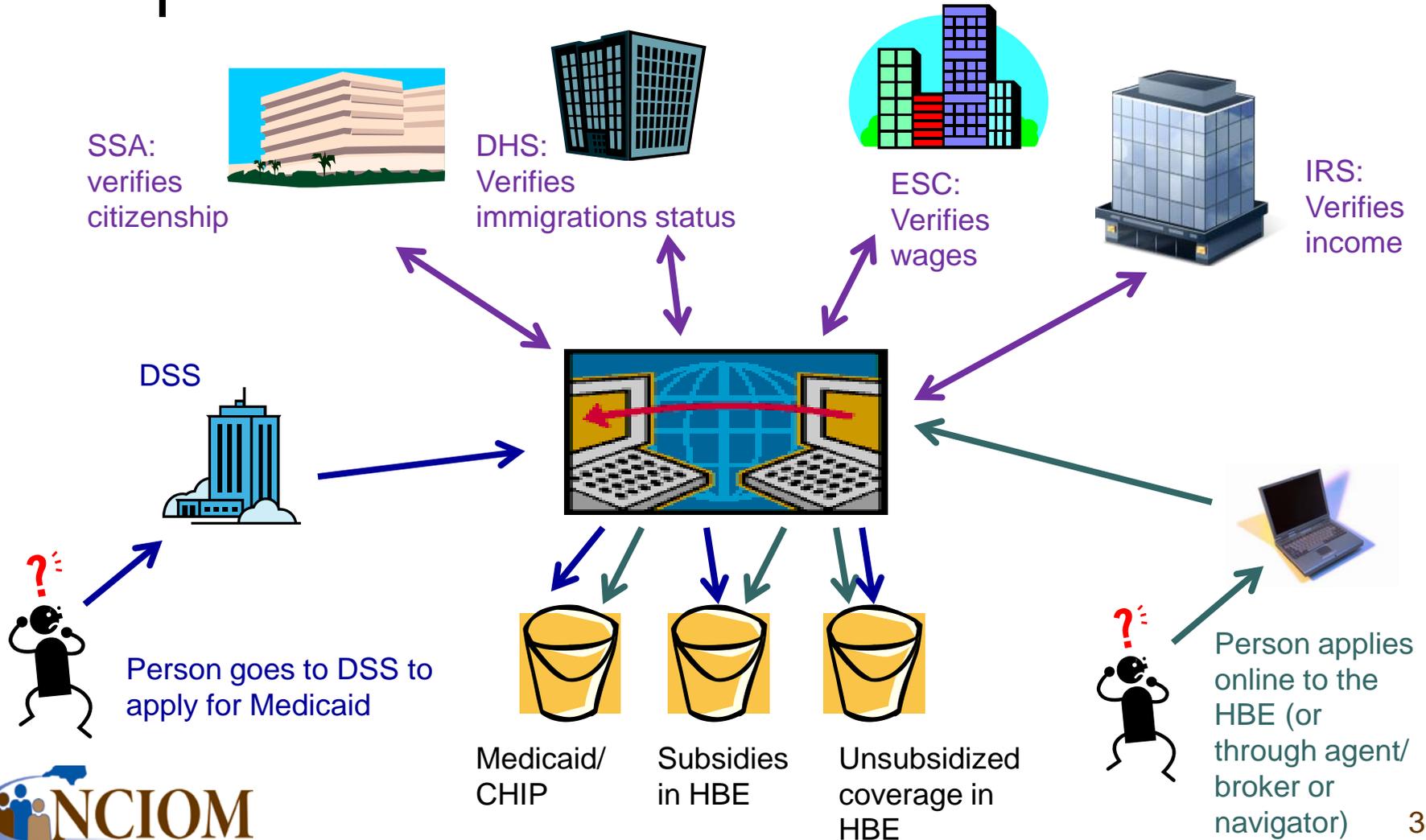
- States will be required to ***simplify enrollment*** and coordinate between Medicaid, CHIP, and the new Health Insurance Exchange. (Sec. 2201; 1413)
 - Secretary will develop a single streamlined enrollment form that will be used to apply for all applicable state health subsidy programs (Medicaid, CHIP, subsidy).
 - Form may be filed online, in person, by mail, or by telephone.
 - Person may file form with HBE or with Medicaid office.
- Electronic data matching (Sec. 1137, 453, 1942 of SSA)
 - Income eligibility: data matches with state unemployment compensation agency, and wage information reported to SSA and IRS.
 - Lawful immigration status with Immigrations Customs Enforcement (ICE).

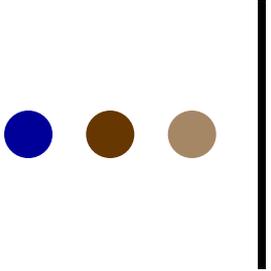


Outreach

- Must conduct outreach to vulnerable populations (Sec. 2201)
 - Vulnerable populations include: children, unaccompanied homeless youth, children and youth with special health care needs, pregnant women, racial and ethnic minorities, rural populations, victims of abuse or trauma, individuals with mental health or substance-related disorders, and individuals with HIV/AIDS.
- Hospitals can determine presumptive eligibility for all Medicaid populations (Sec. 2202)

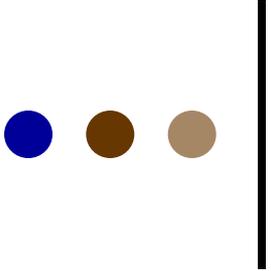
Simplified Application and Enrollment Process





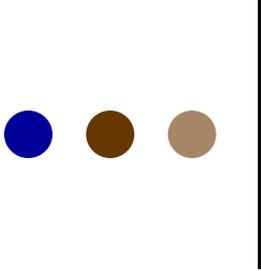
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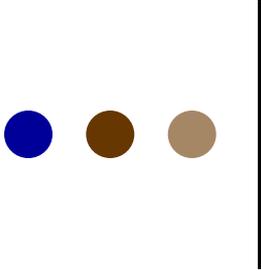
Other ACA Provisions

- Other ACA provisions to:
 - Invest in prevention
 - Increase the supply of health professional workforce and provide incentives to practice in underserved areas
 - Expand the health care safety net
 - Measure, report, and pay for improved quality of care
 - Test new payment and delivery models to improve patient outcomes, improve population health and reduce health care expenditures
 - Create more long-term care options



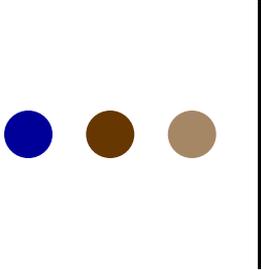
Cost Containment & Financing

- 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



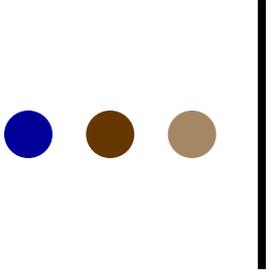
Congressional Budget Office (CBO) Projections

- 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.*



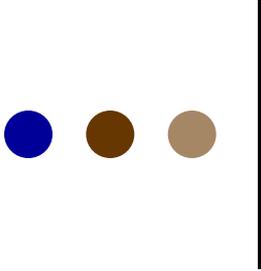
Total Health Spending Slightly Higher Under ACA

- CMS Office of the Actuary estimates that total health care spending will rise slightly higher under the ACA than before law was passed
 - Health care spending projections without the ACA would increase from \$2,472 billion in 2009 to \$4,483 billion in 2019 (19.3% GDP).
 - Health care spending projections after passage of the ACA increases from \$2,473 billion (2009) to \$4,572 billion (2019) (19.6% GDP).
- However, ACA estimated to cover 32 million more people.



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Potential Impact on North Carolina

- Assuming that North Carolina achieves the same coverage rate as is estimated nationally, approximately **1.1 million uninsured people are likely to gain coverage** in North Carolina by 2019*
 - The Division of Medicaid Assistance (Medicaid agency) estimates that approximately 500,000-600,000 people may gain Medicaid coverage by 2019.
 - The total cost to the state will be approximately \$830 million (SFY 2014-2019). The federal government will contribute more than \$15 billion.
 - Approximately 900,000 may gain coverage through the HBE by 2016; ~75% will qualify for subsidy. (Note: not everyone who gains coverage through the HBE will have previously been uninsured.)



Questions

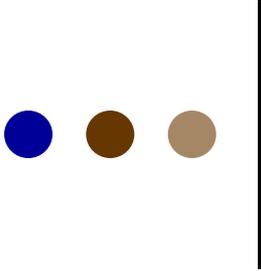


Sliding Scale Subsidies

Individual or family income	Maximum premiums (Percent of family income)	Out-of-pocket cost sharing* (Amount family pays out-of-pocket)	Out-of-pocket cost sharing limits**
<133% FPL	2% of income	6%	\$1,983 (ind)/\$3,967 (fam) (1/3 rd HSA limit)
133-150% FPL	3-4%	6%	\$1,983 / \$3,967
150-200% FPL	4-6.3%	13%	\$1,983/ \$3,967
200-250% FPL	6.3-8.05%	27%	\$2,975/ \$5,950 (1/2 HSA limit)
250-300% FPL	8.05-9.5%	30%	\$2,975/ \$5,950
300-400% FPL	9.5%	30%	\$3,967/ \$7,934 (2/3 ^{rds} HSA limit)

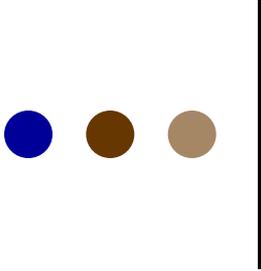
*Out-of-pocket cost sharing includes deductibles, coinsurance, copays.

**Out of pocket limits do not include premium costs. Annual cost sharing limited to: \$5,950 per individual and \$11,900 family in 2010 (HSA limits) (Sec. 1302(c), 1401, 1402, as amended by Sec. 1001 of Reconciliation)



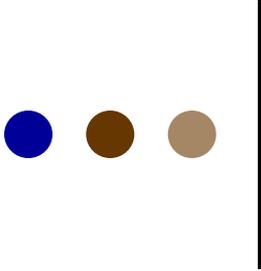
Immediate Insurance- Related Provisions: 2010

- Effective for plan years that begin after September 23, 2010:
 - Prohibits insurers from imposing pre-existing condition exclusions for children (Sec. 10103(e))
 - Prohibits insurers from dropping coverage to people when they get sick (Sec. 1001)
 - Prohibits plans from imposing lifetime caps; and restricts use of annual caps (annual caps prohibited 2014) (Sec. 1001, as amended Sec. 2301 of Reconciliation)
 - Extends coverage for young people up to 26th birthday through parents coverage (Sec. 1001)
 - New private plans must cover preventive services with no cost sharing (Sec. 1001)



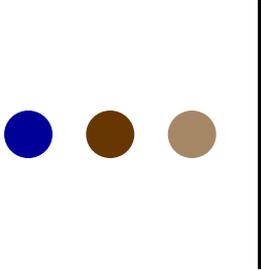
Other Insurance Provisions: 2011-2014

- The Secretary, in conjunction with the states, will establish a procedure to review premium rate increases to determine if they are “unreasonable”
 - The Secretary will rely on a state’s determination if the Secretary determines the state has an effective rate review program
- Insurers must report on their medical loss ratio (MLR) to the Secretary beginning for reporting year 2011, and provide rebates if they do not meet the MLR (2012)
 - No less than 80% for individual or small group
 - No less than 85% for large group



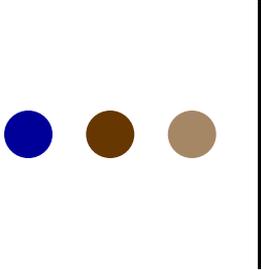
Different Insurance Rules Apply to Different Plans

- Some of the new insurance provisions do not apply to grandfathered plans.
 - Grandfathered plans are group and non-group plans that were in effect on March 23, 2010 and that are maintained continuously
 - For example, grandfathered plans are not required to provide the essential health benefits, coverage of all clinical preventive services, or new rating rules
- Some of the provisions do not apply to ERISA (self-insured) plans
 - ERISA plans are not subject to MLR requirements



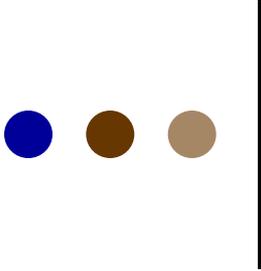
Prevention and Workforce

- 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 for prevention, wellness, and public health activities.
- Provisions to expand the health professional workforce, including primary care, nursing, long-term care, mental health/addiction specialists, dental health, public health, allied health, direct care workforce and community health workers



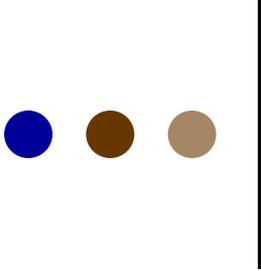
Health Care Workforce: Underserved Areas

- Expansion of National Health Service Corps: Appropriates a total of \$1.5B total over 5 years, FY 2011-2015 (Sec. 5207, 10503)
 - Loan forgiveness for health professionals who agree to practice in health professional shortage areas (HPSAs) for certain length of time (to pay off loan forgiveness)
 - Includes primary care providers, dental providers, and behavioral health providers
 - North Carolina Office of Rural Health and Community Care estimates that North Carolina will be able to recruit an additional 20-25 health professionals/year into underserved areas as a result of this new funding



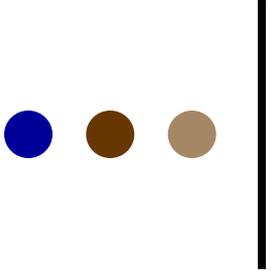
Quality and New Models of Care

- Providers and payers will be required to report data to measure quality of care
 - Data will be made available to the public
 - Increased emphasis paying for the quality and value of services provided
- The ACA includes funding to test new models of delivering and paying for health care services
 - Goal is to improve quality and health outcomes, improve efficiency, and help reduce health care cost escalation



Safety Net Overview

- Federally qualified health centers: Appropriate a total of \$9.5B over five years for operations, \$1.5B for construction and renovation (FY 2011-2015) (Sec. 10503, Sec. 2303 of Reconciliation)
- 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)
- New Medicaid state options to expand home and community-based services