

# The Impact of the Affordable Care Act on North Carolina

North Carolina Institute of Medicine  
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# North Carolina Institute of Medicine

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

*NCGS §90-470*



# National Health Reform Legislation

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

# NC Implementation Efforts

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



\*Lanier Cansler was co-chair when he was Secretary of NC DHHS; Al Delia was co-chair when he was Secretary of NC DHHS

# 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

# How the ACA Responds to these Challenges

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

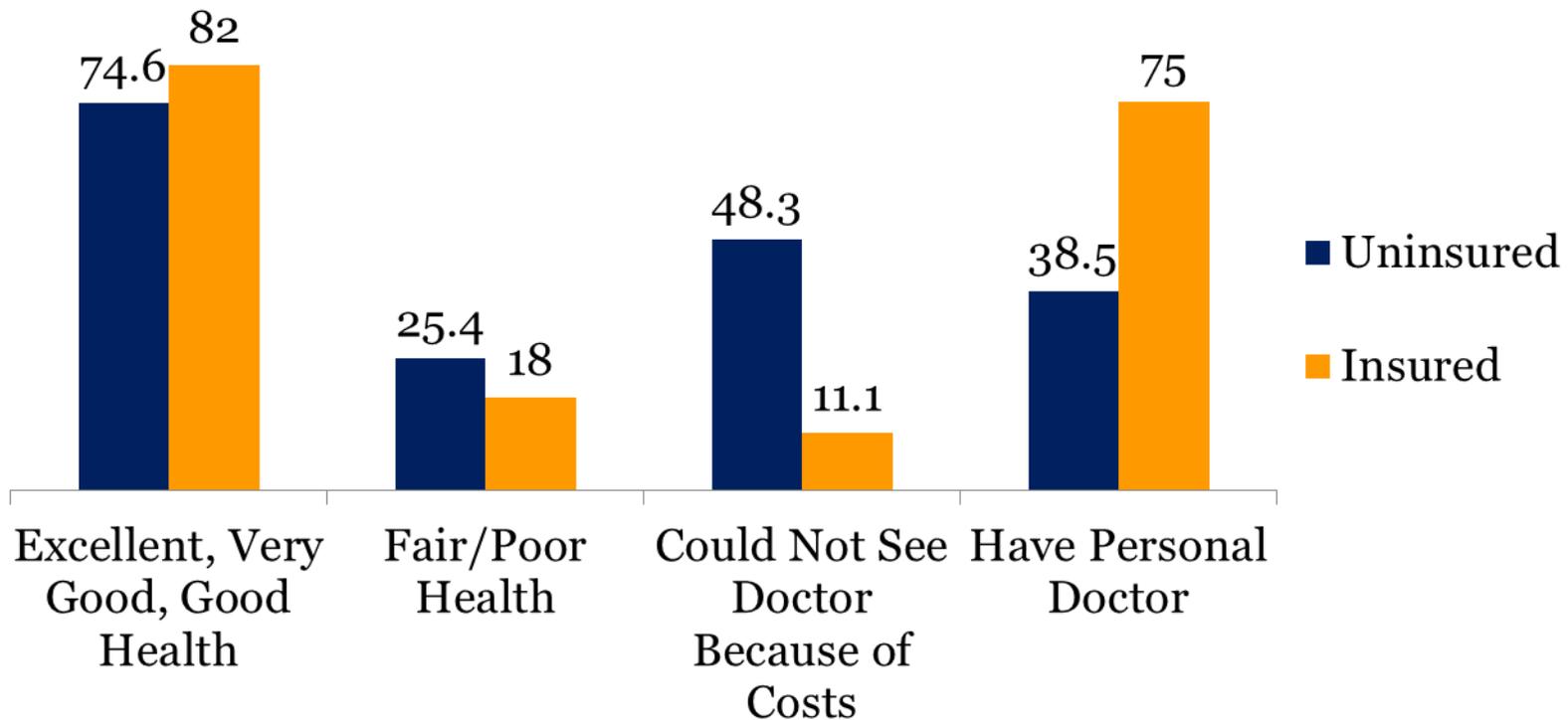
# Problem #1 Insurance Coverage and Access to Care

- Approximately 1.5 million uninsured in North Carolina (19% of the nonelderly population).
- Being uninsured has a profound impact on health and financial wellbeing.
  - People who are uninsured are less likely to have a personal doctor, more likely to report delaying care due to costs, and more likely to end up in the hospital for preventable health problems or late stage cancer.



US Census. Current Population Survey (CPS) Annual Social and Economic Supplement. Health Historical Tables. Table HIA-6.

# Uninsured in North Carolina Report Worse Health, More Access Barriers



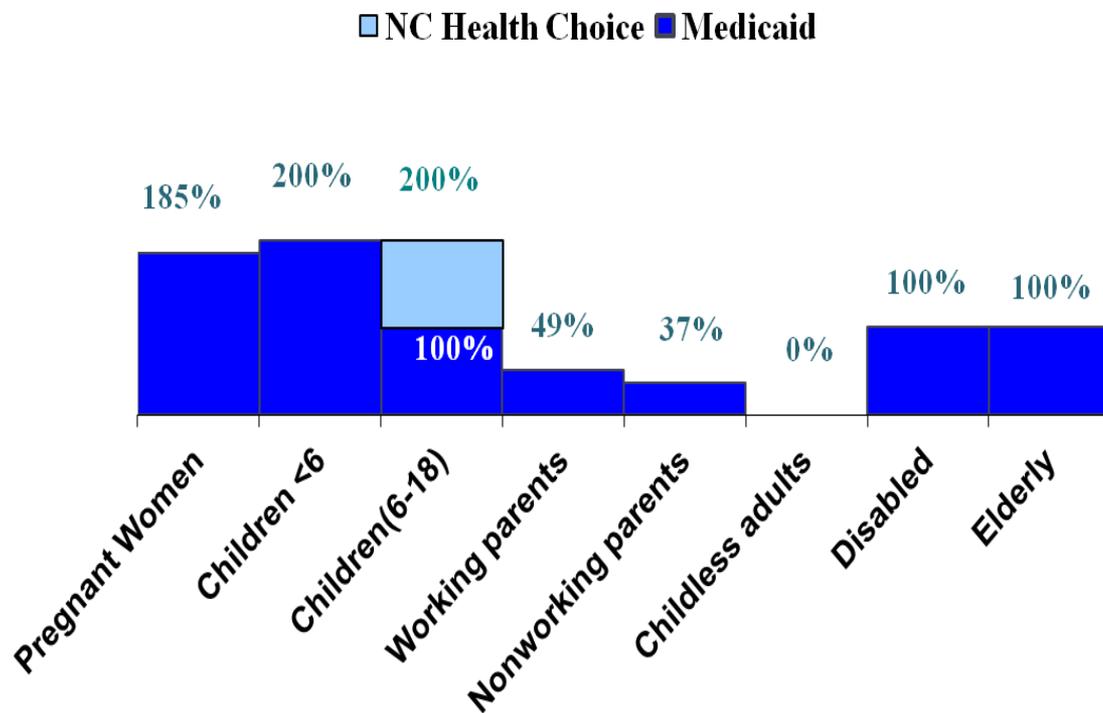
# Coverage Provisions Pre-Supreme Court Decision

- Most people will be required to have health insurance coverage in 2014. The ACA builds on our current system of providing health insurance coverage.
  - *Public coverage*: Many low income people with incomes <138% Federal Poverty Levels (FPL) would gain coverage through Medicaid.
  - *Employer-based coverage*: Most other people would 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 Insurance Marketplace.

# Supreme Court Challenge to ACA

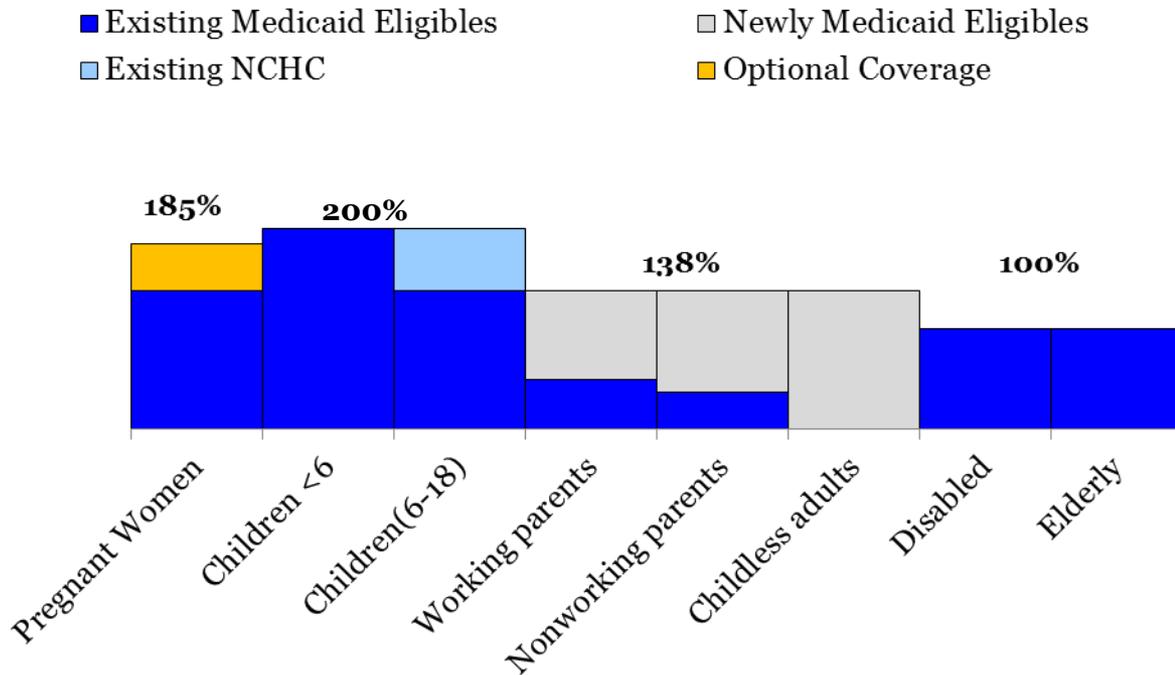
- Supreme Court, in *National Federation of Independent Business v. Sebelius*, 132 S. Ct. 2566 (2012):
  - Upheld the constitutionality of the individual mandate (under Congress' taxing authority).
  - Struck down the government's enforcement mechanism for the Medicaid expansion, essentially creating a voluntary Medicaid expansion.
  - Left the rest of the ACA intact.

# Existing NC Medicaid Income Eligibility (2012) (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)



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

# NC Cost of Medicaid Coverage

- Cost to the state for new Medicaid participants differs, depending on whether the person is an *existing eligible but not enrolled* (“*woodwork*”) or *newly eligible*.
  - *Woodwork*. DMA estimates that between 70,000-80,000 people will gain coverage (2014-2019). The federal government pays ~65% of the costs of the existing eligibles.
  - *Newly eligibles*: DMA estimates that approximately 500,000 people will gain coverage if the state chooses to expand Medicaid to cover the newly eligibles.
    - The federal government pays 100% of the costs of the newly eligibles (2014-2016), then phases down to 90%.

# State Share of Costs of Covering Newly Eligible is Relatively Low

- There will be new costs to pay for services and administration for both the “woodwork” and the newly eligible groups
- There are “offsets” to the state’s share of costs. For example:
  - Pharmaceutical companies pay the federal and state governments a rebate to offset part of the costs of drugs for Medicaid recipients
  - The state pays for some health services for the uninsured. Some of the existing state funding could be redirected to pay the new Medicaid costs for those who gain Medicaid coverage
  - The state will generate new revenues from all the new federal dollars that come into the state

# DMA Estimates for New and Existing Eligibles (2014-2021)\*

	<b>Woodwork (Existing Eligibles) (2014-2021)</b>	<b>New Eligibles (2014-2021)</b>
<b>Eligibles</b>	<b>~70,000-87,000</b>	<b>~494,000-536,000</b>
<b>State</b>	<b>\$912 million total</b>	<b>\$-65 million total</b>
<b>Federal</b>	<b>\$2.6 billion total</b>	<b>\$14.8 billion total</b>
<b>Total</b>	<b>\$3.5 billion total</b>	<b>\$15.7 billion total</b>

- \* Includes service costs, all the offsets (CHIP enhancement, AIDS Drug Assistance Program (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.

# Medicare Changes

- Enhances coverage of clinical preventive services (Sec. 4103-4105, 10402, 10406)
- Phases out the gap in the Part D “donut hole” by **2020** (Sec. 3301, 3315, as amended by 1101 Reconciliation)
- Strengthens the financial solvency of the Medicare program by 7 years (2017-2024)
  - All savings from the legislation must be used to “extend the solvency of Medicare trust funds, reduce Medicare premiums and other cost-sharing for beneficiaries, and improve or expand guaranteed Medicare benefits and protect access to Medicare providers.” (Sec. 3601)

# 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)

# 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\*
- Certain groups are exempt from the penalties, including those who would have to spend more than 8% of their income for the lowest cost premium.

\*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 to purchase coverage through the Marketplace.
- 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)
  - Family Size 1: \$11,170/yr. (100% FPL) - \$44,680/yr. (400% FPL)\*
  - Family Size 2: \$15,130 - \$60,520
  - Family Size 3: \$19,090 - \$76,360
  - Family Size 4: \$23,050 - \$92,200
- If states do not expand Medicaid, poor people (<100% FPL) not eligible for subsidies to purchase coverage in the Marketplace

# Health Insurance Marketplace

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

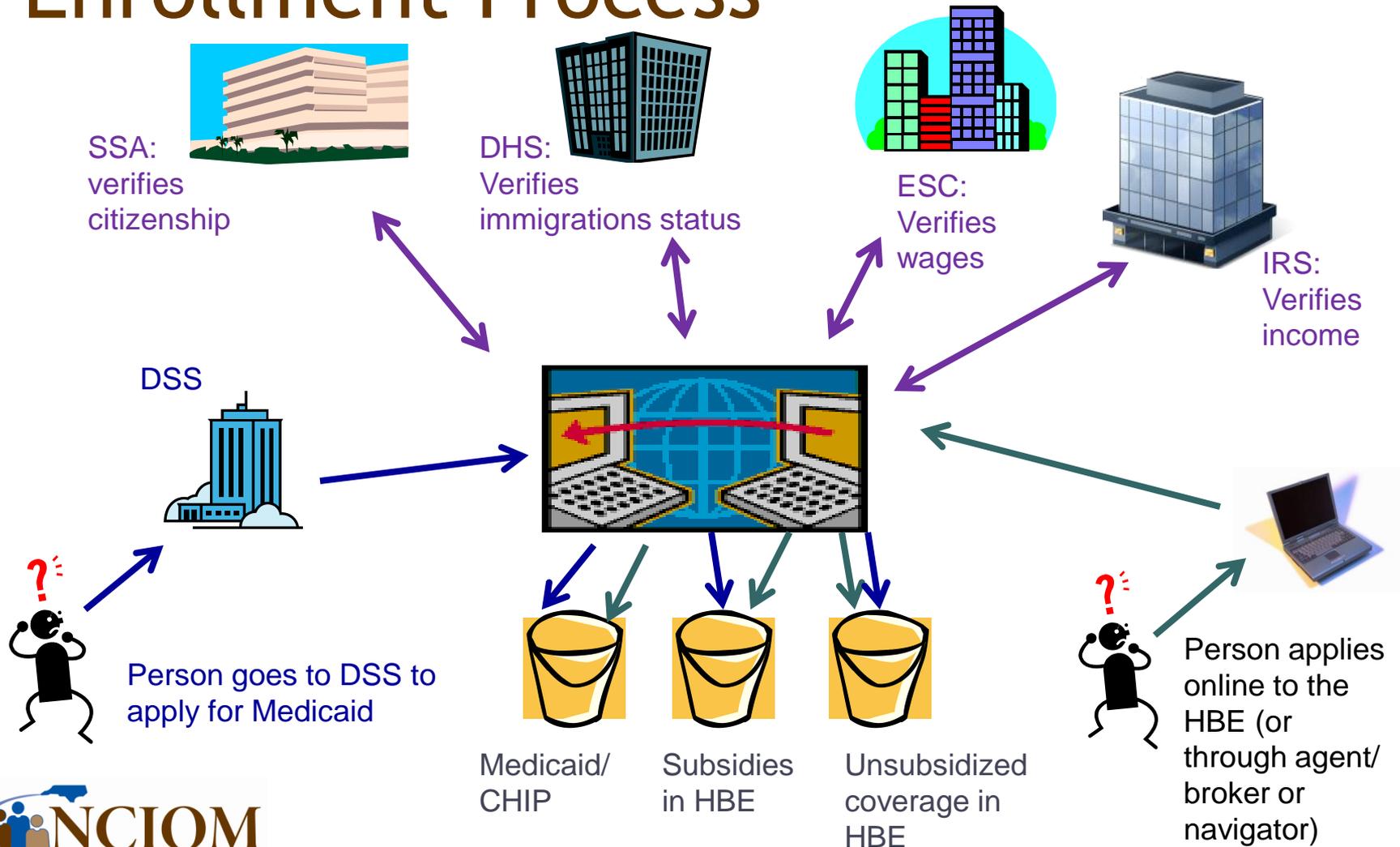
# Partnership HBE

- North Carolina can choose to operate a partnership Marketplace with the federal government. In the partnership, the NC Department of Insurance (NCDOI) would be responsible for:
  - *Consumer assistance* including education and outreach, call center operations, website management
  - *Plan management*, including plan selection, oversight of plan rate increases and benefit packages, monitoring insurers, and data collection and analysis for quality.
- The General Assembly is considering legislation to remove NCDOI's authority to assume partnership responsibilities.

# No Wrong Door

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

# Simplified Application and Enrollment Process



# Essential Benefits Package

- Insurers 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; 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)
  - 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.

# Essential Benefits Package

- In North Carolina, the essential health plan will be based on BCBSNC's most commonly purchased small business health plan: Blue Options PPO.  
<http://cciio.cms.gov/resources/EHBBenchmark/proposed-ehb-benchmark-plan-north-carolina.pdf>
  - In addition, health plans must also cover pediatric dental and vision (based on Federal Employees Dental and Vision Plan), and habilitative services.



\* 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)

# Other Provisions to Expand Access

- The ACA included funding to:
  - Expand the number of community health centers.
  - Expand support for school based health centers.
  - Pay for loan forgiveness for health professionals willing to work in underserved areas.
- Some new funds available to increase health professional workforce.

# Problem #2: Population Health

- North Carolina ranks 33<sup>rd</sup> of the 50 states and DC in population health measures in 2012. (America's Health Rankings, 2012)
  - North Carolina ranked 31<sup>st</sup> in determinants of health (eg, smoking, binge drinking, obesity, poverty, preventable hospitalizations).
  - North Carolina ranked 38<sup>th</sup> 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)
  - Appropriates \$750 million in FY 2011 increasing to \$2 billion in FY 2022 and each fiscal year thereafter.\*
  - Priority areas for the national public health agenda includes health promotion and disease prevention to address lifestyle behavior modification (including smoking cessation, proper nutrition, exercise, mental health, behavioral health, substance use disorder, and domestic violence screenings). (Sec. 4001)

# ACA Prevention Grants

- North Carolina 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).

# 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.
  - Funding for new models of care which change reimbursement to reward quality and health outcomes.

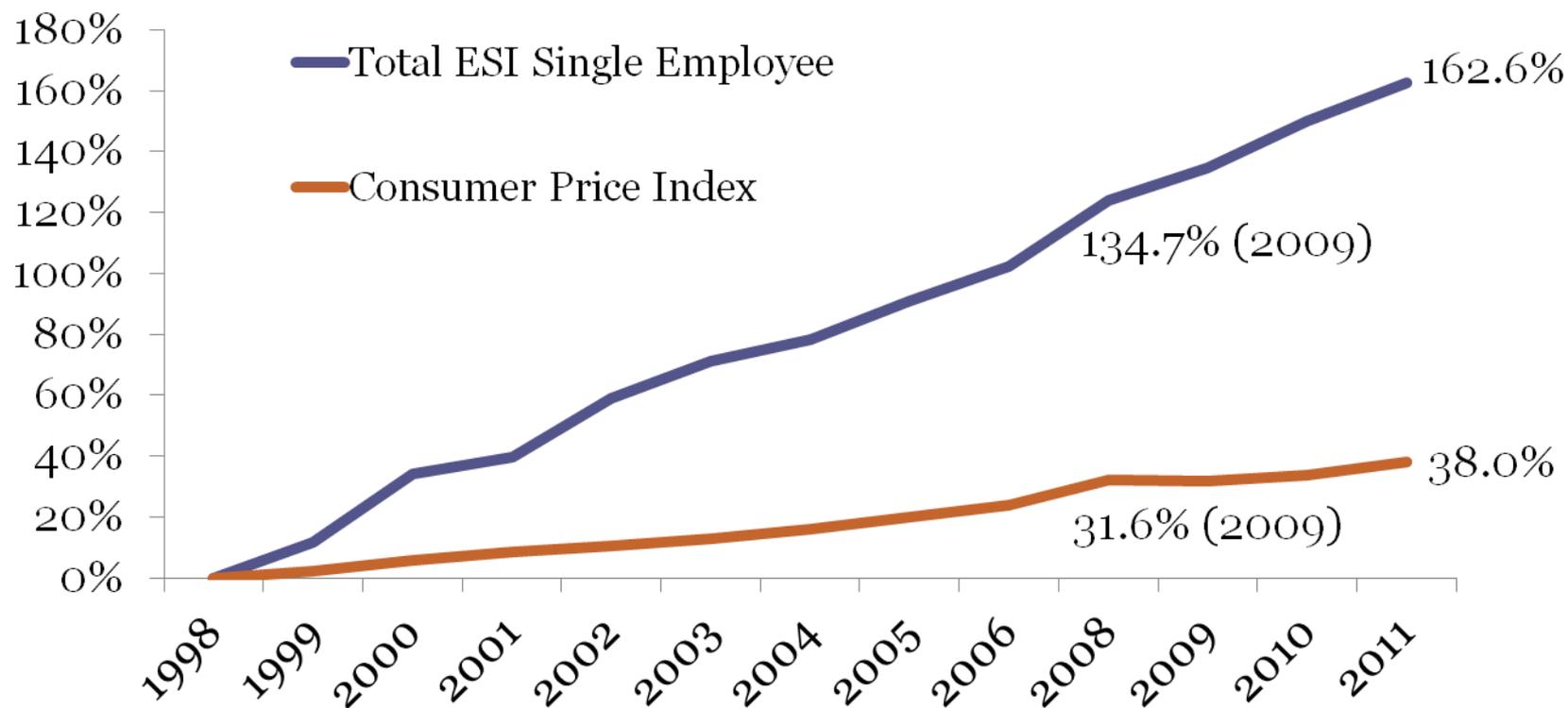
# Examples of Hospital Value-Based Purchasing

- Hospitals are no longer paid for treatment of “hospital acquired conditions”
  - Example: hospital acquired infections
- Hospitals with excess readmissions (risk-adjusted 30-day readmission rates in the lowest quartile) 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.

# 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, 1998-2009)



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

# ACA: Outstanding Challenges

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

# ACA: New Opportunities

- However, ACA offers many opportunities, including:
  - 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

- Examining the Impact of the Patient Protection and Affordable Care Act in North Carolina  
<http://www.nciom.org/publications/?examining-the-impact-of-the-patient-protection-and-affordable-care-act-in-north-carolina>
- 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](http://www.healthcare.gov)
- Congressional Budget Office. Selected CBO Publications  
Related to Health Care Legislation, 2009-2010.  
<http://www.cbo.gov/ftpdocs/120xx/doc12033/12-23-SelectedHealthcarePublications.pdf>
- Kaiser Family Foundation  
<http://healthreform.kff.org/>

# For More Information

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# 2012 Federal Poverty Levels/Year

Family Size	100%	138%	200%	400%
1	\$11,170	\$15,415	\$22,340	\$44,680
2	\$15,130	\$20,879	\$30,260	\$60,520
3	\$19,090	\$26,344	\$38,180	\$76,360
4	\$23,050	\$31,809	\$46,100	\$92,200
Each add'l person:	\$ 3,960	\$ 5,465	\$ 7,920	\$15,840

# Sliding Scale Subsidies

<b>Individual or family income</b>	<b>Maximum premiums (Percent of family income)</b>	<b>Out-of-pocket cost sharing:*</b>	<b>Out-of-pocket cost sharing limits (2014)**</b>
100-133% FPL	2% of income	6%	\$2,250(ind)/\$4,500 (more than one person) (1/3 <sup>rd</sup> HSA limits)
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 proposed rule Dec. 7, 2012.

# New State Costs of Services: Woodwork (in millions)

	2014	2015	2016	2017	2018	2019	2020	2021	Total
New elig	69,683	72,426	75,340	78,035	80,890	83,859	85,888	87,127	
Gross Costs: NC	\$37	\$102	\$169	\$180	\$191	\$203	\$211	\$216	\$1,310
Drug Rebate:NC	-\$0.3	-5	-\$8	-\$11	-\$12	-\$13	-\$14	-\$16	-\$79
CHIP enhance	0	0	-\$64	-\$88	-\$90	-\$92			-\$335
Admin:NC	\$1	\$2	\$2	\$2	\$2	\$2	\$2	\$2	\$16
<b>Net Costs:NC</b>	<b>\$37</b>	<b>\$99</b>	<b>\$98</b>	<b>\$83</b>	<b>\$92</b>	<b>\$101</b>	<b>\$199</b>	<b>\$203</b>	<b>\$912</b>
Net Fed'l with CHIP	\$69	\$183	\$365	\$404	\$426	\$448	\$367	\$375	\$2,636

# Medicaid Expansion (New state costs, in millions)

	2014	2015	2016	2017	2018	2019	2020	2021	Total
New elig	494,010	500,058	506,818	512,906	519,684	525,830	531,264	536,481	
Gross Costs	\$0	\$0	\$0	\$84	\$132	\$159	\$222	\$244	\$841
Drug Rebate	-\$0	-\$0	-\$0	-\$6	-\$9	-\$11	-\$16	-\$19	-\$61
State Offsets	-\$31	-\$62	-\$62	-\$62	-\$62	-\$62	-\$62	-\$62	-\$465
Admin	\$10	\$15	\$15	\$15	\$15	\$15	\$15	\$16	\$116
New Taxes	\$-17	-\$73	-\$77	-\$72	-\$69	-\$67	-\$62	-\$61	-\$497
<b>NC Net Costs</b>	<b>-\$38</b>	<b>-\$121</b>	<b>-\$124</b>	<b>-\$40</b>	<b>\$8</b>	<b>\$34</b>	<b>\$97</b>	<b>\$119</b>	<b>-\$65</b>
Net	\$527	\$2,042	\$2,066	\$2,027	\$2,034	\$2,051	\$2,118	\$2,040	\$14,815