Implementing the Affordable Care Act on North Carolina

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

- 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

Challenges Facing Our Health Care System: ACA Responses

- 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.
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 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)

Medicaid expansion would provide coverage to approximately 500,000 new eligibles in 2014, if the state chose to expand Medicaid.

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

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. 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 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, poor people (<100% FPL) not eligible for subsidies to purchase coverage in the Exchange

*Based on 2013 Federal Poverty Level*

Health Benefits Exchange

- In North Carolina, the federal government will create a Health Benefits Exchange for individuals and small businesses. *(Sec. 1311, 1321)*
- Exchanges 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.
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 (Sec. 1311(j))

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

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 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)
  - 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 would have increased PPHTF to $2 billion in FY 2015, but Congress postponed some of the increased funding to pay for the 2012 Medicare doctors’ fix.

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.
Hospital Value-Based Purchasing Examples

• Hospitals are no longer paid for treatment of “hospital acquired conditions”
• 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.
  ◦ In NC, 88 hospitals will be subject to a penalty (average reduction in DRG payments: 0.25%) (2013).
  ◦ CMS: Care transitions grants: Northwest Triad Care Transitions Program, Access East Community-Based Transition Partnership, Access Care

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)

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.
  1) If state chooses not to expand Medicaid, the poorest people will lack insurance coverage and they will be ineligible for subsidies.
  2) May not be sufficient provider supply in 2014 to handle health care needs of newly insured, and will continue to be maldistribution issues.
  3) Some providers and higher income individuals will pay more in taxes.
  4) 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

- 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 энергөөнөрөн харччын тодорхой

- US Health Reform website
  www.healthcare.gov

- Congressional Budget Office. Selected CBO Publications

- Kaiser Family Foundation
  http://healthreform.kff.org/

For More Information

- Pam Silberman, JD, DrPH
  President and CEO
  North Carolina Institute of Medicine
  919-401-6599 Ext. 23
  pam_silberman@nciom.org

2013 Federal Poverty Levels/Year

<table>
<thead>
<tr>
<th>Family Size</th>
<th>100%</th>
<th>138%</th>
<th>200%</th>
<th>400%</th>
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<tbody>
<tr>
<td>1</td>
<td>$11,490</td>
<td>$15,856</td>
<td>$22,980</td>
<td>$45,960</td>
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<tr>
<td>2</td>
<td>$15,510</td>
<td>$21,404</td>
<td>$31,020</td>
<td>$62,040</td>
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<tr>
<td>3</td>
<td>$19,530</td>
<td>$26,951</td>
<td>$39,060</td>
<td>$78,120</td>
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<tr>
<td>4</td>
<td>$23,550</td>
<td>$34,499</td>
<td>$47,100</td>
<td>$94,200</td>
</tr>
<tr>
<td>Each add'1 person:</td>
<td>$4,020</td>
<td>$5,548</td>
<td>$8,040</td>
<td>$16,080</td>
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</tbody>
</table>

NC Cost of Medicaid Coverage

- Cost to the state for new Medicaid eligibles 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 (2014-2015). 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%.

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

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Eligibles</td>
<td>~70,000-87,000</td>
<td>~494,000-539,000</td>
</tr>
<tr>
<td>State</td>
<td>$912 million total (899m to 820m/yr)</td>
<td>$8-65 million total</td>
</tr>
<tr>
<td>Federal</td>
<td>$8,636 million total</td>
<td>$14.8 billion total</td>
</tr>
<tr>
<td>Total</td>
<td>$3,548 million total</td>
<td>$15.7 billion total</td>
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</table>

* 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.


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.
  - Includes home health, 60 days skilled nursing facility, outpatient rehabilitation (with some visit limits), durable medical equipment ($600 lifetime maximum)
  - 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.
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

Person goes to DSS to apply for Medicaid

DSS

SSA: Verifies citizenship

DHS: Verifies immigration status

IRS: Verifies income

Person applies online to the HBE (or through agent/broker or navigator)

Medicaid/CHIP Subsidies

Unsubsidized coverage in HBE

Sliding Scale Subsidies

<table>
<thead>
<tr>
<th>Individual or family income</th>
<th>Maximum premiums (Percent of family income)</th>
<th>Out-of-pocket cost sharing:*</th>
<th>Out-of-pocket cost sharing limits (2014)**</th>
</tr>
</thead>
<tbody>
<tr>
<td>100-133% FPL</td>
<td>2% of income 6%</td>
<td>$2,250/Ind/$4,500 (more than one person)</td>
<td>1/3rd HSA limits</td>
</tr>
<tr>
<td>133-150% FPL</td>
<td>3-4% 6%</td>
<td>$2,250 / $4,500</td>
<td></td>
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<tr>
<td>150-200% FPL</td>
<td>4-6.3% 13%</td>
<td>$2,500 / $4,500</td>
<td></td>
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<tr>
<td>200-250% FPL</td>
<td>6.3-8.05% 27%</td>
<td>$5,200 / $10,400</td>
<td></td>
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<tr>
<td>250-300% FPL</td>
<td>8.05-9.5% 30%</td>
<td>$6,400 / $12,800</td>
<td></td>
</tr>
<tr>
<td>300-400% FPL</td>
<td>9.5% 30%</td>
<td>$6,400 / $12,800</td>
<td></td>
</tr>
<tr>
<td>400% + FPL</td>
<td>No limit 30%</td>
<td>$6,400 / $12,800</td>
<td></td>
</tr>
</tbody>
</table>

*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 cost limits in proposed rule Dec. 7, 2012.
Reducing Growth of Health Spending: The Importance of Better Integration of Appropriate Care

Stuart H. Altman
Professor of National Health Policy
Brandeis University and
Adjunct Professor UNC School of Public Health

The Issues

Medicare Spending Growth Driving Federal Deficit
Medicare and Other Entitlement Programs Will Consume More of Our National Income

In Addition---The Medicare Trust Fund Is Going Broke
The Medicare HI Trust Fund Is Going Broke?

Need to Redesign Delivery System To Provide More Efficient Higher Quality Care

New Payment System Must Be Developed

ACO’s and Bundled Payments Offer Real Efficiency Opportunities
• They Encourage Better Integration of Care
  » The Substitution of Less Expensive for More Expensive Care
  » The Reduced Use of Marginal and Ineffective Care
  » The Limitation of the Stockpiling of Substitutable types of Services
• They Facilitate the Working Together of Hospitals, Physicians, Post Acute Care Health Professionals
• Most Importantly They Offer an Opportunity To Find Savings Through Better Integration of Acute and Post-Acute Care
The Key is---

**Better Integration to Appropriate Care---and**

---

**Good Care Transition Makes Integration Work**

The movement of patients from one health care practitioner or setting to another as the individual’s condition and care needs change

Occurs at multiple levels
- Within Settings
  - ICU → Ward
- Between Settings
  - Hospital → Home or Hospital → Long Term Care Facility
- Across health states
  - Curative care → Palliative care/Hospice

(c) Eric A. Coleman, MD, MPH

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**Much of This Conference Will Discuss Need for Good Care Transition**

* I Will Continue To Focus on “BIG Picture “Issues*
ACOs Offer Greater Opportunity To Generate Savings (Includes All Health Care)
*Better Integration of Services and Where Appropriate---Place Patients In Lower Cost Settings*

ACOs Need a Vibrant Primary Care System and Home and Community Based Long-Term Care Services
*Savings Potentially The Highest With ACOs---Many Look To Less Complicated “Bundled Payment” Option*

Medicare Bundled Payment Experiment Begins With a Hospital Admission (DRG Payment)
*Payment Includes In-Hospital and Physician Services Plus Post-Acute Care*
For Those Who Work In High Cost Institutional Care Organizations---

Don’t Worry---Growth of Older Populations Will Keep Your Beds Filled

But Be Careful About Adding New Ones!!!

Bundled Payments and ACO’s Have A Better Chance To Succeed If--

• Better Coordination of Care Between Physician, Hospital, and Long-Term Care Services
• Patients Are Assured That Quality and Appropriateness of Care Is Maintained or Enhanced
• Cost Savings are Shared With The Insured
• Bundled Payments Is Combined With Other Reforms Designed To Lower Costs and Improve Quality
Better Use of Post-Acute and Long-Term Care Services

Avoiding Unnecessary Hospital Readmissions

Avg. 2008 Medicare Payment for In-Hospital Care for Select DRGs

2008 Medicare Acute and Post-Acute Payments for Inpatient-Initiated 90-Day Episodes
Episode Spending by Setting: Major Joint Replacement

<table>
<thead>
<tr>
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<th>Total Joint</th>
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<tbody>
<tr>
<td>Index Admission</td>
<td>$10,798</td>
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<tr>
<td>Index other</td>
<td>$2,174</td>
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<tr>
<td>Acute Readmit</td>
<td>$1,465</td>
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<tr>
<td>Rehab</td>
<td>$1,423</td>
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<tr>
<td>SNF</td>
<td>$4,400</td>
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<tr>
<td>HHA</td>
<td>$2,401</td>
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<tr>
<td>Other</td>
<td>$2,769</td>
</tr>
<tr>
<td>Total</td>
<td>$25,430</td>
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Episode Spending by Setting: Congestive Health Failure

<table>
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<tr>
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<tr>
<td>Index Admission</td>
<td>$7,818</td>
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<tr>
<td>Index other</td>
<td>$1,775</td>
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<tr>
<td>Acute Readmit</td>
<td>$7,514</td>
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<tr>
<td>Rehab</td>
<td>$319</td>
</tr>
<tr>
<td>SNF</td>
<td>$4,921</td>
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<tr>
<td>HHA</td>
<td>$1,099</td>
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<tr>
<td>Other</td>
<td>$4,535</td>
</tr>
<tr>
<td>Total</td>
<td>$27,981</td>
</tr>
</tbody>
</table>

**BUT To Succeed--- Must Avoid The Errors of The Past?**
The Errors of The Past

• Providers (Physicians and Hospitals) Were Required To Take More Financial Risk Than They Could Afford or Understand--

• Individuals Were FORCED Into Plans They Didn’t Chose and Didn’t Like--

• Quality of Care Measures Were Limited So Choice of Plan (By Employers) Was Based Primarily on Costs

ACO’s and Bundled Payments Designed To Avoid Problems of The 1990’s

• Providers Required To Assume Limited Risk
  — ACO’s is a “Shared Savings System”. Each Groups Starts From Their Current Spending Levels and Downsides Risk Limited

• Patients Will Not Be Locked Into a Delivery System They Don’t Trust
  — Patients Need to Sign Up With PCP But Can Change PCP or Network With No Penalty

• Attaining or Exceeding "Quality Standards Provider Eligibility for Payment Depends on “
  — Debate on What Quality Standards to Use Is Ongoing

Failure To Reform Delivery System Through Better Care Coordination

Options NOT GOOD!