Understanding National Health Reform

Joint Legislative Oversight Committee on Health

Presentation by:
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North Carolina Institute of Medicine

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NCIOM North Carolina Institute of Medicine
shaping policy for a healthier state

A Word About the NC 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

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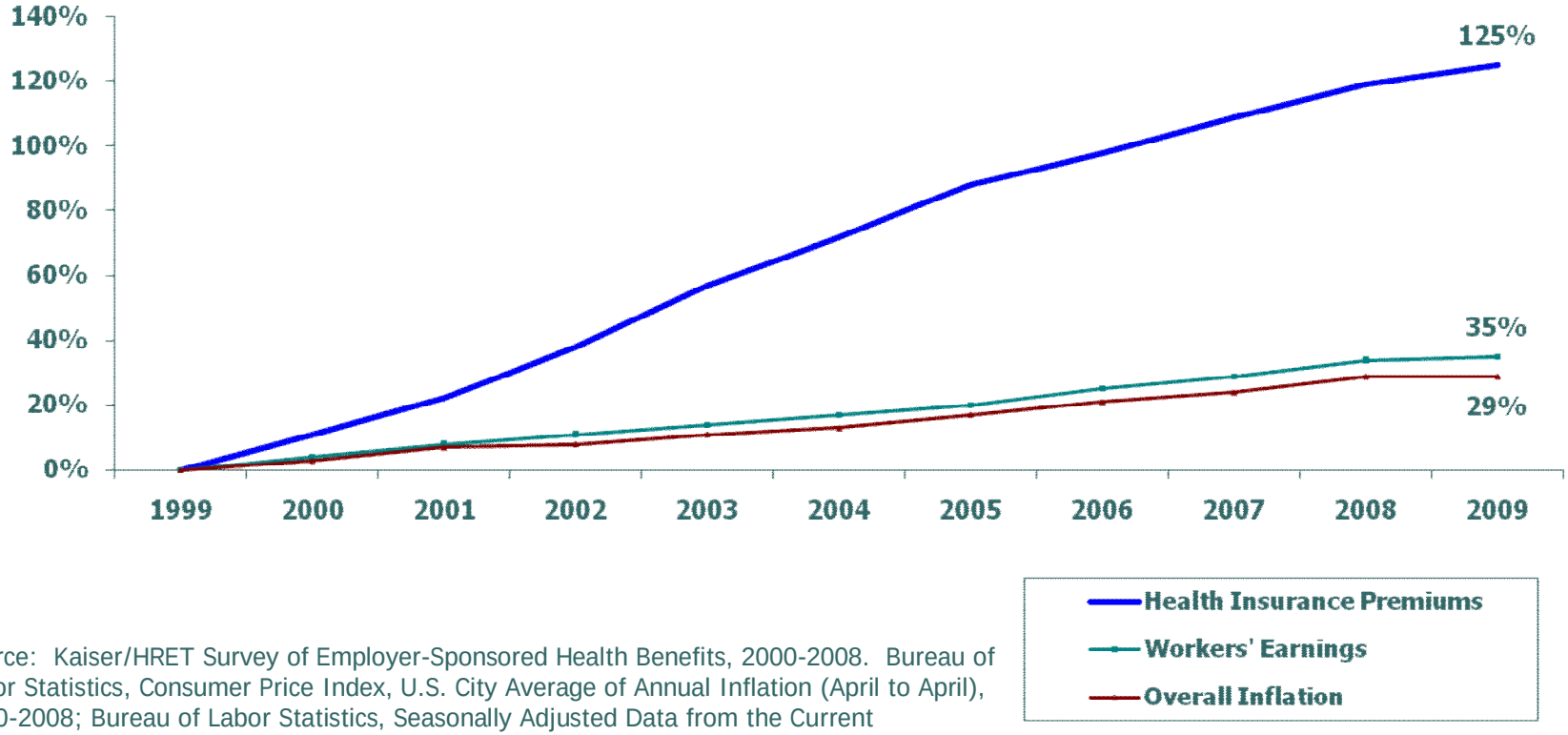
Background

- 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%)
- 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

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.

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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)

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Basics of National Health Reform--Overview

- Overview of health reform legislation
- Changes in public coverage
- Private coverage
- Other provisions
- Cost containment and financing
- CBO estimates
- North Carolina planning efforts

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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.
- New funding for prevention, expansion of the health workforce, long-term care services, increasing the healthcare safety net, and improving quality

Basics of National Health Reform--Overview

- Overview of health reform legislation
- **Changes in public coverage**
  - **Medicaid, CHIP and Medicare**
- Private coverage
- Other provisions
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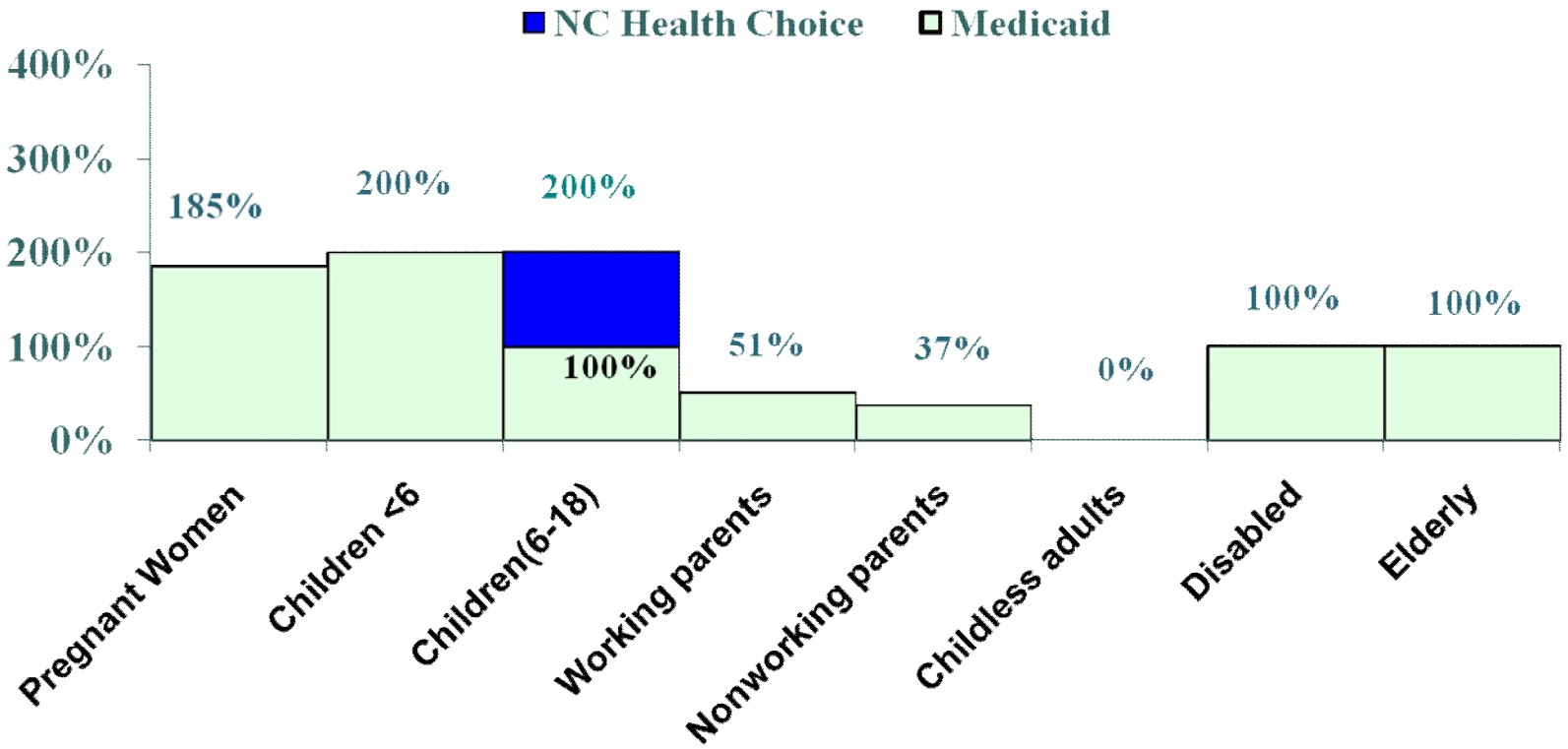
Existing NC Medicaid Income Eligibility (2010)



KFF. State Health Facts. Calculations for parents based on a family of three.

Expansion of Public Programs

- Expands Medicaid to cover all low-income people under age 65 (including childless adults) with incomes up to 133% FPL, based on modified gross income (begins FY 2014) (Secs. 2001, 2002)

Family Size	133% FPL/yr. (2009)
1	$14,404
2	$19,378
3	$24,352
4	$29,327

- States must maintain current income eligibility for children in Medicaid and NC Health Choice until 2019.

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Medicare

- Enhances preventive services, beginning Jan. 2011 (Sec. 4103-4105, 10402, 10406)
- Phases out the gap in the Part D “donut hole” by 2020 (Sec. 3315, as amended by1101 Reconciliation)
  - $250 rebate in 2010
  - 50% discount on brand-name drugs in 2011 (Sec. 3301)
- Strengthens the financial solvency of the Medicare program
  - Extends the life of the Medicare trust fund by 12 years

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Basics of National Health Reform--Overview

- Overview of health reform legislation
- Changes in public coverage
- **Private coverage**
  - **Standardized benefit package**
  - **Individual mandate and subsidies**
  - **Employer responsibilities**
  - **Health insurance "exchanges" and insurance reform**
- Other provisions
- Cost containment and financing
- CBO estimates
- NC planning efforts

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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))

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Essential Benefits Package

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

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*Subsidies tied to the second lowest cost silver plan in the HIE.

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))

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*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 ($43,320/yr. for one person, $58,280 for two, $73,240 for three, $88,200 for a family of four in 2010).* (Sec. 1401, as amended by Sec. 1001 of Reconciliation)
  - Individuals are generally not eligible for subsidies if they have employer-based coverage, TRICARE, VA, Medicaid, or Medicare (Sec. 1401(c)(2)(B)(C), 1501)
  - In comparison: North Carolina's median household income in 2008 was $46,574 (avg. household = 2.5 people).

***2010 Federal Poverty Levels are: $10,830 for an individual, $14,570 for a family of two, $18,310 for a family of three, or $22,050 for a family of four. US Census Bureau. North Carolina. Quick Facts. http://quickfacts.census.gov/qfd/states/37000.html**

Employer Responsibilities

- Employers with 50 or more full-time employees required to offer insurance or pay penalty (Sec. 1201, 1513, amended Sec. 1003 Reconciliation)
  - If employer *does not offer* coverage, the employer must pay $2,000 per full-time employee, excluding first 30 employees.
  - If an employer *does offer* coverage, but at least one full-time employee qualifies for and receives a subsidy, then the employer must pay $3,000 for any full-time employee who receives a subsidy
- Employers with less than 50 full-time employees exempt from penalties. (Sec. 1513(d)(2))

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Subsidies for Small Employers

- Employers with 25 or fewer employees and average annual wages of less than $50,000 can receive a tax credit. (Sec. 1421, Sec. 10105)
  - *Phase I (2010-2013):* Sliding scale tax credit of up to 35% if for-profit employer provides coverage and pays at least 50% of total premium cost.
  - *Phase II (2014-later):* Maximum of 50% tax credit for up to 2 years. Subsidies only available for coverage purchased through the Health Insurance Exchange.

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Health Insurance Exchange

- States will create a Health Insurance 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

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Health Insurance Exchange (HIE)

- "No wrong door approach" between Medicaid and HIE (Sec. 1311, 1411, 1413)
  - Individuals who apply for health insurance through the HIE will have their eligibility determined for Medicaid; those who apply for Medicaid will have their eligibility determined for HIE subsidies
- Patient navigators to help link individuals to Medicaid or private insurance through HIEs

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Insurance Reform

- Insurers are prohibited from:
  - Discriminate against people 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 allowed), and certain other rating factors (Effective 2014; Sec. 1201)
  - Submit premium rate increases to regulators for review and approval if allowed under state law (Effective 2010; Sec. 1003)

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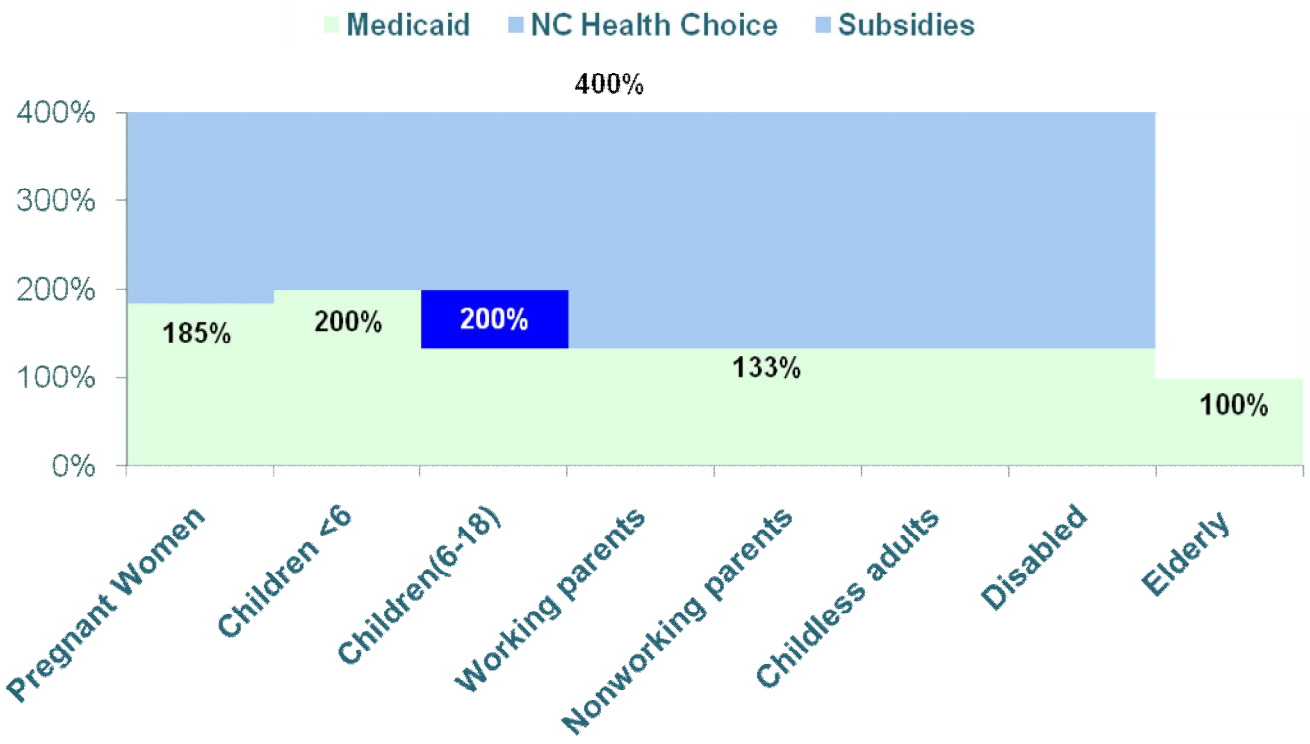
After Health Reform Fully Implemented (Beginning 2014)



Beginning 2014, most people with incomes ≤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

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Basics of National Health Reform--Overview

- Overview of health reform legislation
- Changes in public coverage
- Private coverage
- **Other provisions**
  - **Prevention and Wellness; Workforce; Quality and New Models of Care; Safety Net; Long-Term Care; Other Provisions; States' Roles**
- Cost containment and financing
- CBO estimates
- NC planning efforts

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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

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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 and scholarships to train primary care, nursing, long-term care, mental health/substance abuse, dental health, public health, allied health and direct care workforce

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Health Care Workforce: Underserved Areas

- Expansion of National Health Service Corps (funding to recruit providers to underserved areas):
  - Appropriates a total of $1.5B total over 5 years (FY 2011-2015) (Sec. 5207, 10503)
- Many health professional workforce grant programs offer priority to those applications that plan to work in medically underserved areas (Sec. 5315, 5203, 5205, 5301, 5303, 5306,5307, 5309, 5403, 5507, 5508, 5606, 10501)

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Quality

- HHS Secretary will 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)

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New Models Overview

- Efforts to test new models of care to improve quality and efficiency (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)

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Safety Net

- New funding for community health centers (CHCs)
  (Sec. 10503, Sec. 2303 of Reconciliation)
  - Appropriates a total of $9B over five years for operations ($1B in FY 2011 increasing to $3.6B in FY 2015); and $1.5B over five years for construction and renovation of community health centers (FY 2011-2015) (Sec. 10503, Sec. 2303 of Reconciliation)
- Appropriates $50M each FY 2010-2013 to support school-based health centers (Sec. 4101, 10402)

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Safety Net

- New requirements for charitable 501(c)(3) hospitals. Nonprofit hospitals must: (Sec. 9007, 10903)
  - Conduct a community needs assessment and identify an implementation strategy
  - Have a financial assistance policy for low-income uninsured
  - Provide emergency services
  - Limit charges to people eligible for assistance to amounts generally billed.

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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

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- Congressional Budget Office estimates
- North Carolina planning efforts

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

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*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.

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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.*

* 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.

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

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Health Reform Workgroups

- The overall goal is to ensure the decisions made in implementing the federal health reform legislation serves the best interests of the state as a whole. To do this, the workgroups will:
  - Identify the decisions the state must make in implementing the national legislation.
  - Identify potential funding opportunities
  - Make recommendations to the legislature and executive agencies about options to help North Carolina improve population health, access to care, and health care quality, while slowing health care costs.

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NCIOM Health Reform Resources

- What Does Health Reform Mean for North Carolina? *North Carolina Medical Journal*, May/June 2010;71:3
- NCIOM: North Carolina data on the uninsured http://www.nciom.org/data/uninsured.shtml
- Other resources on health reform are available at: www.nciom.org/data/healthreform.php

Questions

Structure of the Health Reform Workgroups

- The NC Department of Health and Human Services and the NC Department of Insurance is taking the lead in establishing these workgroups.
- 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

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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
  - Provide guidance on the new insurance ombuds program, and the creation of patient navigator programs

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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

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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

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Medicaid and Elder Services

- Co-Chairs:
  - Craigan Gray, MD, JD, MBA
    Director, NC Division of Medical Assistance
    NC Department of Health and Human Services
- 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

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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

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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

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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

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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

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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

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