Understanding National Health Reform

Focus on Children

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North Carolina Institute of Medicine

November 8, 2010

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
Background

- Approximately 20% of the non-elderly (0-64) were uninsured in 2008-2009 (~1.6 million people)
- Approximately 12% of the children (0-18) were uninsured in 2008-2009 (~282,000 people)
  - Family income
    - ~ 214,000 (78% of uninsured children) were in families with incomes <200% FPG
    - ~ 50,000 (18%) were in families with incomes between 200-400% FPG
    - ~ 18,000 (6%) were in families with incomes >400% FPG


Background

- Lack of health insurance impacts on a person’s health, as well as a family’s financial security
  - People who are uninsured are less likely to receive preventive services, and more likely to end up in the hospital for preventable conditions
  - Decline in health insurance coverage directly related to rising health care costs
Health Care: Three Legs of a Stool

Health reform must address the three critical components of our health care system—costs, quality, and access with the goals of improving individual and population health

Costs

Access

Quality, Including Prevention
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)

Basics of National Health Reform--Overview

- Overview of health reform legislation
- Changes in public coverage
- Private coverage
- Other provisions
- CBO estimates
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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.
  - 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, long-term care services, increasing the healthcare safety net, and improving quality
Immediate Insurance-Related Provisions

- Effective for plan years that begin after September 23, 2010:
  - Prohibits insurers from denying coverage to children under age 19 with pre-existing conditions or imposing pre-existing condition exclusions (Sec. 1001, 1201, 10103(e))
  - Extends coverage for young people up to 26th birthday through parents coverage (Sec. 1001, as amended Sec. 2301 of Reconciliation)
  - New private plans must cover preventive services, including evidence-informed preventive care and screenings for infants, children and adolescents, with no cost sharing (Sec. 1001)*
  - More on this on Slide 20
  - Prohibits insurers from dropping coverage to people when they get sick or imposing lifetime caps. Restricts use of annual caps (annual caps prohibited in 2014) (Sec. 1001, as amended Sec. 2301 of Reconciliation)

* These provisions only apply to new group or non-group plans issued after the effective date. These provisions do not apply to grandfathered plans.

Basics of National Health Reform--Overview

- Overview of health reform legislation
- Changes in public coverage
  - Medicaid, CHIP and Medicare
- Private coverage
- Other provisions
- Cost containment and financing
- CBO estimates
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)
  - No asset tests for children and most adults (Sec. 2002)
  - Undocumented immigrants not eligible for Medicaid
  - States cannot cut eligibility or make application process more restrictive for Medicaid and NC Health Choice
Medicaid for Foster Care Youth

- Youth in foster care on their 18th birthday are covered under Medicaid until their 26th birthday (Sec. 2004(a)(2))

Other Medicaid Provisions

- All newly eligible adults will be guaranteed a benchmark benefit package that includes “essential health benefits” (Sec. 2001(a)(2))

- States will be required to simplify enrollment and coordinate between Medicaid, CHIP, and the new Health Insurance Exchange (Sec. 2201; 1413)
  - Must conduct outreach to vulnerable populations (Sec. 2201)

- States must provide no less than the essential benefits package (more on slide 20) but, unlike private plans, can choose if preventive services have cost-sharing
CHIP (NC Health Choice)

- States must maintain current income eligibility for children in Medicaid and CHIP until 2019 (Sec. 2101(b), 10203).
  - After 2019, children who do not qualify for Medicaid will receive coverage through their parents’ employer sponsored insurance, or through the health insurance exchange.

After Health Reform Fully Implemented (Beginning 2014)
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
- CBO estimates

Essential Benefits Package

- HHS Secretary will recommend an essential health care benefits package that includes a comprehensive set of services: (Sec. 1302; Sec. 2713 of Public Health Service Act, amended in Sec. 1001)
  - 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 (US Preventive Services Task Force) with no cost-sharing and all recommended immunizations (Sec. 1001, 10406)
  - Mental health parity law applies to qualified health plans (Sec. 1311(j))
Coverage of Preventive Health Services

- Insurers must provide coverage without cost-sharing of evidence-informed preventive care and screenings as recommended by HRSA and the US Preventive Services Task Force (A and B recommendations). Includes periodic:
  - Health history
  - Measurements (height/weight, head circumference, BMI, blood pressure)
  - Vision and hearing screening
  - Developmental/behavioral assessment (autism, psychosocial/behavioral, alcohol/drug use)
  - Physical exams and procedures such as newborn metabolic screenings, immunizations, lead screening, STI screening/pap smears
  - Oral health
  - Anticipatory guidance
- Of particular interest to this group: covers immunizations; tobacco cessation screening, counseling, and interventions for adults; folic acid supplements; depression screening; STI screening and counseling

Coverage of Preventive Health Services con’t

- Items or services that have an ‘A’ or ‘B’ rating in the current recommendations of the U.S. Preventive Services Task Force (USPSTF) with respect to the individual involved.

- Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC) with respect to the individual involved. These recommendations are contained in four schedules for 2010.
  - A recommendation of ACIP is considered to be “in effect” after it has been adopted by the Director of the CDC. A recommendation is considered to be for routine use after it appears on the Immunization Schedules of the CDC.
Coverage of Preventive Health Services con’t

- Evidence-informed preventive care and screenings for infants, children, and adolescents as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA).
  - The current HRSA supported guidelines appear in two charts: the Periodicity Schedule of the Bright Futures Recommendations for Pediatric Health Care, and the Uniform Panel of the Secretary’s Advisory Committee on Heritable Disorders in Newborns and Children. A guideline is considered to be supported by HRSA on the date on which it is accepted by the Administrator of HRSA.

- With respect to women, evidence-informed preventive care and screening, as provided for in the comprehensive guidelines supported by the HRSA (not otherwise addressed by the USPSTF recommendations). The Department of HHS is developing these guidelines and expects to issue them no later than August 1, 2011.

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))

*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))

*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, $88,200 for a family of four in 2009).* (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)

*2009 Federal Poverty Levels are: $10,830 for an individual, or $22,050 for a family of four.
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* (Amount family pays out-of-pocket)</th>
<th>Out-of-pocket cost sharing limits**</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;133% FPL</td>
<td>2% of income</td>
<td>6%</td>
<td>$1,983 (ind) / $3,967 (fam) 1/3rd HSA limit</td>
</tr>
<tr>
<td>133-150% FPL</td>
<td>3-4% of income</td>
<td>6%</td>
<td>$1,983 / $3,967</td>
</tr>
<tr>
<td>150-200% FPL</td>
<td>4-6.3% of income</td>
<td>13%</td>
<td>$1,983 / $3,967</td>
</tr>
<tr>
<td>200-250% FPL</td>
<td>6.3-8.05% of income</td>
<td>27%</td>
<td>$2,975 / $5,950 1/2 HSA limit</td>
</tr>
<tr>
<td>250-300% FPL</td>
<td>8.05-9.5% of income</td>
<td>30%</td>
<td>$2,975 / $5,950</td>
</tr>
<tr>
<td>300-400% FPL</td>
<td>9.5% of income</td>
<td>30%</td>
<td>$3,967 / $7,934 2/3rd HSA limit</td>
</tr>
</tbody>
</table>

* 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)

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)
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

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
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, 1010)

- 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)

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.
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

Maternal and Child Health-Other Provisions (Sec 2951)

- Funding for maternal, infant and child early home visitation programs
  - NC DPH: Maternal, Infant, and Early Childhood Home Visiting Program Awarded $2,134,807*
- Support, education, and research on postpartum depression
- Funding for personal responsibility education and abstinence education
  - NC DPH: State Personal Responsibility Education Program (State-PREP) Awarded $1,544,312*
  - NC DPH: Pregnancy Assistance Fund: Support for Pregnant and Parenting Teens Awarded $1,768,000*

*These may be multi-year grants*
Prevention and Wellness: Overview

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

Prevention and Public Health Fund

- National Prevention, Health Promotion and Public Health Council (Sec. 4001)
- Prevention and Public Health Fund to invest in prevention, wellness, and public health activities (Sec. 4002)
  - Appropriates $500 million in FY 2010, $750 million in FY 2011, $1 billion in FY 2012, $1.25 billion in FY 2013, $1.5 billion in FY 2014, and $2 billion in FY 2015 and each fiscal year thereafter
  - May be used to fund programs authorized by the Public Health Service Act and for prevention, wellness, and public health activities
  - Half of this funding will be used for health professional workforce training
Workforce Overview

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

Health Care Workforce: Pediatrics

- Primary care: funding to provide grants to schools to develop and operate training in primary care, including general pediatrics (Authorizes $125M in FY 2010 and sums necessary in FY 2011-2014, Sec. 5301)
- Pediatric specialty loan repayment program: Funding for pediatric medical and surgical specialists, or child and adolescent mental and behavioral health care, willing to serve in underserved areas (Authorizes $30M in each FY 2010-2014, Sec. 5203)
- Child and adolescent mental and behavioral health loan repayment if serve in underserved areas (Authorizes $30M in each FY 2010-2014, Sec. 5203)
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)

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)
Safety Net

- New funding for community health centers (CHCs)
  - 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)

- Expansion of National Health Service Corps:
  - Appropriates a total of $1.5B total over 5 years (FY 2011-2015) (Sec. 5207, 10503)

Other Provisions

- Extends family-to-family health information centers through FY 2012 (Sec. 5507(b))
  - Includes Family Voices of North Carolina, a program of the Exceptional Children’s Assistance Center (ECAC)
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- CBO estimates

Cost Containment & Financing

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

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

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- Congressional Budget Office estimates

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.
**PPACA: Summary**

**Costs**
PPACA creates the infrastructure, but does less to immediately reduce health care cost escalation. The legislation begins to change the way health care is delivered and providers are reimbursed to reduce unnecessary care. PPACA also reduces fraud and abuse, administrative overhead, and excess costs currently in the system.

**Access**
PPACA significantly increases access by providing more affordable insurance to most people and expanding the safety net. The bill includes some provisions to increase provider supply.

**Quality**
PPACA improves quality by investing in: prevention, comparative effectiveness research, and the development of quality outcome measures. PPACA also requires data reporting, will provide information to the public, and pay providers and insurers for improved quality.

**Other NCIOM Resources**
Useful Resources: National

- Senate Bill: Patient Protection and Affordable Care Act
  (HR 3590 signed into law March 23, 2010)
  [http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=111_cong_bills&docid=f:hr3590enr.txt.pdf]

- Health Care and Education Reconciliation Act of 2010
  (HR 4872 signed into law March 30, 2010)
  [http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=111_cong_bills&docid=f:hr4872eh.txt.pdf]

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

- Congressional Budget Office
  [http://www.cbo.gov/ftpdocs/114xx/doc11493/LewisLtr_HR3590.pdf]

Useful Information: North Carolina

- NCIOM: North Carolina data on the uninsured
  [http://www.nciom.org/data/uninsured.shtml]

- Sheps Center for Health Services Research, UNC-CH: State profiles of Medicaid and CHIP in rural and urban areas
  [http://www.shepscenter.unc.edu/medicaidprofiles/]

- Kaiser Family Foundation: State Health Facts
  [http://www.statehealthfacts.org/]

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