Implementing the Affordable Care Act: A 2014 Update

North Carolina Legislative
Committee on the Affordable Care Act
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NCIOM North Carolina Institute of Medicine
shaping policy for a healthier state

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

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Agenda

- **ACA has four main components**
  - **Health Insurance Coverage**
  - Population Health
  - Quality of Care
  - New Payment and Delivery Models
- **Cost implications**

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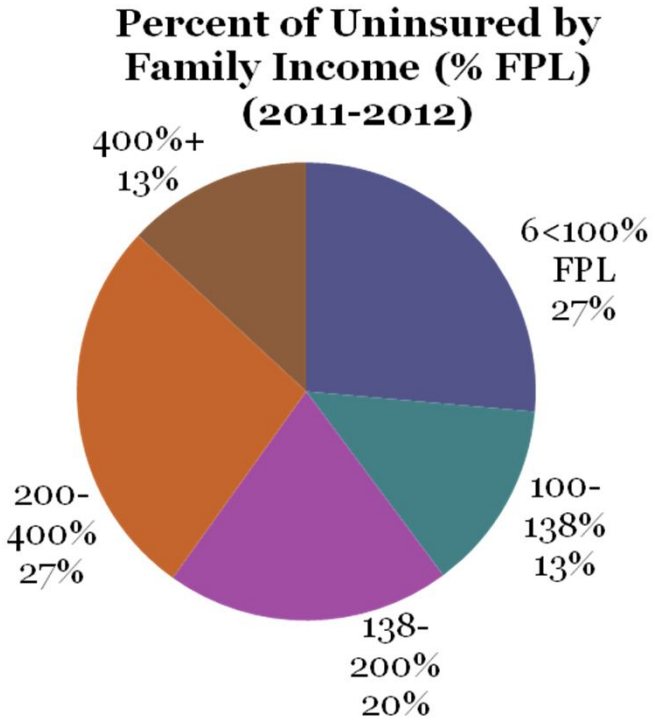
Insurance Coverage

- Approximately 1.6 million uninsured in North Carolina in 2012 (20% of the nonelderly population).
  - ~212,000 uninsured children (<age 18) in 2012 *(~134,000 of whom had incomes below 200% FPL)*
  - ~1.4 million nonelderly adults



US Census. Current Population Survey (CPS) Annual Social and Economic Supplement. Health Historical Tables. Table HIA-6. NCIOM: County level estimates of uninsured (2010-2011)

Being Uninsured Has An Adverse Impact on Health and Financial Wellbeing

- Being uninsured negatively impacts on the health of the uninsured
  - Less likely to get preventive services or help managing chronic illnesses
  - More likely to enter hospital for preventable conditions or with more severe health problems
  - More likely to die prematurely
- Being uninsured also impacts on financial wellbeing
  - More likely to report having trouble paying medical bills and having bills turned over to collection agencies
  - At greater risk of going into bankruptcy

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Kaiser Commission on Medicaid and the Uninsured. The Uninsured: A Primer. October 2013.

More about Uninsured Adults

- Three-fifths (80%) of the uninsured have been uninsured for more than one year
  - 12.7% were uninsured for 1-2 years
  - 15.6% were uninsured for 3-4 years
  - 51.8% were uninsured for 5 years or more or never had insurance

North Carolina Behavioral Risk Factor Surveillance Survey. 2012. http://www.schs.state.nc.us/schs/brfss/2012/nc/all/nc11q02.html.

ACA Coverage Requirements

- Most people will be required to have health insurance coverage in 2014.
  - *Public coverage*: Many low income people with incomes <138% Federal Poverty Levels (FPL) can obtain coverage through Medicaid, at state option.
  - *Employer-based coverage*: Most other people will continue to get health insurance through their employer.
  - *Individual (non-group) coverage*: Others will buy health insurance coverage on their own (some will qualify for subsidies in the health insurance Marketplace).

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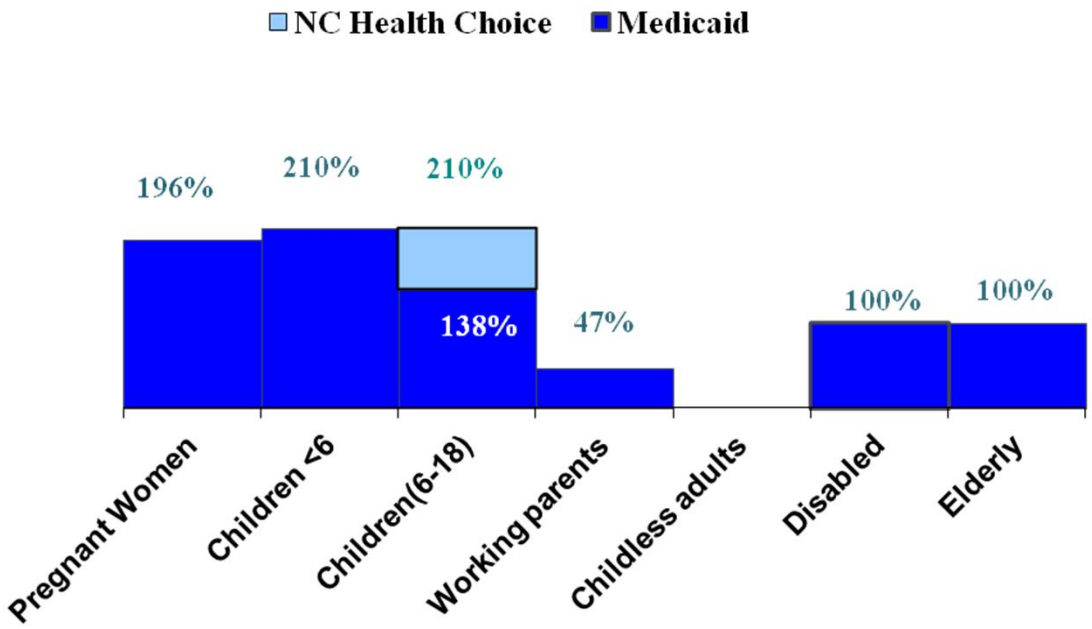
NC Medicaid Income Eligibility (2014)

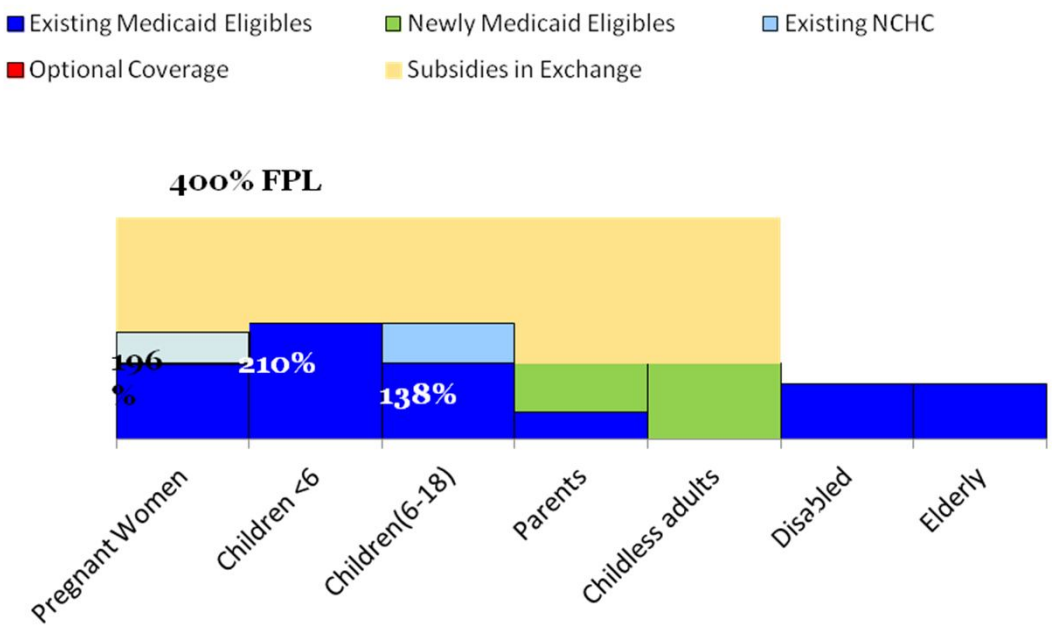
(Percent of Federal Poverty Level, based on new MAGI income levels)



- 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

CMS. State Medicaid and CHIP Income Eligibility Standards Effective January 1, 2014. Calculations for parents based on a family of three. Note: 100% of the federal poverty levels (FPL) (2014) = $11,670/yr. (1 person), $15,730 (2 people), $19,790 (3 people), $23,850 (4 people).

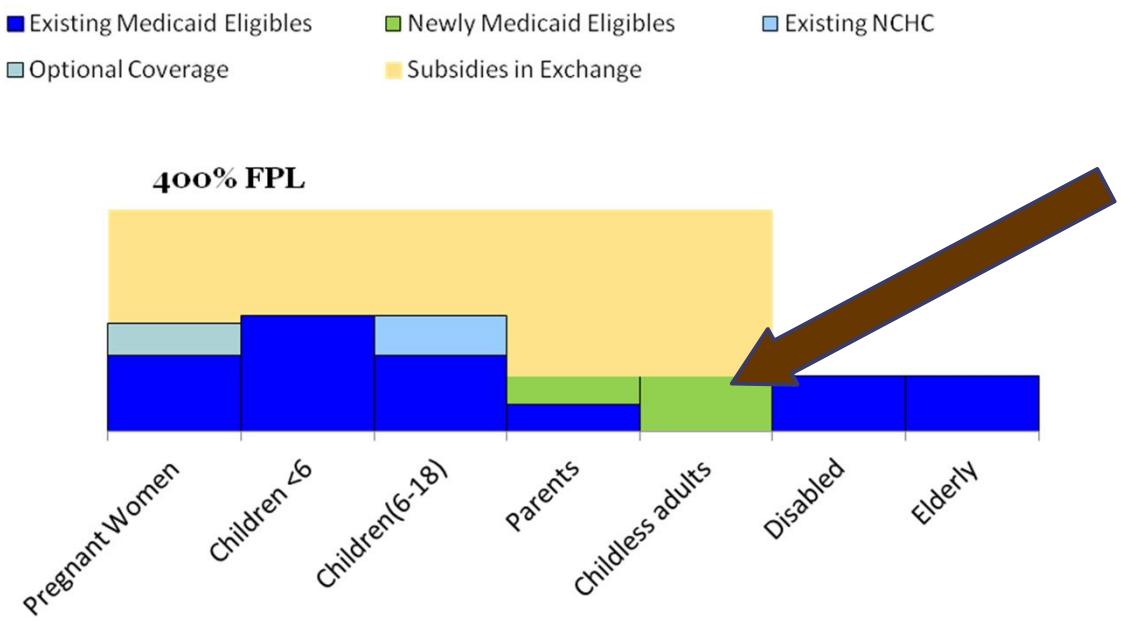
NC Medicaid Income Eligibility *if Expanded* (2014)



- *Approximately 560,000 uninsured adults would be income eligible for Medicaid expansion in 2014, if the state chose to expand Medicaid.*
- *Even without expansion to <u>new</u> eligibles, an additional 70,000-90,000 people likely to enroll (currently eligible but not enrolled).*

Note: 138% FPL (2014)= $16,105/yr (1 person), $21,707 (2 people), $27,310 (3 people), $32,913 (4 people).

NC Medicaid Income Eligibility *with no expansion* (2014)



- *Approximately 377,000 uninsured adults with incomes below the federal poverty level are not eligible for Medicaid under current Medicaid rules, and are not eligible for subsidies in the Exchange*

Note: 100% FPL (2014)= $11,670/yr (1 person), $15,730 (2 people), $19,790 (3 people), $23,850 (4 people).

Employer Responsibilities

- Employers with 50 or more full-time employees required to offer insurance to the full-time employee and his/her dependents 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)
- *Note: the requirement that employers offer health insurance coverage to their employees was delayed until 2015 for employers with 100+ employees or 2016 for employers with 50-100 employees.*

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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 above the tax filing threshold (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 and people with incomes so low that they do not pay taxes.

*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)
  - Subsidies tied to the second lowest cost "silver" plan
  - Cost sharing subsidies also available if family income between 100-250% FPL
- Poor people (<100% FPL) not eligible for subsidies to purchase coverage in the Marketplace.

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*Note: 100% FPL (2014)= $11,670/yr (1 person), $15,730 (2 people), $19,790 (3 people), $23,850 (4 people).

Federally Facilitated Marketplace

- In North Carolina, the federal government has created a health insurance marketplace for individuals. (Sec. 1311, 1321)
- The marketplace:
  - Provides standardized information (including quality and costs) to help consumers choose between qualified health plans.
  - Determines eligibility for the subsidy.
  - Facilitate enrollment for subsidized insurance, Medicaid and NC Health Choice through use of insurance navigators or certified application counselors.
- The online portal for the small business marketplace (SHOP) has not been operationalized.
  - Small businesses can apply via a paper application or agent/broker.

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Other Insurance Consumer Protections

- Insurers may not deny coverage or charge people more because of their pre-existing health status. (Sec. 1201)
- Better financial protections for insured
  - Cannot impose annual or lifetime limits in health plans. (Sec. 1001, 10101)
  - Health plans must have annual limits on out of pocket payments (no more than $6,350/individual; $13,700/family in 2014).
- More comprehensive coverage of services. Examples include:
  - Clinical preventive service offered with no cost sharing.
  - Coverage for mental health and substance abuse problems covered like coverage for other physical health problems.

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Enrollment Process

- ACA creates a “no wrong door” enrollment system so people can enroll in Medicaid, NC Health Choice, or private coverage through the Marketplace.
- Initial enrollment period runs from October 1, 2013 through March 31, 2014.
  - If you fail to enroll during open enrollment period, you generally will not be eligible until the next open enrollment period (November 2014), with certain limited exceptions.

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Special Enrollment Periods

- Some of the criteria to enroll in the Marketplace outside of open enrollment include:
  - Loss of minimum essential coverage (eg, Medicaid, CHIP, employer sponsored insurance)*
  - Gain a dependent
  - Loss of dependent status (eg, aging off parents plan when they turn 26)
  - A permanent move to a new marketplace state
  - Release from jail or prison
  - Change in status to citizen or lawful permanent resident
  - Exceptional circumstances, including people who were in the Medicaid gap who now have incomes above 138% FPL

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North Carolina Enrolling More than Most States into Marketplace

- North Carolina has the fifth highest enrollment* into the marketplace as of March 1, 2014: 200,546 (October 1, 2013-March 1, 2014)
- North Carolina was tied for the 6th largest enrollment as percentage of the uninsured and those previously covered by nongroup insurance as of March 1 (9.8%).
- North Carolinians qualified for $606 million in health insurance subsidies. (Levitt L, et al. How Much Financial Assistance Are People Receiving Under the Affordable Care Act. Kaiser Family Foundation. March 2014. Issue Brief).

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*Enrollment defined as selecting a health plan. The federal government does not collect data on the number of people who paid the premiums.

Outreach and Enrollment Assistance Led to Growth in Medicaid

- There has been a growth of 68,675 people in Medicaid or NC Health Choice between March 2013 and March 2014.
- In addition, as of April 16, 2014 there were 118,913 MAGI Insurance Affordability applications pending (yet to be processed) so Medicaid enrollment is likely to grow further.

Actual Medicaid and NC Health Choice Enrollment (March 2013, 2014)

	Medicaid	NC Health Choice	Total
March 1, 2013	1,582,046	151,446	1,733,492
March 1, 2014	1,723,050	79,117	1,802,167

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Source: Division of Medical Assistance.

ACA Estimated to Reduce Uninsured

- A RAND study estimated that the numbers of nonelderly uninsured adults declined by 9.3 million between Sept. 2013-March 2014, reducing the uninsured adults from 20.5% to 15.8%
  - Medicaid enrollment increased by 5.9 million.
  - Enrollment in employer sponsored insurance grew by 8.2 million.
  - Enrollment in the Marketplace grew by 3.9 million (Note: this is lower than the federal estimates, in part because the survey did not capture all the people who applied in March).
  - Less than 1 million people who previously had insurance in the individual market lost their coverage.

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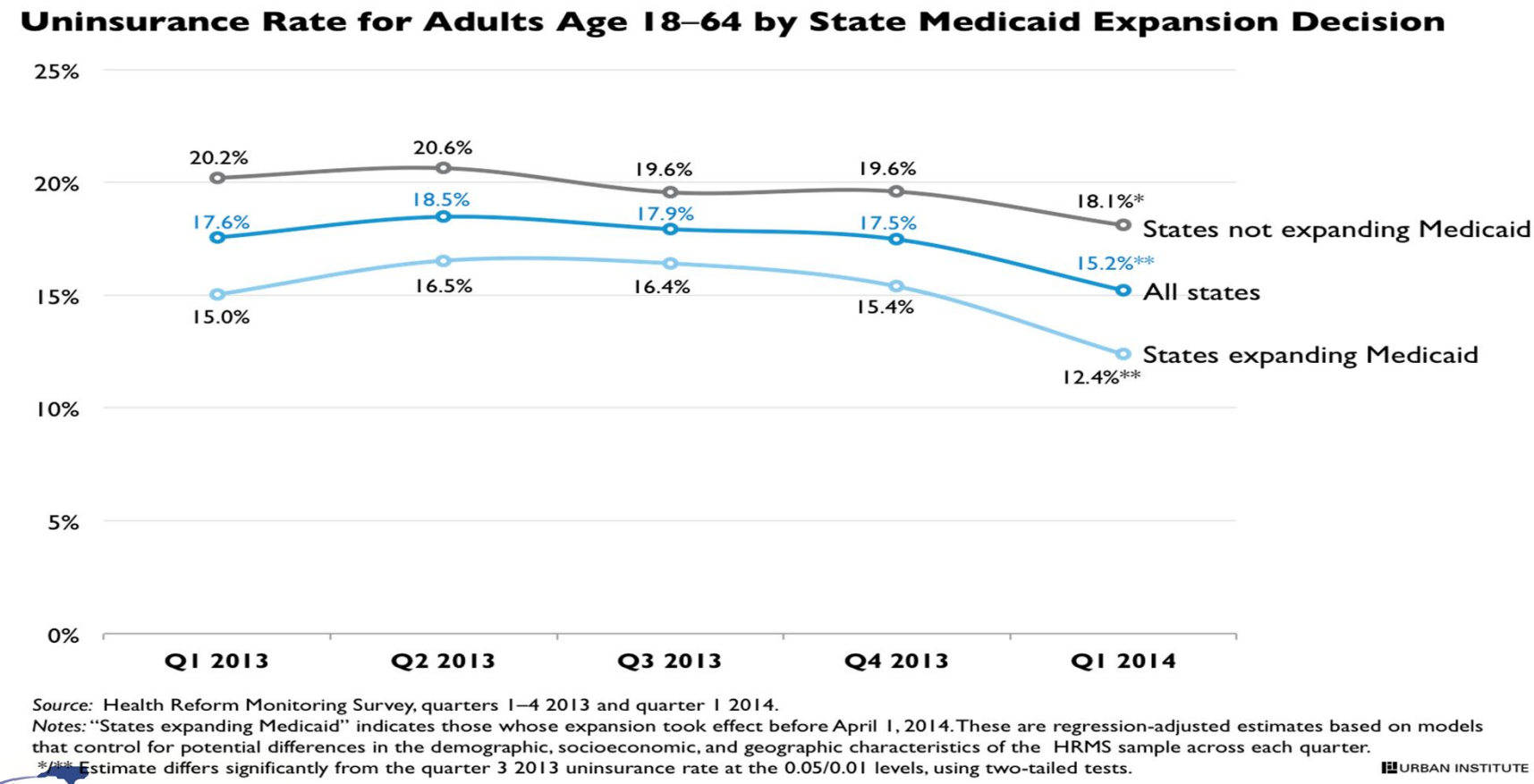
Carman KG, Eibner C. Changes in Health Insurance Enrollment Since 2013. RAND. http://www.rand.org/content/dam/rand/pubs/research_reports/RR600/RR656/RAND_RR656.pdf

Urban Institute Also Shows Decline in Uninsured (Uninsured Adults 18-64)



Urban Institute. Health Reform Monitoring Survey.
http://hrms.urban.org/quicktakes/changeInUninsurance.html

Costs of the ACA

- According to the Congressional Budget Office, the ACA reduces the federal deficit
  - Repealing the ACA would result in an increase in the budget deficit by $109 billion between 2013-2022. (Letter to the Honorable John Boehner, July 24, 2012. http://www.cbo.gov/sites/default/files/cbofiles/attachments/43471-hr6079.pdf)
- However, CMS actuaries estimate that the ACA will increase *overall* health care spending
  - By 2022, the ACA is projected to reduce the uninsured by 30 million, but add approximately 0.1 percentage point to average annual health care spending ($621 billion over the 10 year period). (CMS, National Health Expenditure Projections 2012-2022. http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/downloads/proj2012.pdf)

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Questions

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For More Information

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  - **Population Health**
  - Quality of Care
  - New Payment and Delivery Models
- Cost implications

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Population Health

- North Carolina ranks 35th of the 50 states and DC in population health measures in 2013. (America's Health Rankings, 2013)
- North Carolina was ranked:
  - 33rd in obesity
  - 33rd in adult smoking
  - 33rd in cancer deaths
  - 32nd in cardiovascular deaths
  - 40th in infant mortality deaths
  - 36th in premature deaths

America's Health Rankings. 2013. http://www.americashealthrankings.org/NC/2013.

Affordable Care Act

- Prevention and Public Health Trust Fund to invest in prevention, wellness, and public health activities (Sec. 4002)
  - ACA initially appropriated $500 million in FY 2010 increasing to $2 billion over time.*
  - Creates a national prevention, health promotion, and public health council to establish public health and prevention priorities for the country (Sec. 4001)
  - Priority areas include: tobacco free living, preventing drug abuse or excessive alcohol use, health eating, active living, injury and violence free living, reproductive and sexual health, and mental and emotional wellbeing.

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* Will reach $2 billion in 2022.
http://www.healthcare.gov/prevention/nphpphc/strategy/report.pdf.

North Carolina Received New Prevention Funds

- North Carolina received ACA funds for:
  - Multifaceted interventions for tobacco free living, active living and healthy eating
  - Maternal, infant, and early childhood home visiting programs designed to reduce infant mortality, improve early child health and maternal wellbeing

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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)

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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. (Authorizes $75M for each FY 2010-2014; Sec. 3013-3014)
  - Collection and public reporting of quality data. (Sec. 3015, 10305, 10331)
  - Moving towards paying providers on the basis of quality of care provided, not just volume (called “value-based purchasing”).

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Example of New Quality-Related Payment Policies: Excess Readmissions

- Hospitals with excess readmissions (risk-adjusted 30-day readmission rates) are receiving lower Medicare payments (Sec. 3025)
  - Tracking readmissions for pneumonia, heart failure, and heart attacks. Add'l health conditions will be added in 2015.
  - Payments reduced by up to 1% (FFY 2013), 2% (FFY 2014), and 3% (FFY 2015)
  - In NC, 69% of eligible hospitals were penalized (average reduction in payments across all NC hospitals: 0.33%) (FFY 2014).
    - Nationally 66% of hospitals penalized with average reduction of DRGs by 0.38% of DRG.

Kaiser Health News. Penalty Readmission by State Year 2. http://www.kaiserhealthnews.org/Stories/2013/August/02/readmission-penalties-by-state-year-two.aspx.

Example of New Quality-Related Payment Policies: Hospital Value Based Purchasing (VBP) Program

- Beginning in 2013, hospitals had their Medicare payments increased or reduced depending on how well they perform on certain quality measures.
  - Payments or penalties based on how well hospital performs to peer institutions, and how much they improve over a baseline.
  - Hospitals examined on process of care, patient experience with care, outcomes, and efficiency measures
- In North Carolina, 63% of hospital received a bonus, 37% received a penalty. Average was increase of 0.9% in payments.

Physician Quality Reporting and Value-Based Purchasing

- Physicians that participate in Medicare will be required to report quality measures beginning in 2015, or have Medicare payments reduced by 1.5% (2015) and 2% (2016 and thereafter) (Sec. 3002)
- Medicare will begin "value-based payments" to some physicians beginning in 2015 based on quality and cost measures (Sec. 3007)
  - Some physicians will be paid more, others less, based on quality and costs
  - Payments will be cost neutral to federal government
- Data will be made available to the public on a physician compare website (Sec. 10331)

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Quality Comparison Data

- The Centers for Medicare and Medicaid Services have developed similar quality reporting and incentive systems for: nursing homes, home health, dialysis, and is developing a value-based purchasing program for physicians.
- Data available:
  - Hospitals: http://www.medicare.gov/hospitalcompare/search.html
  - Nursing homes: http://www.medicare.gov/nursinghomecompare/search.html
  - Physician (data under development): https://data.medicare.gov/data/physician-compare (*Note: physician data not yet easily searchable by consumers)*

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New Payment and Delivery Models

- ACA includes funding to test new health care delivery and payment models in Medicare and Medicaid to improve quality, overall population health, and reduce unnecessary health care expenditures
- Some of the new models being tested in North Carolina (and nationally) include: patient centered medical homes, bundled payments, and accountable care organizations.
  - Once new models are shown to work in different communities and with different delivery systems, the Secretary of HHS has the authority to implement broadly in other communities.

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Patient Centered Medical Homes

- Primary care that is comprehensive and covers care across the lifespan, incorporates a team of health professionals, is patient centered, incorporates information support to improve quality and outcomes, and includes payment mechanisms to promote better care coordination across professionals.
  - Community Care of North Carolina is nationally recognized as a PCMH for the Medicaid population.
  - North Carolina has the 2nd highest number of NCQA PCMH practice recognitions, and the 3rd highest number of provider recognitions.

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Bundled Payments

- The CMS bundled payment model pays a group of providers for a episode of care (eg, major joint replacement, heart attack, diabetes).
  - Providers are incentivized to better coordinate care because if the total payments to providers are less than the “target” amount and the providers meet certain quality measures, then the providers can share savings.
  - Model being tested in Blue Ridge Healthcare System (Morganton), Duke University Hospital (Durham), First Health Moore Regional Hospital (Moore), Amedisys Home Health of Fayetteville, Chapel Hill, Louisburg

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Accountable Care Organizations

- An ACO is an organization of eligible providers and suppliers who are accountable for the quality, cost, and overall care of the an assigned group of enrollees (eg, Medicare beneficiaries).
- ACOs can share Medicare savings with the federal government IF:
  - The ACO complies with all the ACO requirements, AND
  - The ACO meets quality standards, AND
  - The ACO has measured savings below a calculated threshold
- North Carolina testing 2 models: Shared Savings Program, Advance Payment Model (for rural)

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North Carolina ACOs

- Some of the Medicare ACOs include:
  - Coastal Carolina Quality Care (New Bern)
  - Cornerstone Health Care (Triad)
  - Duke Connected Care
  - Physicians Healthcare Collaborative (Wilmington)
  - Triad Healthcare Network
  - WakeMed Key Community Care (Raleigh)
  - Accountable Care Coalition of Caldwell County
- Some of these organizations are also developing ACO payment contracts with commercial payers

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Important Contact Information

- Federal website to apply:
  - www.healthcare.gov
    cuidadodesalud.gov (for Spanish)
- North Carolina website to apply
  - Epass.nc.gov
- Paper applications can be accessed at:
  http://marketplace.cms.gov/getofficialresources/publications-and-articles/publications-and-articles.html
- To make appointment with NC navigator or Community Health Center for assistance
  - 1-855-733-3711
  - Federal website: localhelp.healthcare.gov

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Enrollment Assisters

- Different types of people will be trained to help people enroll:
  - *Navigators.* Federal government contracted with different organizations across state to provide education, outreach, and enrollment facilitation.
  - *Community health centers.* Community health centers received federal grants to hire people to help with enrollment.
  - *Certified application counselors.* Trained volunteers.
  - *Agents/brokers.*
- All must be trained and certified by the federal government before they can help people enroll into coverage.

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Simplified Application and Enrollment Process

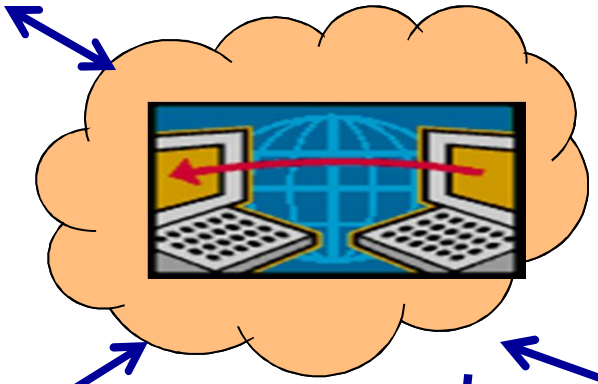
Step 2: Verify identify, income, citizenship, and immigration status through online data from federal databases

Step 3: Screen to determine if potentially eligible for Medicaid/CHIP

Step 4 a: If no, determine eligibility for subsidies, and pick an insurance plan

Step 4b: If yes, application sent to NC DHHS. Use federal and state administrative databases to determine eligibility. If eligible, enroll in Medicaid/ NC Health Choice

Federal Marketplace



Step 1: Person can apply by phone, online, or with personal help

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Same process can work in reverse if person first applies at DSS

Sliding Scale Subsidies

Individual or family income	Maximum premiums (Percent of family income)	Out-of-pocket cost sharing:*	Out-of-pocket cost sharing limits (2014)**
100-133% FPL	2% of income	6%	$2,250 (ind)/$4,500 (more than one person)
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%	$6,350/ $12,700
300-400% FPL	9.5%	30%	$6,350/ $12,700
400% + FPL	No limit	30%	$6,350 / $12,700

*Out-of-pocket cost sharing includes deductibles, coinsurance, and copays, but does not include premiums, noncovered services, or services obtained out of network. Subsidies tied to the second lowest cost silver plan in the market.

Example of Subsidies: Smith Family

- Assume Smith family of 4 earns $50,000/year (212% FPL) and lives in Greenville (Region 14).
  - Mike (age 40), Sally (age 35), Tim (age 13), Becky (age 6)
  - Second lowest cost silver plan will cost: Mike ($297.71/mo), Sally ($284.66/mo.), Tim and Becky ($147.92/mo. each) for a total of $878.22/mo. (This assumes no one is a smoker.)
  - They are required to pay $3,360/yr. or $280/month (6.72% of their income) for the second lowest cost silver plan
  - Therefore, the amount of subsidy that is available is: $598.22/mo.
  - In addition, the Smith family is eligible for a cost sharing subsidy, which would reduce the amount they pay out of pocket to 27% on average (from 30%), and would reduce the out-of-pocket limits to $5,200/ind. or $10,400 for a family.

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Smith Family

- Smiths can take the $598.22 subsidy and purchase:
  - Lowest cost silver plan ($868.23), which would reduce their premium from $280.42/mo. to $270.01.
  - Lowest cost bronze plan ($740.43) which would reduce their premium to: $142.21.
    - However, if they use their subsidy to purchase a bronze plan, they will *not* be eligible for a cost sharing subsidy.
  - Lowest cost gold plan ($1,063.67) which would increase their premium to $465.45/mo. but decrease their out of pocket costs to 20%.

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Changes in Insurance Coverage for Adults (Rand, 2013-2014)

2014

2013	No Ins.	ESI	M'caid	Ind. Market	Market -place	Other	Totals 2013
No Ins.	26.2 (+/-3.7)	7.2 (+/-2.2)	3.6 (+/-1.3)	0.5 (+/-0.4)	1.4 (+/-0.7)	1.8 (+/-1.0)	**40.7** (+/-4.4)
ESI	2.1 (+/-1.3)	102.4 (+/-5.3)	0.9 (+/-0.7)	1.3 (+/-0.7)	0.4 (+/-0.3)	1.7 (+/-0.7)	**108.7** (+/-5.2)
M'caid	1.0 (+/-0.7)	1.3 (+/-0.9)	9.2 (+/-2.0)	0.1 (+/-0.1)	0.2 (+/-0.2)	0.7 (+/-0.5)	**12.3** (+/-2.3)
Ind. Market	0.7 (+/-0.9)	1.8 (+/-1.0)	0.2 (+/-0.2)	5.4 (+/-1.5)	0.8 (+/-0.4)	0.5 (+/-0.7)	**9.4** (+/-2.1)
Other	1.5 (+/-1.0)	4.2 (+/-1.6)	4.3 (+/-2.0)	0.6 (+/-0.5)	1.2 (+/-0.7)	15.6 (+/-2.6)	**27.5** (+/-3.7)
Total 2014	**31.4** (+/-4.1)	**116.9** (+/-5.1)	**18.2** (+/-3.0)	**7.8** (+/-1.8)	**3.9** (+/-1.1)	**20.3** (+/-3.0)	**198.5**

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Carman KG, Eibner C. Changes in Health Insurance Enrollment Since 2013. RAND. http://www.rand.org/content/dam/rand/pubs/research_reports/RR600/RR656/RAND_RR656.pdf

2014 Federal Poverty Level (Year)

Family Size	100% Federal Poverty Level (FPL)	138% FPL	200% FPL	250% FPL	400% FPL
1	$11,670	$16,105	$23,340	$29,175	$46,680
2	$15,730	$21,707	$31,460	$39,325	$62,920
3	$19,790	$27,310	$39,580	$49,475	$79,160
4	$23,850	$32,913	$47,700	$59,625	$95,400
Each add'l	$4,060	$5,603	$8,120	$10,150	$16,240

Office of the Assistant Secretary for Planning and Evaluation. 2014 Poverty Guidelines. http://aspe.hhs.gov/poverty/14poverty.cfm