The Affordable Care Act and North Carolina

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Roadmap

- What is in the ACA as it relates to healthcare/ insurance? (15 min.)
- Major changes to ACA since enactment (5 min.)
- Major impacts of the ACA in nation and NC (15 min.)
- Considerations for the future (10 min.)

Outline

- What is in the ACA related to healthcare/ insurance?
  - Expanded coverage
  - Medicaid changes
  - Medicare changes

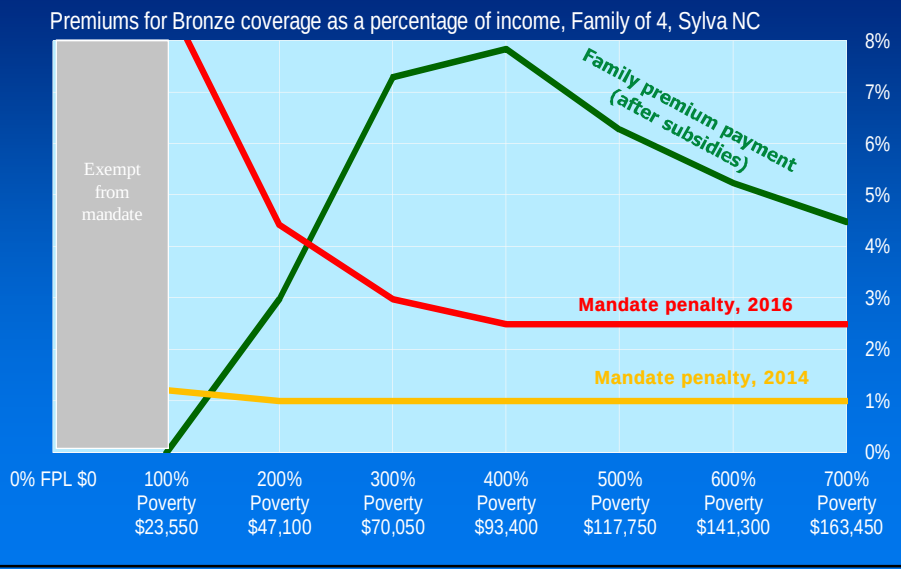
Expanded Coverage

- Breadth and depth of coverage to be expanded using carrots and sticks
- Individual mandate
- Principal sources of expanded coverage
  - Medicaid
  - Health exchanges (marketplaces)
  - Employer sponsored insurance (ESI)

Individual Mandate

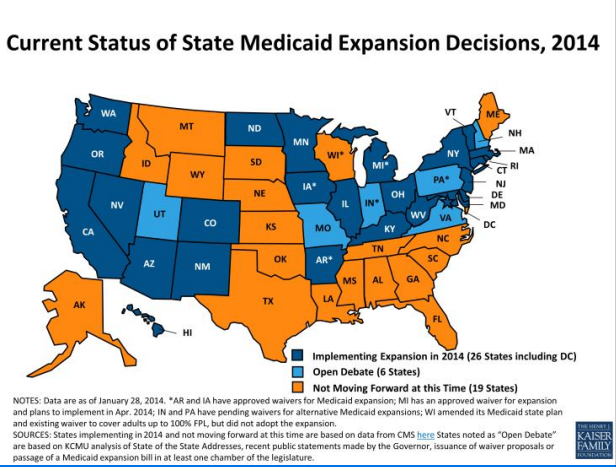
- Exemptions (~40% of uninsured)
  - Members of certain religious groups
  - Native American tribes
  - Undocumented immigrants
  - Incarcerated individuals
  - People below poverty
  - People for whom health insurance is considered unaffordable (where insurance premiums after employer contributions and federal subsidies exceed 8% of family income)
- Individual mandate penalty
  - 2014: Greater of $95/adult & $47.50/child or 1% of income
  - 2015: Greater of $325/adult & $162.50/child or 2% of income
  - 2016: Greater of $695/adult & $347.50/child or 2.5% of income
- Sole enforcement mechanism: deduct from tax refunds

Mandate Penalty Generally Below Cost of Coverage

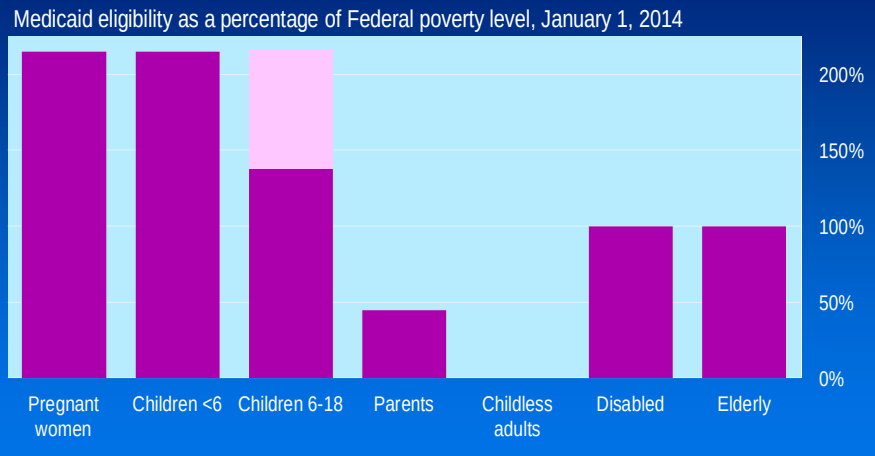


States Expanding Medicaid

- Cover all non-elderly below 138% poverty
- Categorical distinctions eliminated
- Enhanced Federal matching funds
  - 100% (2014-16)
  - 95% (2017)
  - 94% (2018)
  - 93% (2019)
  - 90% (2020-???)

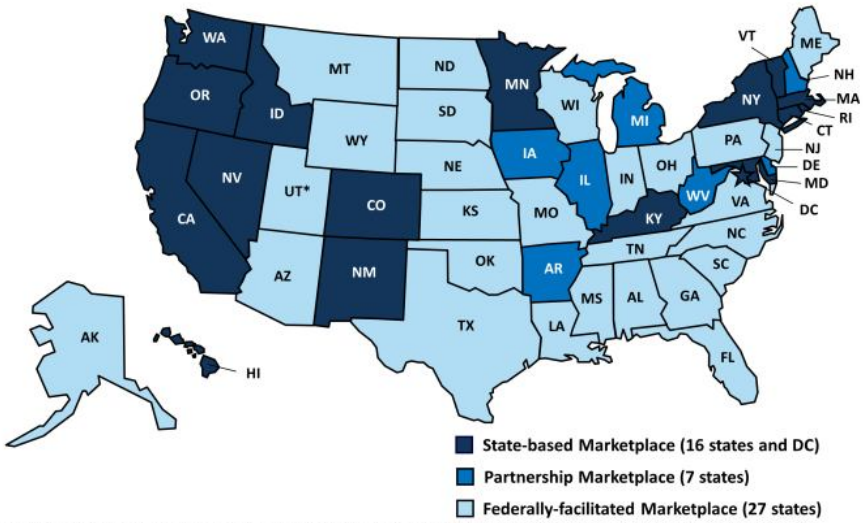


NC Medicaid Eligibility Standards



Source: Kaiser Family Foundation. Statehealthfacts.org. Parents eligibility based on a family of three. Figures include 5% income disregard. Available at: www.statehealthfacts.org (accessed March 12, 2014).

State Health Insurance Marketplace Decisions, 2014



* In Utah, the federal government will run the marketplace for individuals while the state will run the small business, or SHOP, marketplace.

SOURCE: State Decisions For Creating Health Insurance Marketplaces, 2014, KFF State Health Facts: http://kff.org/health-reform/state-indicator/health-insurance-exchanges/.

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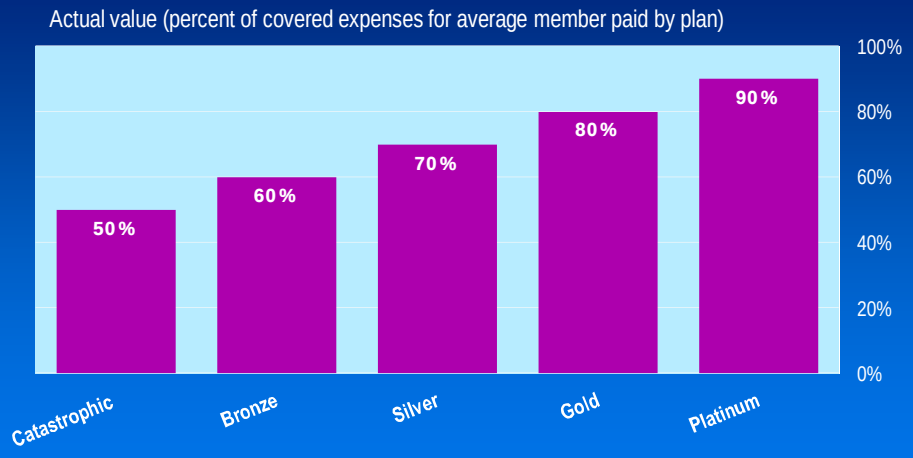
Health Insurance Exchanges (Marketplaces)

- Individuals without other coverage and small groups will be able to purchase coverage through Exchanges starting 2014
  - Separate Exchange for individuals and small groups (SHOP)
  - Self-employed may use either Exchange
- Eligibility to use SHOP Exchanges
  - States *may* define small group as up to 100 employees in 2014-2015
  - States *must* define small employers as up to 100 starting 2016
  - States *may* expand exchanges to even larger businesses starting 2017
  - In 2014, small firms can only offer employees 1 plan through SHOP
- Private exchanges may operate in parallel to state- and federally-run Exchange

Standardized Benefits

- Essential health benefits (10 categories of services)
- Free preventive health services
- Maximum limits on cost-sharing
- No lifetime or annual dollar limits on benefits
- Minimum actuarial value=60%

Standardized Coverage Under ACA



Note: Premium subsidies can be applied to any plan EXCEPT catastrophic.
Cost-sharing subsidies available only to those selecting Silver coverage.

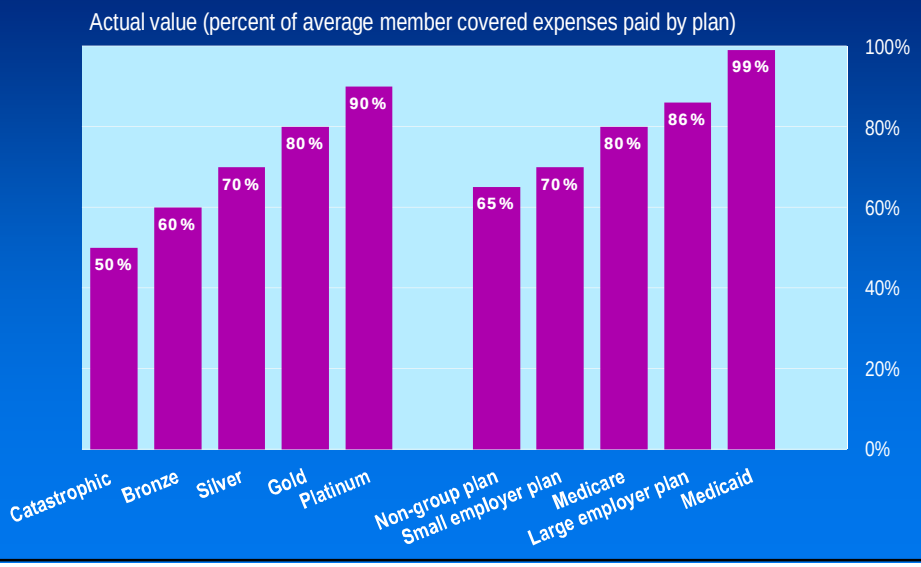
Illustrative Plan Designs for Single Coverage (2014)

Tier	Actuarial Value	Deductible	Patient Coinsurance	Out-of-Pocket Limit
Bronze 1	60%	$4,375	20%	$6,350
Bronze 2	60%	$3,475	40%	$6,350
Silver 1	70%	$2,050	20%	$6,350
Silver 2	70%	$650	40%	$6,350

Note: Gold (AV=80%) and Platinum (AV=90%) plans also would have OP limits of $6,350. Also, individuals under 30 may purchase a "catastrophic" plan that covers only 3 primary care visits and required preventive services before the deductible of $6,350; actuarial value for such plans typically would be < 60%.

NOTES: http://www.kff.org/healthreform/upload/8303.pdf
SOURCE: Kaiser Family Foundation

Comparison of ACA Standardized Coverage with Current Plans



Subsidies Available Exclusively Through ACA Exchanges

- Premium subsidies
  - Pegged to 2nd lowest cost Silver plan; can be used for any plan (except catastrophic)
  - Advance premium tax credits for incomes 100-400% of poverty
  - Subsidies reduce net cost of premiums to 2%-9.5% of family income
- Cost sharing subsidies (restricted to Silver plans)
  - Limited to families from 100-250% FPL
  - Increases plan actuarial value from 70% to between 73%-94%
- Temporary small business tax credits

Cost of Premiums on HIX for Family of Four (2016)

Percent of Federal Poverty Level (FPL)	Income Level	Percent of Income	Maximum Annual Premium
400%	$96,000	9.93%	$9,530
300%	$72,000	9.93%	$7,148
200%	$48,000	6.58%	$3,160
100%	$24,000	2.09%	$502

NOTES: Estimated average premium for 2nd lowest cost Silver plan = $14,100.
SOURCE: Urban Institute calculations

Employer-Sponsored Insurance: Small Employers

- No employer mandate for <50 (individual mandate still applies)
- Employees can buy subsidized coverage on non-group Exchanges
- *If* firm offers coverage, standardized benefits mandated
- Employers can buy on SHOP Exchanges. Recall:
  - States *may* define small group as up to 100 employees in 2014-2015
  - States *must* define small employers as up to 100 starting 2016
  - States *may* expand exchanges to even larger businesses starting 2017

Employer-Sponsored Insurance: Large Employers

- Employer mandate to offer affordable coverage to FT workers (30+ hrs.) in firms with 50+ FTE workers
- Penalties if employees buy subsidized plan on non-group Exchange
  - ~$2,000/worker if firm does not offer coverage
  - ~$3,000/worker receiving subsidized Exchange coverage if firm's coverage either is inadequate (AV<60%) or unaffordable
- Modest added benefits requirements
- States *may* permit larger employers to buy on SHOP Exchanges

Medicaid Changes

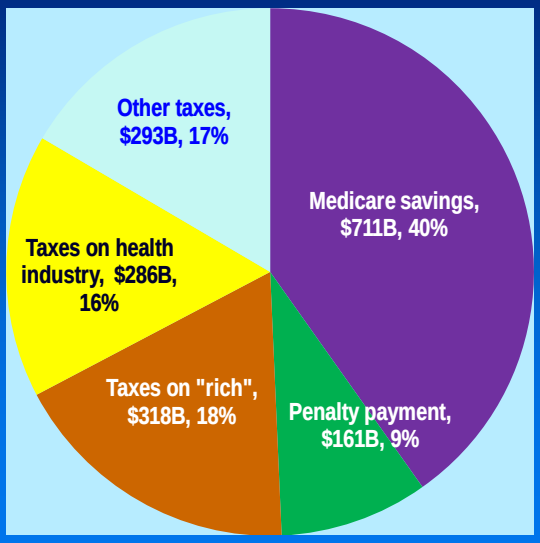
- Enhanced payments for primary care doctors (2013-2014 only)
- Cuts in Disproportionate Share (DSH) payments to hospitals
- Patient-centered medical care homes for chronically ill
- Demonstration projects
  - Bundled payments
  - Global capitated payments to safety net hospitals
  - Pediatric accountable care organizations
- Various changes to LTC (e.g., new options for home and community-based care waivers)

Medicare Changes: Benefits Enhancements

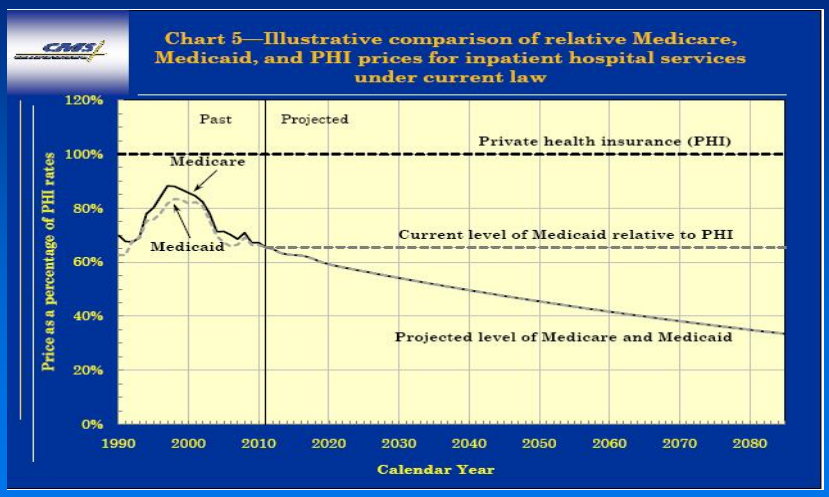
- Eliminate cost-sharing for preventive services
- Annual comprehensive risk assessment
- Eliminate donut hole in Part D prescription drug coverage

40% of ACA will Be Financed Through Medicare Savings

Major sources of revenue for ACA 2013-2022 $1,764B

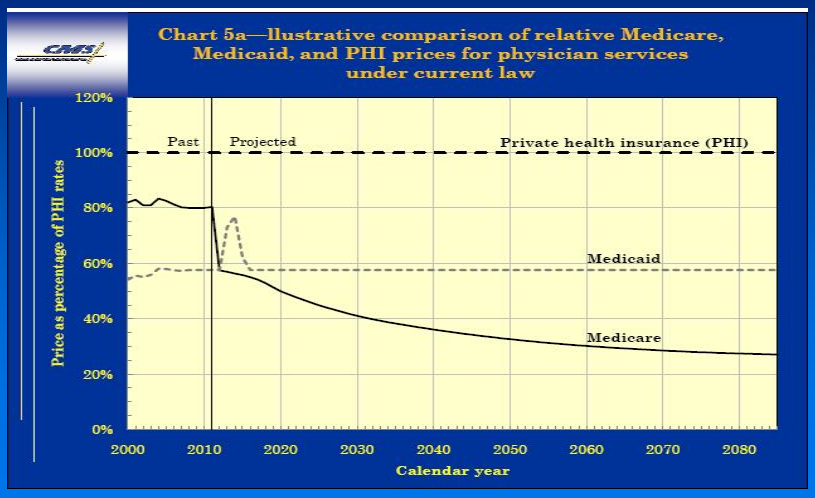


Medicare Changes: Hospital Payment Cuts



Source: Richard Foster, The Financial Status of Medicare. Presentation for the American Enterprise Institute, May 16, 2011.

Medicare Changes: Physician Payment Cuts



Source: Richard Foster, The Financial Status of Medicare. Presentation for the American Enterprise Institute, May 16, 2011.

Medicare Changes: Medicare Advantage Plan Cuts

- Cuts ~$200 billion from Medicare Advantage plans over next decade
- Cuts = $13,000 per MA enrollee over 10 years
- Cuts will increase premiums by $65-145 per month for some MA enrollees
- Medicare actuary projects ~half of MA plan members in 2017 will lose coverage due to cuts
  - MA covers 15 million (~25% of Medicare enrollees)
  - MA members are disproportionately low income minorities

Medicare Changes: Other Potential Cost-saving Measures

- Note: Medicare cuts amount to >10% of projected Medicare spending over next decade
- Demonstration projects
  - Accountable care organizations (Medicare Shared Savings Program)
  - Pay for performance
  - Bundled payments
  - Independence at home
- Comparative effectiveness research
- IPAB-Independent Payment Advisory Board

Outline

- What is in the ACA related to healthcare/ insurance?
- Major changes to ACA since enactment
  - Statutory Changes (15)
  - Supreme Court (2)
  - Administrative Changes (21)

Statutory Changes

- CLASS Act eliminated (long term care program)
- 1099 reporting requirement scrapped
- Various components defunded (Consumer Operated and Oriented Plan=COOPs) or funding reduced

Changes Made by Supreme Court

- Individual mandate violates Commerce Clause
  - However, it can be construed as a tax, which is constitutionally permissible
  - Tax means optional (read: lower) compliance with mandate
- Threat to take away ALL federal Medicaid funds from states refusing Medicaid expansion is unconstitutionally coercive
  - Medicaid expansion is optional for states
  - Only 27 states currently moving forward

Administrative Changes

- Employer mandate delayed
  - Large employers (>100 workers) 1 yr. delay (until 2015)
  - Large employers can cover only 70% of workers in 2015; 95% in 2016 and after
  - Medium employers 50-99 workers) 2 yr. delay (until 2016)
- Non-qualified health plans extended 2 years (through 2016)
- Cancelled plan members qualify for catastrophic hardship waiver until 2016
- Substantial loosening of individual mandate requirements until 2016
- SHOP exchanges: choice of plans delayed until 2015

Outline

- What is in the ACA related to healthcare/ insurance?
- Major changes to ACA since enactment
- Major impacts of the ACA in nation and NC
  - Coverage
  - Health spending
  - Quality/health status
  - Employment
  - Federal budget deficit

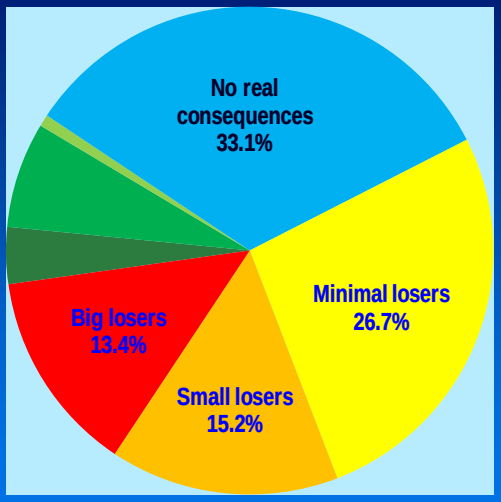
Winners and Losers from ACA

Minimal winners 0.8%

Small winners 7.0%

Big winners 3.8%

300 million total population in 2013 (excludes unauthorized immigrants



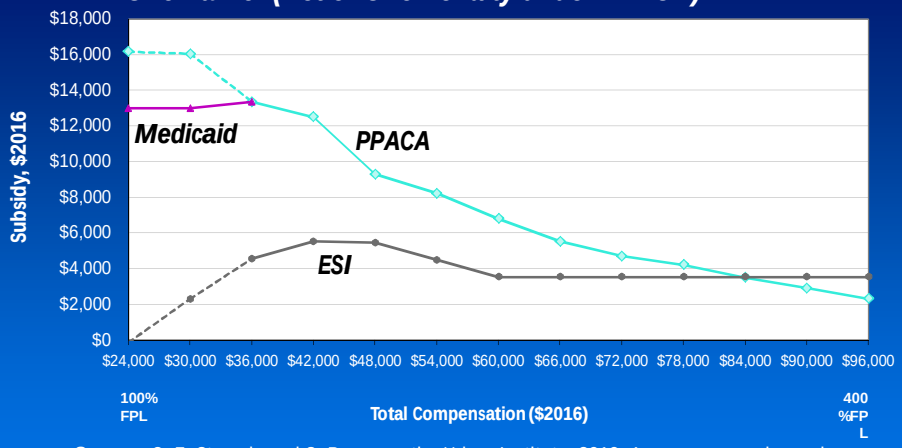
Note: figures calculated assuming all unrepealed components of ACA including employer mandate had been completely and fully Implemented by 2013.

Source: all figures estimated by Christopher J. Conover, Duke University

Impact on Coverage: Uninsured Risk

- **Reduction in uninsured**
  - *Long Run*: By design, ACA only reduces # uninsured by 45%
  - *2014*: Latest CBO projections show 23% reduction in uninsured in 2014
  - *Today*: Chances are 50:50 whether the law has actually reduced the number of uninsured.
- About half of uninsured reduction due to Medicaid expansion
- In NC:
  - 1.5 million daily uninsured
  - ACA could reduce # by about 200,000 by end of 2014
  - ACA could reduce # by about 400,000 by end of 2016

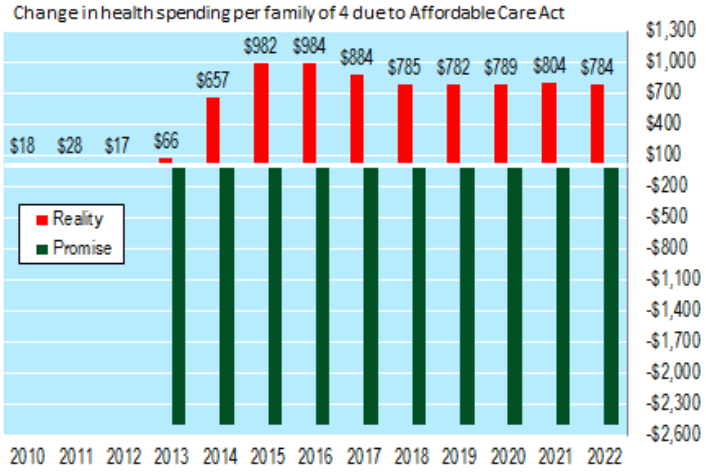
Subsidy under PPACA and ESI in 2016, Family of Four with One Earner *(Net of One Penalty under PPACA)*



Source: C. E. Steuerle and S. Rennane, the Urban Institute, 2010. Assumes a premium value of $14,100 and estimated cost share of $5,000 for a family of four in 2016. Based on CBO estimates for the Patient Protection and Affordable Care Act. Updated employer penalty, premium and cost share subsidy information for Reconciliation Bill from the Kaiser Family Foundation. Medicaid premiums based on the Health Policy Center's estimates of premiums for new Medicaid enrollees. All costs, including the value of the penalty, are calculated in 2016 dollars. 100% FPL is estimated to be $24,000 for a family of 4 in 2016.

Health Spending

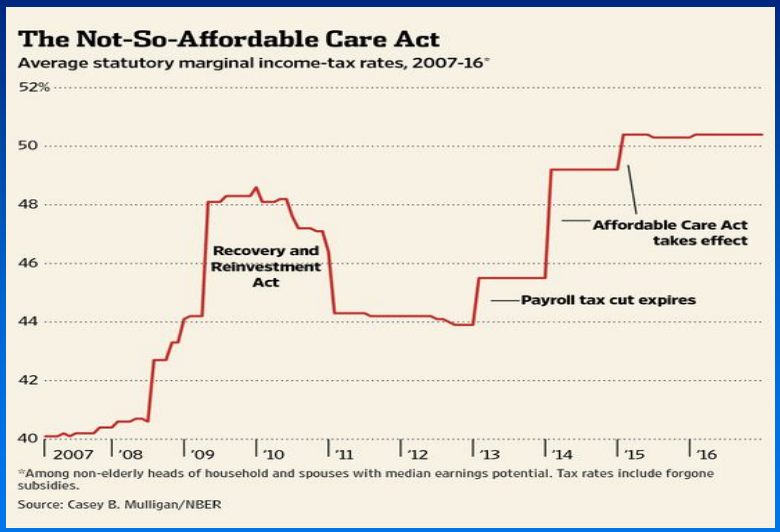
Obamacare will add $7,450 to average health spending for a family of 4 between 2014 and 2022



Quality/Health Status

- Evidence on mortality benefits from expanded coverage is thin, especially as it relates to Medicaid
- Various quality initiatives unproven to date:
  - Bundled payments
  - Independence at Home
  - Value-based purchasing (pay for performance)
- Potential adverse effects on health/mortality
  - Every $1,000 reduction in Medicare reimbursements to hospitals was associated with a 6-8% increase in hospital mortality rates
  - 1 million lost life years annually due to tax on medical devices

The Adverse Effects of ACA on Work Incentives



Source: Casey Mulligan, How ObamaCare Wrecks the Work Ethic, Wall Street Journal, October 2, 2013

Employment

- Up to 10 million FT workers shifted to PT status
- 2.9 million fewer FTE workers
- Approximate NC impact
  - ~300,000 FT workers shifted to PT status
  - ~90,000 FTE workers

Federal Budget Deficit

- ACA will add $2T to deficit in its first 2 decades
- Federal government share of GDP will rise 59% over next 75 years
- Health spending will account for 85% of that increase
- Federal unfunded liabilities = $200 trillion
- Implications for NC
  - May portend policymakers will stick with draconian Medicare cuts rather than abandon ACA coverage promises
  - Federal ability to maintain enhanced Medicaid match in serious doubt

Outline

- What is in the ACA related to healthcare/ insurance?
- Major changes to ACA since enactment
- Major impacts of the ACA in nation and NC
- Considerations for the future
  - Legal challenges to ACA
  - Viability of Exchanges after 2014
  - Medicaid expansion dilemma

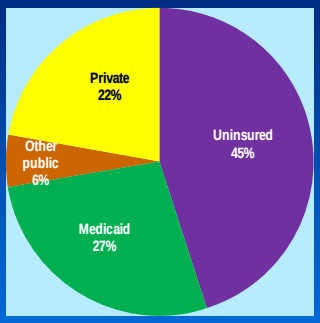
Legal Challenges to ACA

- Contraception mandate
  - Does requirement to offer contraception, including abortifacients violate religious freedom?
  - 2 cases scheduled for hearing 3/25 before U.S. Supreme Court
  - Won't materially affect ACA no matter how decided
- Exchange subsidies
  - Are subsidies permitted in 33 states with federally-run Exchanges?
  - Halbig v. Sebelius Scheduled for hearing 3/25 before U.S. Court of Appeals for the D.C. Circuit
  - Ruling against ACA would eliminate subsidies on federally-run Exchanges, effectively eviscerating the law

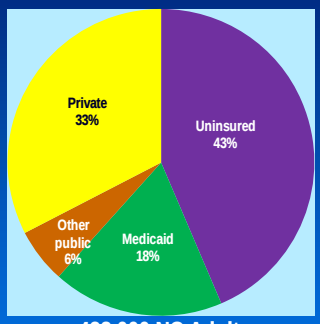
Viability of Exchanges After 2014

- Adverse selection due to lower-than-hoped enrollment of young adults
  - Compounded by repeated delays of employer mandates/penalties/exceptions
  - Large premium increases in 2015 would compounded problem further
  - Higher mandate penalties offset by weak enforcement tools
- If insurance carrier bailouts denied by Congress, either:
  - Large premium increases in 2015 or
  - Many plans will abandon Exchanges

Medicaid Expansion Creates a Sophie's Choice in NC



1,052,000 NC Adults
Age 19-64
Under 100% Poverty



438,000 NC Adults
Age 19-64
100-138% Poverty

- 49 = # potentially losing private coverage per 100 uninsured poor covered by Medicaid expansion
- 91 = # <138% who lose opportunity to obtain private coverage on Exchange, per 100 uninsured covered by Medicaid expansion

Medicaid Expansion Dilemma

- Benefits of Medicaid too often overstated:
  - Economic impact studies use 1-sided book-keeping
  - Medicaid *increases* ER use by 40%
  - Evidence that Medicaid improves health is thin especially if the alternative is private coverage
- Highly uncertain Federal government will retain enhanced match for expansion states
  - TennCare case study: >200,000 lost coverage when state ran out of $
  - If NC elects to expand, it should do scientifically

Conclusions