

Implementation of the Affordable Care Act in North Carolina

Pam Silberman, Lanier M. Cansler, Wayne Goodwin, Berkeley Yorkery, Kimberly Alexander-Bratcher, Sharon Schiro

The Affordable Care Act (ACA) offers the potential to improve population health, health care access, and health care quality, while slowing the rate of increase in health care costs. But accomplishing these goals will not be easy. Implementing the new law creates challenges for North Carolina and the families, businesses, health professionals and organizations, and insurers in the state. Because of the complexities of the new law and its far-reaching consequences, the North Carolina Department of Insurance (DOI) and the North Carolina Department of Health and Human Services (DHHS) asked the North Carolina Institute of Medicine (NCIOM) to convene work groups to examine the new law and gather stakeholder input, to ensure that the decisions the state makes in implementing the ACA serve the best interests of the state as a whole. The effort is being led by the NCIOM Health Reform Overall Advisory Committee, cochaired by Lanier M. Cansler, CPA, secretary of the North Carolina DHHS, and Wayne Goodwin, JD, commissioner of the North Carolina DOI.

The advisory committee is helping to coordinate the efforts of 8 separate work groups that have focused on the following sections of the ACA: Medicaid; health benefits exchange (HBE) and insurance oversight; health professional workforce; prevention; quality; new models of care; safety net; and fraud, abuse, and overutilization. The work groups began meeting in August 2010 and have met approximately every month since. Altogether, 260 people from across the state are members of the advisory committee, work groups, or work group steering committees. Meetings are open to the public, and many individuals other than those in the advisory committee or work groups have participated in person or online. Financial support for this effort is provided by generous grants from the Kate B. Reynolds Charitable Trust, The Duke Endowment, the Blue Cross and Blue Shield of North Carolina Foundation, the John Rex Endowment, Cone Health Foundation, and the Reidsville Area Foundation. The North Carolina Network of Grantmakers has a Web site (available at: <http://www.ncgrantmakers.org>) that tracks new ACA grant announcements, to make it easier for North Carolina nonprofit agencies and other organizations to learn about funding opportunities related to the ACA. A copy of the interim report from the work groups is accessible on the NCIOM Web site (available at: <http://www.nciom.org/wp-content/uploads/2011/03/HR-Interim-Report.pdf>).

Coverage Provisions

One of the primary reasons for passing the ACA was to make health insurance more accessible and affordable. In North Carolina, approximately 1.7 million nonelderly people (20.4% of the nonelderly population) were uninsured in 2009 [1]. The ACA builds on existing systems to expand coverage to uninsured individuals by extending Medicaid coverage to more low-income adults, strengthening the employer-based health insurance system, and making it easier and more affordable for many individuals and small businesses to purchase private coverage. According to the Congressional Budget Office, 92% of nonelderly people in the United States will have health insurance coverage by 2019 because of the ACA [2]. On the assumption that North Carolina will achieve a similar reduction in the number of uninsured people, more than 1.1 million uninsured North Carolinians are likely to gain coverage by 2019.

Public insurance. Beginning in 2014, the ACA will require states to expand Medicaid coverage to most uninsured adults who have a modified adjusted gross income of no greater than 138% of the federal poverty level (133%, plus a 5% income disregard allowed by the legislation); for a family of 4, the limit is equivalent to an annual household income of \$30,429 (ie, 138% x \$22,050). The federal government will pay an enhanced match rate for newly eligible individuals but not for those who would have been eligible under the state's Medicaid eligibility rules that were in effect in March 2010.

The North Carolina Division of Medical Assistance (DMA) estimates that the expansion of Medicaid will cover approximately 525,000 new people during state fiscal year (SFY) 2014, increasing to approximately 560,000 people overall by SFY 2019 (S. Owen, chief business operating officer, North Carolina DMA, electronic communication, February 22, 2011). North Carolina's share of the coverage during SFYs 2014-2019 for new enrollees is estimated to be

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Address correspondence to Dr. Pam Silberman, North Carolina Institute of Medicine, 630 Davis Dr, Ste 100, Morrisville, NC 27560 (psilberman@nciom.org).

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approximately \$830 million, and the federal share is estimated to be more than \$15 billion. North Carolina is likely to incur additional costs in operating new eligibility and enrollment systems to ensure that individuals can apply simultaneously for Medicaid, NC Health Choice (ie, North Carolina's Children's Health Insurance Program), and private, subsidized coverage offered through the HBE. North Carolina may also incur new costs if it chooses to expand the array of services offered. However, there are also ways for the state to offset some of the new costs it will likely incur from the expanded coverage. For example, as uninsured individuals acquire public or private coverage, the state may be able to reduce costs in other programs that served these individuals while they lacked coverage. It is difficult to quantify the full financial impact of the ACA on North Carolina until the state has a better understanding of the required benefit package for newly eligible individuals, as well as federal guidance on the new service options and enhanced match rates. Thus, the North Carolina DHHS will continue to work to estimate the potential costs and cost offsets as further federal guidance becomes available.

Individual and employer-sponsored private insurance. Most of the other coverage changes occur in the private insurance market. The more immediate provisions focus on making coverage more affordable for people with preexisting conditions and for early retirees. The ACA appropriated \$5 billion over federal fiscal years (FFYs) 2010-2014 to create federally funded high-risk pools to provide more-affordable coverage to people with preexisting health problems who have been uninsured for at least 6 months. In North Carolina, the federally funded high-risk pool is being operated by Inclusive Health. North Carolina's share of this \$5 billion appropriation was \$145 million. In addition, the ACA appropriated \$5 billion over FFYs 2010-2015 to create a temporary reinsurance pool to help offset the high claims costs to businesses (including state and local governments) that provide health insurance to early retirees aged 55 years or older who are not eligible for Medicare. As of January 27, 2011, a total of 101 North Carolina employer groups—including the State Health Plan, 28 counties, 20 North Carolina towns and cities, and other businesses and organizations—met the eligibility requirements for reinsurance to offset part of the claims costs for early retirees [3]. The State Health Plan estimates that it will receive \$22.7 million in SFY 2011, \$57.9 million in SFY 2012, and \$8.9 million in SFY 2013 from the federal reinsurance pool (M. Moon, chief financial officer, North Carolina State Health Plan, electronic communication, January 18, 2011).

The ACA also made changes to insurance laws that became effective for health plans renewed after September 23, 2010. For example, insurers are now required to offer parents the option of continuing insurance coverage for children up to 26 years of age, regardless of whether the children are full-time students. Insurers are also prohibited from imposing lifetime dollar limits for coverage, and the law begins to

phase out annual limits. Insurers that offer child-only coverage are also prohibited from excluding children with preexisting conditions. There are also new requirements to ensure that insurers spend at least a minimum amount of the premiums they collect on medical expenses and quality improvement, rather than spending them on administrative costs or retaining them as profits.

The ACA includes enhanced consumer protections, including the creation of consumer ombudsman programs. The North Carolina DOI obtained federal grants of \$1 million, to strengthen the rate-review process, and \$850,000, to strengthen its consumer-assistance/ombudsman program. In addition, the North Carolina DOI Seniors' Health Insurance Information Program, the Area Agencies on Aging, and the Community Resource Connections for Aging and Disabilities received a combined amount of \$1,752,034 to expand outreach efforts and enroll qualifying Medicare beneficiaries in the low-income prescription drug subsidy program and/or the Medicare Savings Program.

Most of the other changes to insurance law go into effect in 2014. The secretary of the US DHHS will define the essential benefits that private insurers must cover in their nongrandfathered insurance plans. Over time, most people in the private market will be covered by the essential health benefits. Beginning in 2014, insurers can no longer exclude people or charge them more because of preexisting conditions. To ensure a large enough pool of individuals to cover the higher costs of insuring individuals with preexisting health conditions, the ACA requires most people to have health insurance coverage or pay a financial penalty. The ACA provides subsidies to individuals to help make insurance coverage more affordable. People are eligible for these subsidies if their annual income is less than 400% of the federal poverty level (eg, \$88,200 for a family of 4 in 2010), if they are not eligible for public coverage (eg, Medicare, Medicaid, NC Health Choice, or TRICARE) and if they do not have access to affordable employer-sponsored insurance. Analysis of Current Population Survey data suggests that close to 800,000 uninsured nonelderly people have incomes that are too high to qualify for Medicaid or NC Health Choice but are less than 400% of the federal poverty level (M. Holmes, Cecil G. Sheps Center for Health Services Research, unpublished analysis, 2011). Some, but not all, of these individuals will be eligible for a subsidy to purchase coverage in the HBE [4, 5]. Others may gain coverage through their employers.

Beginning in 2014, the ACA also requires large employers (ie, businesses with 50 or more full-time employees) to offer health insurance coverage that meets certain standards or pay financial penalties. Almost all (97%) of these firms already offer coverage in North Carolina [6]. In contrast, only 33.8% of small businesses (ie, businesses with fewer than 50 full-time employees) offer group health insurance coverage. Small businesses are not required by the ACA to offer health insurance coverage. However, the ACA provides

a sliding-scale tax credit to some small businesses to help them afford coverage. On the basis of Current Population Survey data [4] (M. Holmes, unpublished analysis, 2011), Medical Expenditure Panel Survey data [7], and the assumption that all firms qualifying for the partial credit would receive a 17.5% tax credit, the NCIOM estimates that small businesses in North Carolina may be able to qualify for more than \$200 million in tax credits through the small-business tax credit.

The ACA requires each state to have an HBE that offers information to help individuals and businesses compare health plans on the basis of quality, provider networks, and costs and that helps individuals and small businesses enroll in coverage. If a state chooses not to create its own HBE, the federal government will create one to offer coverage to individuals and small groups in the state. The Health Reform Overall Advisory Committee and Health Benefits Exchange and Insurance Oversight Workgroup recommended that North Carolina create its own HBE, which would give the state greater control over its operations. The North Carolina DOI received a \$1 million planning grant from the federal government to help with some of the design issues. Currently, the North Carolina General Assembly is considering legislation to create a North Carolina HBE. Federal funds are available to cover the developmental costs for any state that decides to create its own HBE.

Improving Population Health

Ultimately, the goal of any broad-scale reform of the health system should be to improve population health. The ACA includes new funding to invest in wellness and public health infrastructure. This focus on improving population health is particularly important to North Carolina. The state typically ranks among the bottom third of all states for most health status indicators, and in 2010 North Carolina ranked 35th in overall health [8].

The ACA appropriated \$500 million in FFY 2010 and \$750 million in FFY 2011 for a new prevention and public health fund to help fund new prevention efforts and to fund grants to strengthen the public health infrastructure. The North Carolina Division of Public Health and local health departments applied for and were awarded approximately \$11.6 million in ACA grants aimed at strengthening the public health infrastructure and improving population health.

Increasing Access to Health Services

To meet the health care needs of newly insured individuals, the ACA authorized new workforce programs and appropriated funding to strengthen the health care safety net.

Expanding the health professional workforce. The ACA expanded or authorized new health professional training programs to increase the number of primary care professionals, nurses, public health professionals, allied health professionals, mental health and substance abuse professionals, dental health professionals, and direct-care work-

ers. In addition, the legislation aimed to change the way that health professionals are trained, to best meet the workforce needs of the future. However, although the ACA authorized many new training programs, Congress did not appropriate new funding to support all of them. As a result, in FFY 2010, the US DHHS secretary used approximately half of the prevention and public health fund to support workforce training programs for health professionals.

State agencies and academic institutions in North Carolina have successfully competed for more than \$9.5 million in ACA workforce awards. For example, the University of North Carolina (UNC)-Chapel Hill School of Medicine received funding to expand its pediatrics residency program, and the New Hanover Regional Medical Center and South East Area Health Education Centers received funding to expand their family medicine residency program; the Duke University School of Medicine and Methodist University received funding to expand their physician assistant programs; the Duke University School of Nursing received funding to expand its nurse practitioner program; the UNC-Chapel Hill Gillings School of Global Public Health received funding to expand its public health workforce; the North Carolina Commission on Workforce Development and the UNC-Chapel Hill Cecil G. Sheps Center for Health Services Research received funding to identify strategies the state can employ to increase the per capita primary care workforce during the next 10 years; and the North Carolina DHHS Office of Long-Term Services and Supports received funding to improve training for personal and home care aides.

Although the ACA does not include new appropriations for most of the new workforce training programs, it does include \$1.5 billion in new funding, distributed over 5 years, to expand the National Health Service Corps. The North Carolina Office of Rural Health and Community Care, which is the lead agency in administering the National Health Service Corps in North Carolina, estimates that the state will be able to use these funds to recruit an additional 20-25 health professionals per year during 2011-2015 to practice in underserved areas (J. Price, director, North Carolina Office of Rural Health and Community Care, electronic personal communication, January 27, 2011).

Expanding the safety net. The ACA includes provisions to increase and strengthen the health care safety net. The ACA appropriated a total of \$9.5 billion, distributed over 5 years, to expand the number of community and migrant health centers, expand the array of services provided, and increase the number of people served. In addition, the ACA includes \$1.5 billion for construction and renovation. North Carolina currently has 26 federally qualified health centers (FQHCs) and 2 FQHC look-alikes operating in 45 counties across the state.

North Carolina FQHCs received ACA grant funds totaling \$19.2 million to support capital improvements and renovations and to expand access to care through existing FQHCs. In addition, the Health Resources and Services Administration

issued a grant opportunity to support the establishment of new service delivery sites for FQHCs. The North Carolina Community Health Center Association, with financial support from the Kate B. Reynolds Charitable Trust, worked with communities across the state to help them prepare grant applications. As a result, North Carolina submitted 30 applications for competitive New Access Point grants. If all of these applications were selected for funding, the grants would fund services in 24 new counties, bringing the total number of North Carolina counties with an FQHC up to 69. However, the recent FFY 2011 budget reconciliation agreement reduced core FQHC funding by approximately \$600 million. This effectively reduced funding for New Access Points by approximately two-thirds. Thus, it is unlikely that all of the New Access Point grants will be funded (B. Money, North Carolina Community Health Center Association, personal communication, May 2, 2011).

In addition to the direct funding for FQHCs, the ACA includes new requirements for charitable hospitals to maintain their tax-exempt status. Under the new provisions, charitable hospitals must conduct a community needs assessment and identify an implementation strategy to show that they are addressing community needs. Nonprofit hospitals are also required to have a financial assistance policy, provide emergency services, and limit charges to people eligible for assistance to the amounts generally billed.

Enhancing Quality and Reducing Health Care Costs

North Carolina has many existing initiatives aimed at improving health care quality while reducing health care costs, yet more work is needed.

Quality. The ACA includes many provisions aimed at measuring and reporting on the quality of care provided by health professionals, health care organizations, and insurers. Over time, these data will be made available to the public. In addition, the ACA provides greater investments in comparative effectiveness research to determine which treatments, medications, or services work best under which conditions. The ACA also begins to change the way that health professionals and providers are reimbursed, from a system based largely on reimbursing providers on the basis of the volume of services provided to systems that are based, in part, on the quality and outcomes achieved.

North Carolina had already begun several initiatives aimed at improving quality of care before the enactment of the ACA, including but not limited to Community Care of North Carolina (CCNC), the North Carolina Healthcare Quality Alliance, the Regional Extension Center, Improving Performance in Practice, the North Carolina Center for Hospital Quality and Patient Safety, and the North Carolina Center for Public Health Quality. Representatives from these organizations, along with representatives from other health care provider groups, served on the NCIOM Quality Workgroup. The ACA has many requirements to improve quality and patient safety. For example, beginning

in October 2012, Medicare will reduce payments to hospitals that have excess readmissions for 3 conditions: heart attack, heart failure, and pneumonia. Stakeholder groups have been identified to educate providers about the new requirements. Furthermore, many of the existing statewide quality improvement organizations are working with providers to help them implement quality improvement strategies to meet these new requirements.

New models of care. The ACA includes many new provisions aimed at changing the way that Medicare, Medicaid, and NC Health Choice deliver care and pay health professionals and other health care organizations for services. The intent of these provisions is to test models to increase quality and reduce unnecessary costs. The secretary of the US DHHS is charged with evaluating these demonstrations, identifying successful initiatives, and disseminating the successful financing and delivery models more widely throughout the country.

Development and implementation of new models of care are essential to improve the value delivered by the US health care system. North Carolina is already recognized for the work it has done through CCNC to create patient-centered medical homes in the Medicaid program. CCNC helps improve health outcomes and reduce health care costs, particularly for Medicaid enrollees with chronic or complex health problems. Because of the success already achieved with CCNC, North Carolina was among 8 states selected to receive the first round of demonstration grants awarded through the Center for Medicare and Medicaid Innovations (also known as “the Innovation Center”) to test a multipayer, advanced, patient-centered medical home [9]. Under this grant, Medicare will pay an estimated \$11.8 million in per-member per-month payments to local primary care providers and participating CCNC networks to provide care coordination and care management to Medicare enrollees. This is part of a larger public-private partnership that includes the North Carolina DMA, the State Health Plan, Blue Cross Blue Shield of North Carolina, and North Carolina Community Care Networks.

North Carolina also received 2 grants to test or expand existing initiatives to improve quality and health outcomes. Roanoke Chowan Community Health Center received \$255,000 through the ACA to expand its existing telehealth monitoring initiative. Access II Care (which serves Buncombe, Henderson, and McDowell counties in North Carolina) and the North Carolina Office of Rural Health and Community Care received a medical liability reform and patient safety planning grant of \$297,710 from the Agency for Healthcare Research and Quality to develop a system of near-miss reporting and improvement tracking in primary care.

Fraud, abuse, and overutilization. The ACA includes funding to support more-aggressive efforts to eliminate fraud and abuse and to recover overpayments in Medicare, Medicaid, and CHIP. These new efforts are expected to yield \$6 billion

in savings to the federal government during the next 10 years (and a corresponding reduction in costs to states' Medicaid and CHIP programs). Many of these efforts will require North Carolina to implement new surveillance and enforcement procedures and to educate health care providers about the new provisions.

Conclusion

The ACA is complex and touches all aspects of the US health care system. Not surprisingly, the legislation has been controversial. Any legislation that impacts 17% of the economy and affects how health care services are delivered and financed is likely to be controversial. Some argue that the bill does not go far enough toward ensuring universal coverage, while others decry the lack of real cost containment. Some oppose the individual mandate, while others are concerned about the new requirements placed on employers and state government. Yet few people seriously argue that the existing health care system is sustainable. The United States spends more per capita on health care than any other country, yet these costs yield less value in terms of life expectancy and other important measures of health. The country spends enormous sums of money on new technology and better "sick care" but does not make the investments in prevention that could help keep people healthy. Providers continue to be paid on the basis of the volume of services provided, without ensuring the quality of these services. Furthermore, millions of people remain uninsured, which has an adverse impact on individuals, families, and society.

The ACA is not perfect and is likely to evolve as we learn what works and what needs to be changed. However, it provides North Carolina with a unique opportunity to identify strategies to expand health insurance coverage and improve access to health services, quality, and population health. North Carolina has a strong history of identifying innovations that have led to improved access, quality, and patient outcomes, as well as to reductions in unnecessary health expenditures. However, there is a need for further progress. Working together, North Carolina health professionals, consumers, insurers, and business and community leaders can identify innovative strategies that will lead to further improvements in quality, outcomes, and population health; improved access; increased efficiency; and reduced costs. **NCMJ**

Pam Silberman, JD, DrPH president, North Carolina Institute of Medicine, Morrisville, North Carolina.

Lanier M. Cansler, CPA secretary, North Carolina Department of Health and Human Services, Raleigh, North Carolina.

Wayne Goodwin, JD commissioner, North Carolina Department of Insurance, Raleigh, North Carolina.

Berkeley Yorkery, MPP project director, North Carolina Institute of Medicine, Morrisville, North Carolina.

Kimberly Alexander-Bratcher, MPH project director, North Carolina Institute of Medicine, Morrisville, North Carolina.

Sharon Schiro, PhD vice president, North Carolina Institute of Medicine, Morrisville, North Carolina.

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