

Implementing the Affordable Care Act in North Carolina: The Rubber Hits the Road

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The health insurance mandate, perhaps the best-known provision of the Patient Protection and Affordable Care Act of 2010 (ACA), is slated to go into effect on January 1, 2014. Yet most people do not know how the ACA will affect them. More than one-third of people in a recent national poll were unaware that new health insurance marketplaces will make it easier to purchase coverage or that some people will qualify for subsidies to help them purchase coverage. The ACA includes many other provisions that will have a profound impact on our health care delivery system. Some changes are already helping to break down silos in the delivery of care. Groups of health care professionals are working together to manage the health of populations. The ACA places a much greater emphasis on measuring quality and on paying health professionals and health care institutions based on the value of the services they provide. In addition, the ACA makes greater investments in prevention and in population health management. This issue brief highlights some of the health system changes that have taken place over the past 3 years, as well as some of the potential changes that are yet to come relating to insurance coverage, access to care, quality of care, rising health care costs, and overall population health.

Despite the fact that the Patient Protection and Affordable Care Act of 2010 (ACA) was passed more than 3 years ago, there continues to be substantial confusion about what the law does—and does not—do [1]. In a Kaiser Health Tracking poll conducted in March 2013, a majority of people (57%) reported that they do not have enough information to know how the ACA will affect them. This includes more than two-thirds of uninsured individuals and those in households that might be eligible for assistance in paying their premiums. Although most people in this poll knew about the individual insurance mandate (74%), fewer knew about the potential Medicaid expansion (59%), the creation of health insurance marketplaces (58%), or the availability of subsidies to help people pay for coverage (62%) [2].

Most of the publicity to date has been about the insurance coverage provisions of the ACA. However, the ACA goes far beyond insurance coverage. The legislation addresses 4 fundamental problems in our current health care system: barriers

to access created by lack of insurance coverage and an inadequate supply of providers; uneven quality of care; rapidly rising health care costs; and poor population health outcomes. In upcoming months, the media will pay increasing attention to the new insurance options that will be available in the health insurance marketplaces (formerly called exchanges), as the initial open enrollment period runs from October 1, 2013, through March 31, 2014. What has received less coverage are the other changes in our health care delivery system that are the result—in large part—of the passage of the ACA. But these changes are at least as profound as those in the insurance marketplace.

Over the past 3 years, the federal government has made changes that have the potential to transform the way we pay for and deliver care. Changes are already helping to break down silos in the delivery of care. For example, hospitals are working more closely with community providers to reduce the number of hospital readmissions. Hospitals and local health departments are collaborating to address community health needs. And groups of health care professionals are working together to manage the health of populations. The ACA places a much greater emphasis on measuring quality and on paying health professionals and health care institutions based on the quality of the services they provide. In addition, the ACA makes greater investments in prevention and in population health management.

This issue brief highlights some of the health system changes that have occurred over the past 3 years, as well as some of the potential changes yet to come. It updates previously published articles in this journal [3, 4] about the implementation of health reform in North Carolina. This issue brief is divided into 4 sections, each of which addresses one of the major health care challenges facing our system: insurance coverage and access to care, quality of care, rising health care costs, and overall population health.

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Insurance Coverage and Access to Care

In 2010–2011, almost 1 in 5 nonelderly North Carolinians—more than 1.5 million people—were uninsured [5]. Uninsured individuals are more likely to report barriers to obtaining needed health care services. On the 2011 Behavioral Risk Factor Surveillance System Survey, almost half (48%) of uninsured adults surveyed in North Carolina reported that there had been a time in the past 12 months when they needed to see a doctor but could not do so because of the cost, whereas only 11% of those with insurance coverage reported facing that access barrier [6]. Likewise, only 44% of uninsured individuals had seen a doctor for a routine checkup within the past 12 months, compared with 80% of those who had insurance coverage [7]. National research has shown that uninsured individuals are less likely to receive preventive health screenings, are more likely to be diagnosed with advanced health problems, and are more likely to die prematurely than are those with insurance [8].

As enacted, the ACA was expected to result in coverage for approximately 33 million of the 60 million uninsured Americans by 2022 [9]. The legislation sets out to accomplish this goal by building on our current system of health insurance coverage. Medicaid is expanded to cover adults with incomes up to 138% of the federal poverty level (FPL). Specifically, the ACA expands Medicaid to adults with incomes up to 133% of the FPL, plus it included a 5% income disregard, thus effectively raising the Medicaid income limits to 138% of the FPL [10]. The ACA will also require employers with 50 or more full-time-equivalent employees to provide employer-sponsored insurance for those working full time [11]. Individuals without other health insurance coverage and small businesses will be able to shop for coverage through the new online health insurance marketplaces to be set up in every state [12]. The law provides tax subsidies for health insurance premiums, on a sliding-scale basis, to individuals or families with incomes

between 100% and 400% of the FPL if they are not eligible for public coverage and do not have access to affordable employer-sponsored insurance [13]. (See Table 1 for a list of FPL cutoffs for households of different sizes.) Per the so-called “individual mandate,” most people will be required to have health insurance coverage beginning in 2014 or to pay a penalty [14].

Several lawsuits were filed to challenge the constitutionality of both the individual mandate and the mandatory Medicaid expansion. The Supreme Court of the United States decided these issues on June 28, 2012. In *National Federation of Independent Business v. Sebelius* [15], the court upheld the constitutionality of the individual mandate, deeming it to be a constitutional exercise of the taxing authority of the US Congress. However, the court decided that the mandatory expansion of Medicaid to cover low-income adults was unconstitutionally coercive to the states. As a result, the Medicaid expansion became optional to the states. The rest of the ACA was left intact.

Medicaid Coverage

In North Carolina, approximately 41% of uninsured adults have incomes below 138% of the FPL [5] and would therefore be income-eligible for the Medicaid expansion. However, not everyone who is income-eligible would actually qualify for coverage. The ACA did not expand Medicaid coverage to undocumented immigrants or to lawful immigrants who have been in the United States for less than 5 years. In addition, past history shows that not everyone who is eligible for a public program actually applies for it. In fact, a recent study by Sommers and colleagues [16] estimated that only 62% of nonelderly adults who are eligible for Medicaid and who lack private insurance coverage are enrolled in Medicaid nationwide.

The North Carolina Division of Medical Assistance (DMA) estimated that between 494,010 and 536,481 people would gain Medicaid coverage during the years 2014 through 2021 if the state were to expand coverage to low-income adults [17]. For the first 3 years (2014–2016), the federal government would pay 100% of the costs of providing services to newly eligible individuals, and the federal match rate would then gradually be reduced to 90% by 2020 [10]. North Carolina would also achieve some savings in existing state programs if the state were to expand Medicaid, because the state currently pays for some (limited) services to uninsured individuals that would be covered through Medicaid under the expansion, with the federal government picking up all or most of the cost. In addition, the federal dollars that would flow into North Carolina would generate new state tax revenues. Thus the effect on state finances of expanding eligibility to cover this new group of adults would range from a net savings of approximately \$124 million in state fiscal year (SFY) 2016, when the federal government would be paying 100% of the costs of services, to a net cost of approximately \$120 million

TABLE 1.
Yearly Household Incomes Representing Certain Percentages of the 2013 Federal Poverty Level (FPL)

Number of people in the household	100% FPL	138% FPL	200% FPL	400% FPL
1	\$11,490	\$15,856	\$22,980	\$45,960
2	\$15,510	\$21,404	\$31,020	\$62,040
3	\$19,530	\$26,951	\$39,060	\$78,120
4	\$23,550	\$32,499	\$47,100	\$94,200
Each additional person	\$4,020	\$5,548	\$8,040	\$16,080

Note. 100% and 400% FPL are cutoffs used to determine eligibility for subsidies in the marketplace, 138% FPL is the cutoff for the Medicaid expansion, and 200% FPL is the maximum family income for a child to qualify for Medicaid or North Carolina Health Choice.

Source: Office of Assistant Secretary for Planning and Evaluation, US Department of Health & Human Services. 2013 Poverty Guidelines. <http://aspe.hhs.gov/poverty/13poverty.cfm>. Accessed April 24, 2013.

in SFY 2021 and thereafter, when the federal match rate would have been reduced to 90% [17]. As of May 2, 2013, the governors of 27 states had indicated an interest in expanding Medicaid. In contrast, governors of 20 states, including North Carolina, had indicated that they do not want to expand Medicaid. The governor's offices in 3 other states were weighing their options [18].

The North Carolina General Assembly passed legislation this year to reject the Medicaid expansion [19]. However, North Carolina, like any other state that rejects the Medicaid expansion this year, can choose to expand coverage at a later date. Likewise, states that choose to expand coverage now can later reject the Medicaid expansion [20]. Choosing Medicaid expansion in a later year would mean forgoing 1 or more years of the 100% federal match.

Even though the North Carolina General Assembly has chosen not to expand Medicaid, the ACA will nevertheless lead to more people being covered through Medicaid or through North Carolina Health Choice for Children (NCHC). NCHC is North Carolina's Children's Health Insurance Program (CHIP) for children whose parents earn too much to qualify for Medicaid but whose family income is no more than 200% of the FPL. The DMA has estimated that between 69,683 and 87,127 new people will enroll in Medicaid or NCHC between 2014 and 2021 [17]. These are people who are currently eligible for one of these programs but who are not enrolled in either. The ACA creates a "no wrong door" approach to eligibility and enrollment. In the health insurance marketplace, the same application will be used to determine eligibility for Medicaid, NCHC, and/or private coverage [21]. In fact, the system must first determine whether a person or family is eligible for public coverage before determining their eligibility for subsidies in the marketplace. In his commentary in this issue of the NCMJ, Atkinson [22] discusses how the state and county departments of social services are implementing the state's new eligibility system and preparing for the potential increase in enrollment that is likely to occur starting this fall.

Many of the people who will gain public coverage will be children, as approximately 150,000 uninsured children are currently income-eligible for either Medicaid or NCHC [5]. Since this group of new enrollees was already eligible but was not enrolled, the federal government will only pay its regular share of the costs of their health care services (currently approximately 65% for Medicaid enrollees). The cost to the state for covering those individuals who are currently eligible and are likely to gain coverage will range from approximately \$37 million in 2014 to \$203 million in 2021 [17].

Employer-Sponsored Insurance

More than half (57%) of nonelderly North Carolinians had employer-sponsored health insurance in 2011 [23]. Although employer-sponsored insurance is the primary source of coverage for nonelderly individuals who are insured, having

a job does not guarantee coverage. Most uninsured individuals either work themselves, or they live in a household where someone is working full-time. In fact, more than 70% of uninsured North Carolinians live in households with at least 1 full-time worker, and more than one-quarter live in a household with 2 or more full-time workers [5].

The ACA requires large employers to offer health insurance coverage to their full-time employees or to pay a penalty [11]. For this purpose, a large employer is defined as any employer having 50 or more full-time-equivalent employees, and a full-time employee is defined as someone who works 30 hours or more per week. Employers must offer their employees and the employees' dependents (defined as children under the age of 26 years) [24] minimum essential coverage, which is comprehensive health insurance coverage that has an actuarial value of at least 60% [25]. That means that the health insurance must pay, on average, at least 60% of the costs of the covered services, leaving the individual employee to pay no more than 40% in out-of-pocket costs, including deductibles, coinsurance, or copayments.

If an employer does not offer coverage, or if they offer coverage that has an actuarial value of less than 60%, and at least one of their employees seeks and obtains subsidized coverage in the state's health insurance marketplace (described more fully below), then the employer will be required to pay a financial penalty to the Internal Revenue Service. Employers will be required to pay \$2,000 per year for each full-time employee (not counting the first 30 employees) [11].

Although large employers must offer coverage that meets the 60% actuarial value requirement, they are not required to pay any particular proportion of the cost of the premiums. However, employers may be subject to a penalty if the coverage they offer is not affordable to the employee. The test of affordability is whether the employee must spend more than 9.5% of his or her income on health insurance premiums for self-only coverage [25]. Employers who offer coverage will be required to pay a penalty of \$3,000 per year for any full-time employee who qualifies for subsidies in the health insurance marketplace [11]. Employers also have new reporting requirements as a result of the ACA [26]. Recently, the US Department of the Treasury announced that it would delay the reporting requirements, which effectively delays the employer mandate, until 2015 [27].

Some people have expressed concern that employers may drop coverage because of the ACA [28]. The Congressional Budget Office estimates that by 2022 there will be between 1 million and 4 million fewer people with employer-sponsored insurance than there would have been had the ACA not been enacted [29]. Other experts predict a slight increase in employer-sponsored insurance as a result of the ACA [30]. Historically, employers have not been required to offer health insurance coverage to their employees, but many have chosen to do so as a means of recruiting qualified employees. If employer-sponsored health insur-

ance coverage does decline, this will continue a preexisting trend. The percentage of private firms that offer health insurance coverage to their employees in North Carolina dropped from 57% in 1999 to 48% in 2011; nationally during that same time period, this percentage dropped from 58% to 51% [31, 32]. Whether the ACA will affect this trend is unclear. Longobardo discusses some of the challenges that employers may face in implementing the ACA in his commentary in this issue [33].

Individual (Nongroup) Coverage

Beginning in January 2014, most people will be required to have health insurance or to pay a penalty [14]. Most people who have health insurance will meet this requirement through their existing coverage; this could be Medicaid, NCHC, Medicare, VA health benefits obtained through the Veterans Health Administration, the Department of Defense health care program TRICARE, employer-sponsored insurance, or insurance they buy on their own. Certain other individuals will be exempt from the insurance mandate, including those would be required to pay more than 8% of their income for the lowest-cost health insurance premium, those whose income is so low that they are not required to file taxes, prisoners, and some people with religious exemptions. In addition, the federal government recently expanded the exemptions to include people who would have been eligible for the Medicaid expansion but who live in states that chose not to expand Medicaid [34].

Health insurance coverage is expensive. In 2011, the

average annual premium in North Carolina for an employer-sponsored plan was \$5,230 for an individual or \$14,304 for a family [35, 36]. Recognizing the high cost of health insurance, the ACA includes premium and cost-sharing subsidies for many individuals who seek private nongroup coverage. Individuals do not qualify for subsidies if they have access to publicly subsidized health insurance coverage (eg, Medicaid, NCHC, or Medicare) or to affordable employer-based coverage. In addition, individuals must meet income eligibility criteria, with subsidies limited to individuals with a family income between 100% and 400% of the FPL [13]. The subsidies are available on a sliding scale that is based on household income (Table 2). To qualify, an individual must purchase insurance through the state's federally facilitated health insurance marketplace. Because people with incomes below 100% of the FPL would have qualified for Medicaid under the legislation as it was passed, the ACA excludes most low-income individuals with incomes below 100% of the FPL from qualifying for subsidies in the marketplace.

In North Carolina, the federal government will create 2 insurance marketplaces—one for individuals and families, and the other for small businesses (the latter will be a Small Business Health Options Program, called a SHOP). Essentially, these marketplaces will be online tools that help consumers or small businesses understand and compare insurance options. The marketplaces will provide information about the plans that are being offered, covered benefits, premium costs, out-of-pocket costs, and the quality of the plans [12]. The marketplaces will also help determine

TABLE 2.
Sliding-Scale Health Insurance Subsidies To Be Provided as Part of the Patient Protection and Affordable Care Act of 2010

Household income, as a percentage of the federal poverty level	Maximum premium that can be charged, as a percentage of household income ^a	Out-of-pocket cost sharing, as a percentage of total costs ^b	2014 out-of-pocket cost-sharing limits ^c For an individual / For a family
Subsidized			
100%-133%	2%	6%	\$2,250 / \$4,500
133%-150%	3%-4%	6%	\$2,250 / \$4,500
150%-200%	4%-6.3%	13%	\$2,250 / \$4,500
200%-250%	6.3%-8.05%	27%	\$5,200 / \$10,400
250%-300%	8.05%-9.5%	30%	\$6,400 / \$12,800
300%-400%	9.5%	30%	\$6,400 / \$12,800
Not subsidized			
>400%	No limit	30%	\$6,400 / \$12,800

^aThe maximum premiums listed as a percentage of household income assume that the family purchases the second-lowest cost "silver" plan. If a family were to purchase the lowest-cost plan instead, they would pay a smaller proportion of their income in premiums. Conversely, if a family purchased a higher-cost plan they would pay the difference between the premium amount for the plan they chose and the premium for the second-lowest cost silver plan.

^bOut-of-pocket costs include deductibles, coinsurance, and copayments; premium costs are not included. Thus, people with incomes up to 250% of the federal poverty guideline will pay a smaller proportion of total costs than will other individuals purchasing a silver plan.

^cThese out-of-pocket cost-sharing limits are taken from a bulletin from the Centers for Consumer Information and Insurance Oversight (CCIIO) at the Centers for Medicare & Medicaid Services titled Actuarial Value and Cost Sharing Reduction Bulletin. CCIIO Web site. <http://ccio.cms.gov/resources/files/Files2/02242012/Av-csr-bulletin.pdf>. Published February 24, 2012. Accessed April 29, 2013.

eligibility for premium and cost-sharing subsidies and for coverage exemptions. The federal government recently created a Web site where people can access information about new insurance options: www.healthcare.gov. This Web site already includes information about the health reform law, and the marketplace applications and health plan comparison information will be available on October 1, 2013. Holliday and Lerche provide more information about the federally facilitated marketplaces in their commentary in this issue [37]; they also discuss the role that the North Carolina Department of Insurance will continue to play in regulating insurers and health plans.

Although many people will be able to go online and apply for coverage themselves, other people will want help in filing their application. The federal government will operate a toll-free hotline to answer questions and help people enroll in coverage (phone: 1-800-318-2596; TTY: 1-855-889-4325). The hotline will also refer people to trained enrollment counselors who can provide in-person assistance with the enrollment process. The overwhelming majority (77%) of uninsured individuals in North Carolina have been uninsured for longer than 1 year, and almost half (45%) have been uninsured for 5 years or longer [38]. Thus a large proportion of people who lack coverage in our state have no recent experience with health insurance. As the ACA requires, the federal government will contract with at least 2 organizations in every state that can help people understand their insurance options [39]. These entities, called navigators, will be trained and certified by the federal government. They will have a responsibility to conduct broad education and outreach about the ACA coverage requirements, and they will provide in-person assistance to individuals to help them understand their insurance options and enroll in coverage. Navigators must provide neutral, unbiased information and cannot advise people on which plan to select. Other trained and certified individuals, called certified application counselors, will also be available to help people enroll. Licensed agents and brokers will also be available to help individuals and/or small businesses select and enroll in coverage in the new marketplace, if they receive the requisite training and certification. The federal government will select navigator entities by August 15, 2013. Obiol describes the role of navigators in more detail in her commentary [40].

Health Insurance Coverage

Plans offered to individuals or small businesses, either inside or outside the marketplaces, must provide coverage of essential health benefits [41]. This includes services such as care from physicians and other health professionals; hospitalizations; emergency services; prescription drugs; maternity services; and treatment for mental health and substance use disorders, which must be covered in parity with coverage for physical health problems. In addition, parents will have coverage for vision and oral health services for their children. North Carolina's essential health benefits

Helpful Resources

To help people understand their health insurance options, the federal government has established a Web site and a toll-free hotline.

Web site: www.healthcare.gov

Toll-free hotline: 1-800-318-2596 (phone) or 1-855-889-4325 (TTY)

package is based on the most commonly purchased small-business health plan in North Carolina: Blue Cross and Blue Shield of North Carolina's Blue Options PPO (preferred provider organization) plan [42]. Insurers that choose to participate in the new marketplaces also have other requirements they must meet, including quality standards, network adequacy rules, and a requirement to contract with essential community providers [43]. In her commentary in this issue, Burke describes some of the implementation challenges facing insurers that are interested in participating in the marketplaces [44].

In addition to essential health benefits, almost all insurance policies will be required to provide "first dollar" coverage (with no deductible or copayment) for in-network clinical preventive services that have been rated "A" or "B" by the US Preventive Services Task Force and for all immunizations that are recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention [45]. Insurers must also cover additional preventive services for children and women. The January/February 2013 issue of the NCMJ focuses on the new preventive services package for children. Beginning in 2014, insurers may not exclude people with preexisting health problems, nor will they be allowed to charge those individuals higher premiums [46]. Furthermore, they cannot impose annual or lifetime limits on the amount that is paid for covered services [47]. The ACA also includes out-of-pocket limits on covered services, thus protecting individuals and families from catastrophic costs [48].

Other Access Provisions

Health insurance coverage helps people pay for necessary health care services, thereby reducing financial barriers to care. Yet health insurance coverage alone is not sufficient to ensure access. There must also be health care professionals available to provide services. The ACA includes some provisions aimed at increasing the health professional workforce, and educational institutions in North Carolina have qualified for some of the grants associated with these provisions [49]. Most of the funding to date has focused on increasing numbers of nurses, nurse practitioners, and physician assistants—that is, health professionals who could be trained between 2010 (when the legislation was passed) and 2014, so that they will be ready to practice when the coverage expansion becomes effective. In addition, the legislation includes new funding to expand the National Health Service Corps, which provides scholarships or loan forgiveness for health professionals who are willing to practice in areas where there are shortages of health professionals

[50]. Ricketts discusses these workforce provisions in his commentary [51].

The ACA also specified that \$9.5 billion be spent over a 5-year period (federal fiscal years [FFYs] 2011–2015) to expand or create new Federally Qualified Health Centers (FQHCs), which are also known as community and migrant health centers [52]. North Carolina received funding to create 11 new service locations, plus additional funding to help FQHCs achieve accreditation as patient-centered medical homes (PCMHs). Money discusses in his sidebar how the new funding will expand access to care and improve quality of care; he also describes some of the challenges that North Carolina's FQHCs will face in 2016 [53].

Improving Quality

The Agency for Healthcare Research and Quality ranks states on 149 different measures of health care quality. In 2011, the most recent year for which rankings are available, North Carolina's performance score for overall health care quality was "average" compared with the performance scores of other states [54]. North Carolina has undertaken many efforts aimed at improving quality of care, most of which predate the enactment of the ACA. The March/April 2013 issue of the NCMJ describes the efforts of various health care institutions and professional organizations to improve quality of care and patient safety.

Although many of the state's efforts to improve the quality of health care predate the ACA, the ACA has helped to accelerate these efforts. The legislation includes many provisions aimed at improving quality of care and health outcomes [55]. For example, the ACA requires the Secretary of the US Department of Health & Human Services to define quality, requires health care institutions and providers to report on quality of care measures, and includes provisions aimed at making data regarding quality of care available to the public. Data regarding the quality of care provided by hospitals and nursing facilities are already available at <https://www.healthcare.gov/where-can-i-find-provider-information>, and data regarding the quality of care provided by physicians will be made available in the next few years.

The ACA also includes provisions that begin to change the way that health care institutions and providers are paid; these provisions aim to reward providers based on quality of health care services and health outcomes. This builds on previous efforts by the Centers for Medicare & Medicaid Services (CMS) to reward quality. For example, in 2008 the CMS stopped paying hospitals for care provided to Medicare patients with hospital-acquired conditions, such as surgical-site infections following certain surgeries or removal of a foreign object left behind in the patient's body during a prior surgery [56]. The ACA extends this payment provision to Medicaid [57].

In addition, the ACA includes provisions that reduce Medicare payments to hospitals that have an excessive number of readmissions [58]. Hospitals with too many read-

missions will be subject to a reduction in Medicare diagnosis-related group (DRG) payments of up to 1% in FFY 2013, 2% in FFY 2014, and 3% in FFY 2015. Initially, the CMS is tracking readmissions only for pneumonia, heart failure, and heart attacks, but this list of conditions will be expanded in 2015. In the first 6 months of FFY 2013, 59 hospitals in North Carolina were penalized for having too many readmissions, with an average reduction in reimbursement of 0.25% [59].

This year, the CMS began its Value-Based Purchasing (VBP) Program, which is another requirement of the ACA [60]. Under the VBP program, the CMS varies payments to hospitals based on the quality of the care delivered by the hospital; a hospital either receives bonuses or has its Medicare payments reduced based on the quality of care it is determined to have provided. Initially, in FFY 2013, the CMS examined 12 clinical measures of timely and effective care, as well as 8 patient satisfaction measures [61]. Hospitals were evaluated based on their aggregate achievement on these 20 measures, compared with the performance of other hospitals or compared with their own baseline performance. More than two-thirds (69%) of the 83 hospitals in North Carolina that were subject to the VBP program received a bonus, while the remaining 31% received a penalty [62]. On average, North Carolina hospitals experienced an increase in DRG payments of 0.11% as a result of this VBP program. Lawler and Floyd discuss how Vidant Health has been preparing for the VBP program in its 10-hospital system [63].

Reducing Escalating Health Care Costs

One of the biggest challenges facing the US health care system is the rapid escalation of health care costs. The United States spends more on health care than any other country, whether health care spending is measured as a percentage of gross domestic product (GDP) or in terms of per-capita costs. For example, the United States spent 17.7% of its GDP on health care in 2010 [64]. The Netherlands was the second highest spender of the 34 industrialized nations that are part of the Organisation for Economic Co-operation and Development (OECD); data reported in 2010 showed that the Netherlands spent 12.1% of its GDP on health care. Similarly, when health care spending is measured in terms of per-capita costs, the United States spent \$8,247 per capita in 2010 on health care. The country with the second highest costs was Norway, which spent \$5,413 per capita (in US dollars).

Health care costs are consuming an ever-increasing proportion of US and state finances, employer earnings, and family take-home pay. Between 2001 and 2011, the average employer health insurance premium for a single employee in North Carolina rose 188%, from \$2,778 per year in 2001 to \$5,230 per year in 2011, while the average premium for family coverage increased 204%, from \$7,012 per year to \$14,304 per year [34]. General inflation increased only 27% during that 11-year period [65].

The ACA includes many provisions aimed at reducing

rising health care expenditures. Some of these provisions will have an immediate impact on health care spending, but they may not bend the cost curve. For example, the ACA cuts payments to Medicare Advantage plans [66], which historically have been overpaid compared with traditional Medicare [67]. The ACA also reduces the automatic increases in Medicare reimbursement to certain health care providers ("market basket" updates) [68]. These payment reductions will reduce Medicare spending in the short term, but they may have little impact on the rate of growth in future years.

Other ACA provisions are aimed at reducing the longer-term rate of growth in health care spending. Former CMS administrator Donald M. Berwick and RAND Corporation analyst Andrew D. Hackbarth have argued that between 21% and 34% of all health care spending is due to waste [69]. They attribute waste to the following 6 concerns: failures of health care delivery (eg, quality problems that lead to patient injuries or worse clinical outcomes); failures of care coordination caused by our siloed health care system; overtreatment; administrative complexity; pricing failures resulting from lack of transparency and a competitive marketplace; and fraud and abuse. The ACA takes several steps to address these problems. The law appropriates \$10 billion over 10 years (FFYs 2011-2019) to study and test new payment and delivery models aimed at improving the patient's experience in the health care system (access and quality), improving population health, and reducing rising health care costs. These models include the PCMH, bundled payments, and accountable care organizations (ACOs) [70, 71]. These models are aimed at addressing 3 of the 6 identified sources of waste: failures of health care delivery, failures of care coordination, and overtreatment.

A PCMH essentially consists of multidisciplinary teams that provide comprehensive primary care, which includes preventive, acute, and chronic care. PCMHs actively engage patients in their own care, use electronic health records and information support to improve quality of care and patient outcomes, and generally include some form of payment reform to help support care coordination and care management [72]. North Carolina was one of the first states to receive a demonstration grant from the Center for Medicare & Medicaid Innovation; the money was used to test a multi-payer PCMH model in 7 rural counties [17].

The concept behind episode-of-care models is to provide a bundled payment to a group of providers to cover all of the services provided to a patient during a single episode of care (eg, hip replacement, knee replacement, pacemaker placement, or treatment for a heart attack). The CMS is testing 4 different episode-of-care models: 3 are retrospective (meaning that the federal government will examine actual expenditures for an episode of care after services are rendered and compare them against a target price), and 1 is prospective (paying the hospital a prospective amount for all the services provided by the hospital, physicians, and other

practitioners in the hospital for a specific clinical episode) [71]. Four North Carolina health care organizations are participating in the bundled payment initiative; 3 are health care systems and 1 is a home health agency. A commentary by McDonald describes the efforts of FirstHealth Moore Regional Hospital to test bundled payments for 4 clinical conditions [73]. This model is also being tested with private payers. Blue Cross and Blue Shield of North Carolina and CaroMount are testing a similar episode-of-care payment model for knee surgery [17].

The CMS is also testing ACOs, or Medicare shared savings arrangements, as part of the ACA. An ACO is an organization of eligible providers who assume responsibility for the quality, cost, and overall care of an assigned group of enrollees. Medicare ACOs can share savings with the CMS if they meet all of the ACO requirements, meet certain quality standards, and have measured savings below a calculated savings threshold. The CMS is currently testing 2 types of ACOs in Medicare: the Shared Savings Program and the Advance Payment Model, the latter of which is geared for rural providers with fewer enrollees [71]. Currently, 6 groups of health care providers in North Carolina are testing some form of Medicare ACO. In her commentary in this issue, Terrell discusses the work that she and her colleagues are doing at Cornerstone Health Care to participate in this Medicare demonstration project [74]. In addition, Community Care of North Carolina has received a grant to test a pediatric accountable care collaborative [17].

The ACA also appropriates new funding to support efforts to reduce fraud and abuse and to eliminate overpayments [75]. The ACA requires states to make changes in their state laws to more aggressively monitor fraud and abuse in Medicaid and CHIP. North Carolina passed a law satisfying this requirement in the summer of 2011 [76]. The ACA also includes provisions aimed at simplifying and standardizing health insurance administration [77, 78].

Improving Population Health

The goal of any health care system should be to improve the population's health. Yet the United States does not fare well compared with other countries when we examine population health measures. For example, among the 33 industrialized OECD countries reporting life expectancy data in 2010, the United States ranked 26th in life expectancy at birth (the country with the longest life expectancy was ranked 1st) [64]. Among the 33 countries reporting infant mortality rates that year, the United States ranked 30th; only Chile, Turkey, and Mexico had more deaths per 1,000 live births. Similarly, North Carolina does not fare well in comparison with other states. North Carolina ranked 33rd among the 50 states and the District of Columbia on overall population health based on a comparison of 24 different health-related measures [79].

The ACA includes provisions aimed at changing our health care system from one that focuses almost exclusively

on treating illness to one that promotes health and well-being. The ACA has created the National Prevention Council and appropriates new funding for prevention [80]. The council is chaired by the US Surgeon General and includes 17 secretaries or other heads of federal agencies who are responsible for services or programs that potentially affect the health of the population. Included on this council are the secretaries of the Departments of Health & Human Services, Agriculture, Education, Labor, Transportation, Defense, Housing and Urban Development, and Veterans Affairs, and the Directors of the Domestic Policy Council and the Office of National Drug Control Policy. The Prevention Council has identified 7 priority areas: tobacco-free living, the prevention of drug abuse and excessive alcohol use, healthy eating, active living, injury- and violence-free living, reproductive and sexual health, and mental and emotional well-being [81]. The council's goal is to increase the number of Americans who are healthy at every stage of life.

The ACA has also created a new Prevention and Public Health Trust Fund (PPHTF) to invest more heavily in prevention and health promotion [82]. The ACA appropriated \$500 million in new funding in FFY 2010, \$750 million in funding in FFY 2011, and \$1 billion in FFY 2012. Federal appropriations were scheduled to increase to reach \$2 billion by FFY 2015. However, the Middle Class Tax Relief and Job Creation Act of 2012 [83] cuts \$6.25 billion out of the PPHTF over the next 9 years. As a result, the Trust Fund will not reach \$2 billion until FFY 2022 [84].

The US Department of Health & Human Services has distributed part of the PPHTF to states and localities through competitive and formula-based grants. North Carolina has done well in competing for the competitive grant awards. For example, the state received \$10.6 million in grant funding between 2010-2012 to support evidence-based home visiting programs for infants and young children [85]. North Carolina is also receiving \$14.9 million in 2011-2012 as part of a Community Transformation Grant (CTG) that will support efforts to reduce tobacco use and to promote healthy eating and active living [86]. The CTG grant is unique in that it supports multifaceted interventions at the community, policy, and clinical levels.

Although the work of the National Prevention Council and the PPHTF funding may be the most visible indications of the ACA's focus on prevention and wellness, they are by no means the only examples of the act's emphasis on improving population health. The ACA requires non-profit hospitals that want to maintain their tax-exempt status to conduct a community health needs assessment at least once every 3 years and to show what they are doing to address those needs [87]. In North Carolina, hospitals and public health agencies are collaborating to conduct the community health needs assessments and to develop interventions to improve population health. In their commentary in this issue, Randolph and Morrow [88] discuss how North Carolina is using the federal prevention funding and what

the state is doing to support community-wide population health efforts.

Conclusion

Our experience with health care "reform" is still unfolding. We will not know for several years whether this health reform experiment is a success, a failure, or a little of both. The legislation has great potential to expand coverage to many uninsured individuals, to invest more heavily in prevention, and to improve quality of care. Furthermore, some of the new payment and delivery models supported by the CMS are likely to lead to improved quality of care, reduced waste, and greater collaboration between physicians, hospitals, home health, and other health care providers.

Yet there continue to be many challenges as we try to implement this complex legislation. Most people do not understand the law. How will people be educated about the new insurance options that will become available beginning this fall? How will we ensure that the poorest North Carolinians receive necessary health care services? Will our efforts to improve value in our health care system work? If so, will they continue to work as we move from pilot programs and demonstration projects to national implementation? Further, will we have the funding needed to successfully address the 4 major health challenges facing our country, given that some of the funding appropriated to support new programs or expansions has been cut by subsequent Congressional action?

Our current health care system has serious problems. We have far too many people without any coverage or with inadequate coverage. The quality of care is uneven, health outcomes are poor, and the rate of increase in health care spending is unsustainable. The ACA creates the needed framework for change, but the success or failure of the legislation will depend largely on our collective efforts to address these underlying health system challenges. **NCMJ**

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