



Update on Health Reform Implementation in North Carolina

North Carolina Local Health Directors' Legal Conference

Presentation by:
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North Carolina Institute of Medicine
April 21, 2011



Agenda

- A word about the NC Institute of Medicine
- Background information on North Carolina's health system
- Implementing health reform in North Carolina



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The North Carolina Institute of Medicine (NCIOM)

- 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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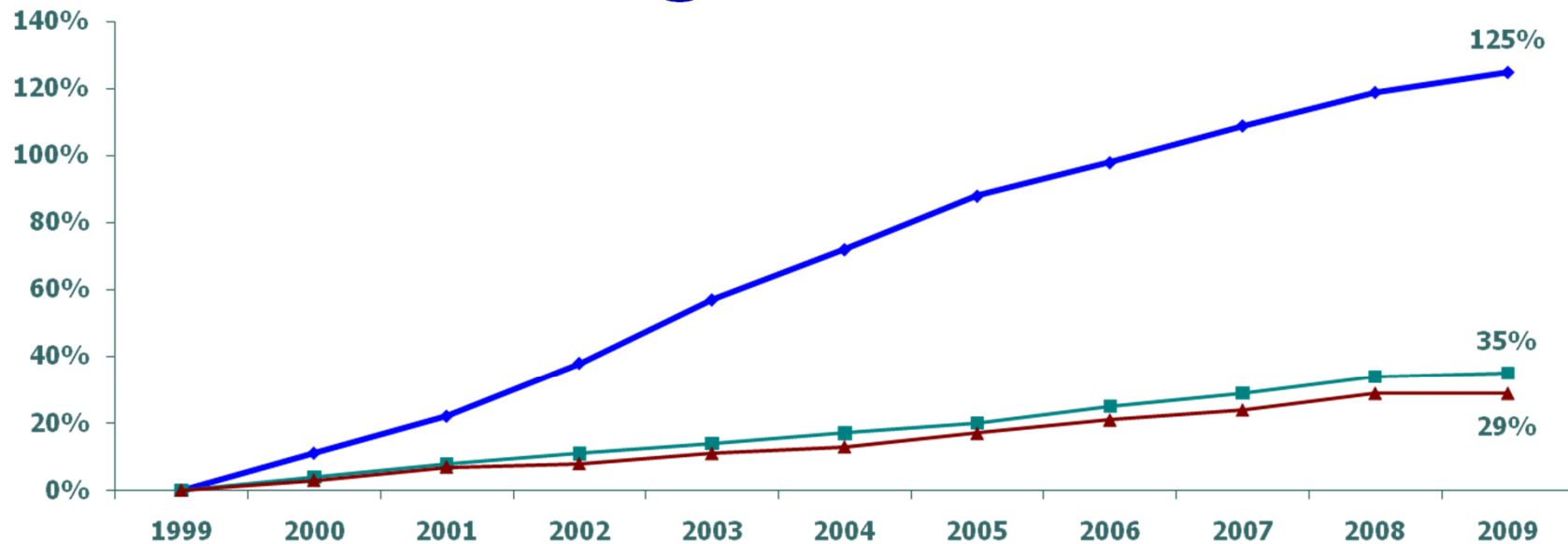
North Carolina: Uninsured

- Estimates of the uninsured:
 - Recent Census numbers showed approximately 1.7 million non-elderly uninsured in NC in 2009 (20% state's nonelderly population).
- Lack of health insurance impacts a person's health.
 - People who are uninsured are less likely to receive preventive services, more likely to end up in the hospital for preventable conditions or late stage cancer, and more likely to die prematurely.
 - Lack of insurance coverage affects a family's financial security.



Source: US Census. Health Insurance Coverage Status and Type of Coverage by State—Persons Under 65. Table HIA-6.

US Health Care Costs Rising More Rapidly Than Inflation or Earnings (1999-2009)



Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2000-2008. Bureau of Labor Statistics, Consumer Price Index, U.S. City Average of Annual Inflation (April to April), 2000-2008; Bureau of Labor Statistics, Seasonally Adjusted Data from the Current Employment Statistics Survey, 2000-2008 (April to April). Claxton G. et. al. Job-Based Health Insurance: Costs Climb at a Moderate Rate. Health Affairs. Sept. 15, 2009.





North Carolina: State Comparisons

- North Carolina ranks 35th of the 50 states in population health measures. (America's Health Rankings, 2010)
 - Based on a composite of 22 measures including behaviors, community and environment, public and health policies, clinical care, and health outcomes.
- North Carolina was ranked 41st on health system performance (Commonwealth Fund, 2009)
 - Based on a composite of 63 measures across five domains: access, prevention and treatment, avoidable hospital use and costs, equity, and healthy lives.



America's Health Rankings:

<http://www.americashealthrankings.org/yearcompare/2009/2010/NC.aspx>

<http://www.commonwealthfund.org/Maps-and-Data/State-Scorecard-2009/DataByState/State.aspx?state=NC>



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Rationale for National Health Reform Legislation

- The Affordable Care Act (ACA) was enacted to address certain underlying problems in our current health system including, but not limited to, coverage, costs, quality, and population health.



Potential Impact on North Carolina

- The ACA offers both opportunities and challenges:
 - More than 1.1 million uninsured people are likely to gain coverage in North Carolina by 2019.*
 - However, this will require significant new state funds
 - The ACA included new grant funds for prevention, testing new models of care, and some new opportunities to expand the health professional workforce.
 - The ACA includes new requirements for state government, insurers, providers, employers and individuals.



*Estimate assumes that 92% of North Carolina population is insured by 2019.

● ● ● | Health Reform Workgroups

- The NC Department of Health and Human Services (DHHS) and NC Department of Insurance (DOI) asked the NCIOM to convene workgroups to examine how to best implement the ACA in North Carolina and to identify new funding opportunities.
 - *Overall Advisory Committee:*
Co-Chairs: Secretary Lanier Cansler, CPA; Insurance Commissioner Wayne Goodwin, JD
 - *Eight work groups:* Health Benefit Exchange and Insurance Oversight; Health Professional Workforce; Medicaid Provisions and Elder Law; New Models of Care; Prevention; Quality; Safety Net; Fraud and Abuse



Workgroup Charge

- Each workgroup was charged with examining ACA provisions that:
 1. North Carolina had the responsibility, or choice, about whether to implement (e.g., Medicaid expansion, development of a health benefits exchange).
 2. North Carolina could help providers or other groups prepare for new responsibilities (e.g., quality; and fraud, abuse, and overutilization requirements).
 3. North Carolina organizations could apply for new funding opportunities to further state health goals (e.g., prevention, workforce, safety net).
 4. North Carolina had new opportunities to improve health outcomes or reduce health expenditures (e.g., new models of care).



NC Foundations

- Health reform workgroups supported by generous grants from:
 - Kate B. Reynolds Charitable Trust
 - Blue Cross and Blue Shield of North Carolina Foundation
 - The Duke Endowment
 - John Rex Endowment
 - Cone Health Foundation
 - Reidsville Area Foundation
- North Carolina Network of Grantmakers created ACA grant tracking system: www.ncgrantmakers.org



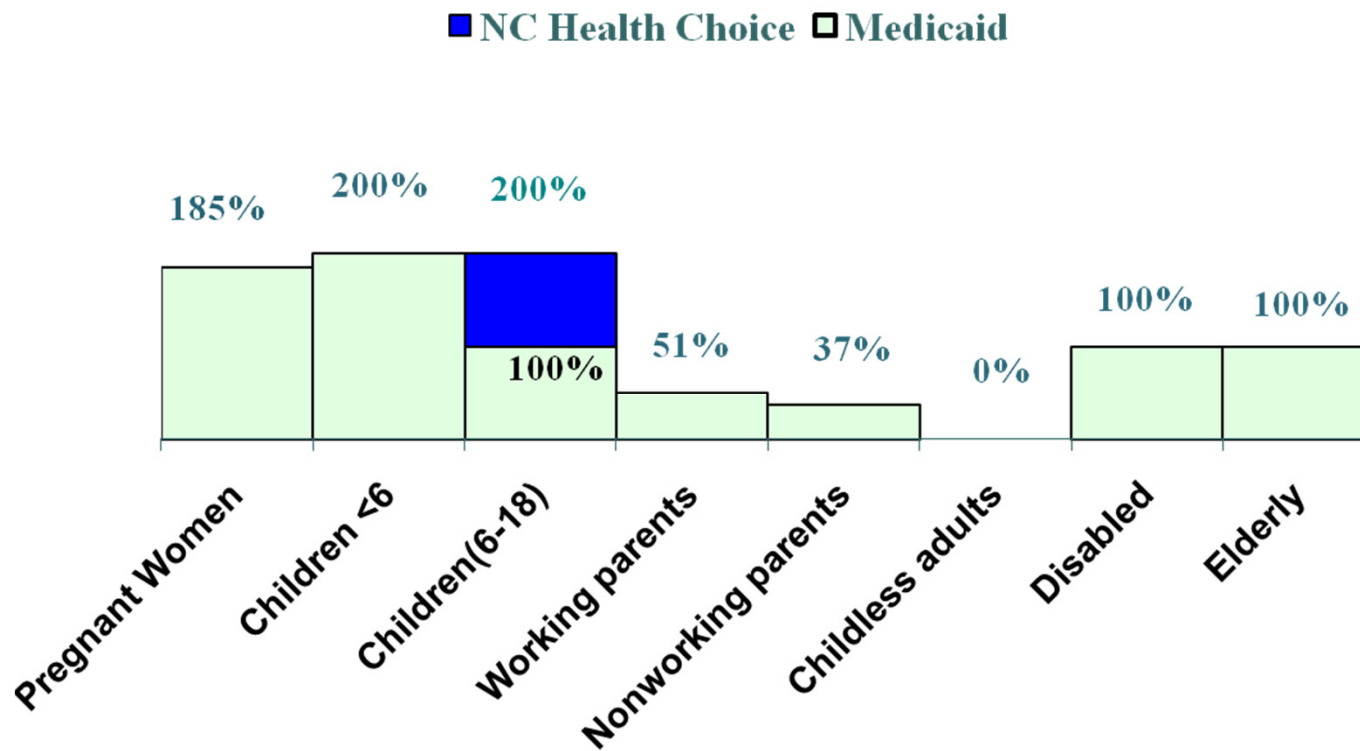
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● ● ● | Overview of Health Reform

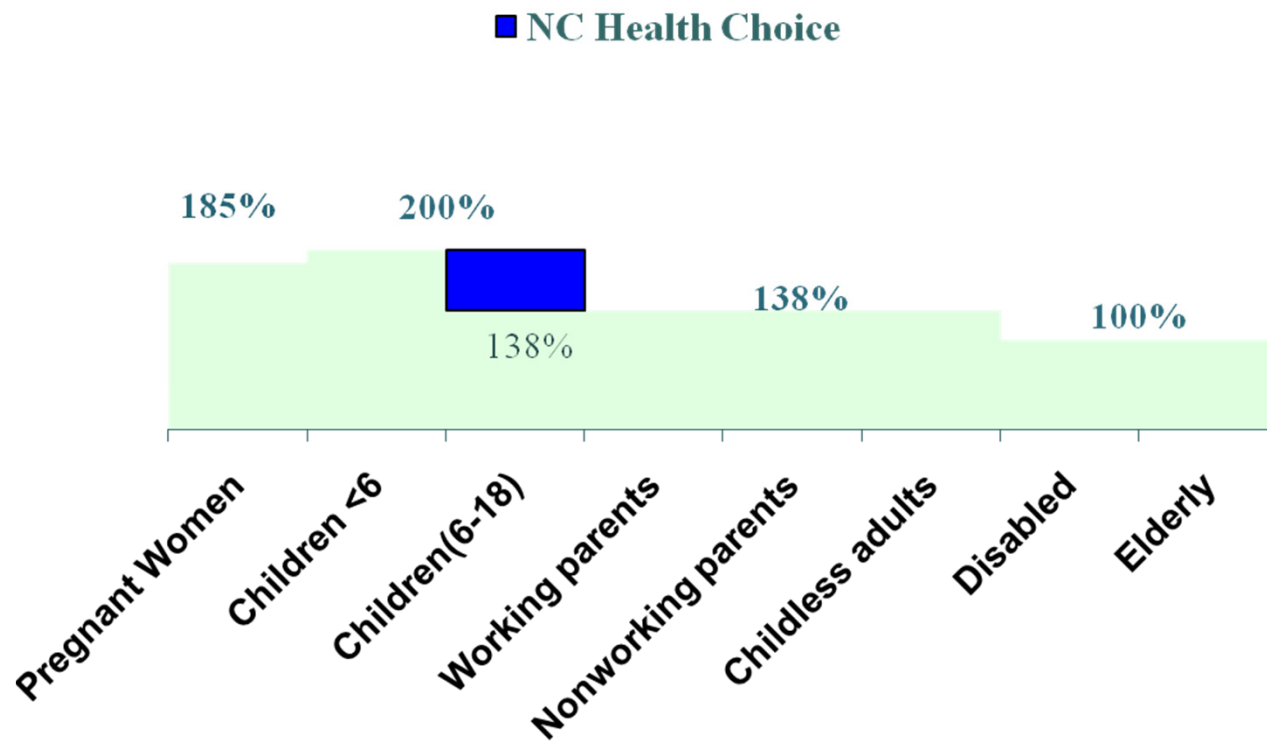
- By 2014, the bill requires most people to have health insurance and large employers (50+ employees) to provide health insurance--or pay a penalty.
 - Builds on our current system of public coverage, employer-sponsored insurance, and individual (non-group) coverage.
- New funding for prevention, expansion of the health workforce, long-term care services, increasing the healthcare safety net, and improving quality.

Existing NC Medicaid Income Eligibility (2010)



Currently, childless, non-disabled, non-elderly adults can not qualify for Medicaid

Existing NC Medicaid Income Eligibility (2014)



Beginning in 2014, adults can qualify for Medicaid if their income is no greater than 138% FPL, or \$30,429 for a family of four (2010)

Source: Affordable Care Act (Sec. 2001, 2002). The ACA expands Medicaid for adults up to 133% FPL, but also includes a 5% income disregard. Effectively, this raised the income limits to 138% FPL.



Medicaid and Elder Services

- **The ACA expands Medicaid eligibility to all adults with income up to 138% FPL.**
 - The federal government pays 100% of costs of new eligibles for three years, then phases down to 90% of costs.
 - The federal government pays ~64% of costs of people who were eligible, but newly enrolled.
- The NC Division of Medical Assistance estimates the more than 500,000 people will become eligible for Medicaid.
 - The total cost to the state will be approximately \$830 million (SFY 2014-2019). The federal government will contribute more than \$15 billion.



Medicaid Eligibility Rules

- Generally requires states to maintain current enrollment and eligibility standards until the state Exchange is established (Sec. 2001)
- No asset tests or use of income disregards to determine eligibility for children and most adults (Sec. 2002)
 - Asset rules still used for long-term care, home and community based services, medically needy program
- **Undocumented immigrants not eligible for Medicaid**
 - Most lawfully present immigrants are not eligible for coverage for the first five years (except state option for pregnant women and children)



Enrollment Simplification

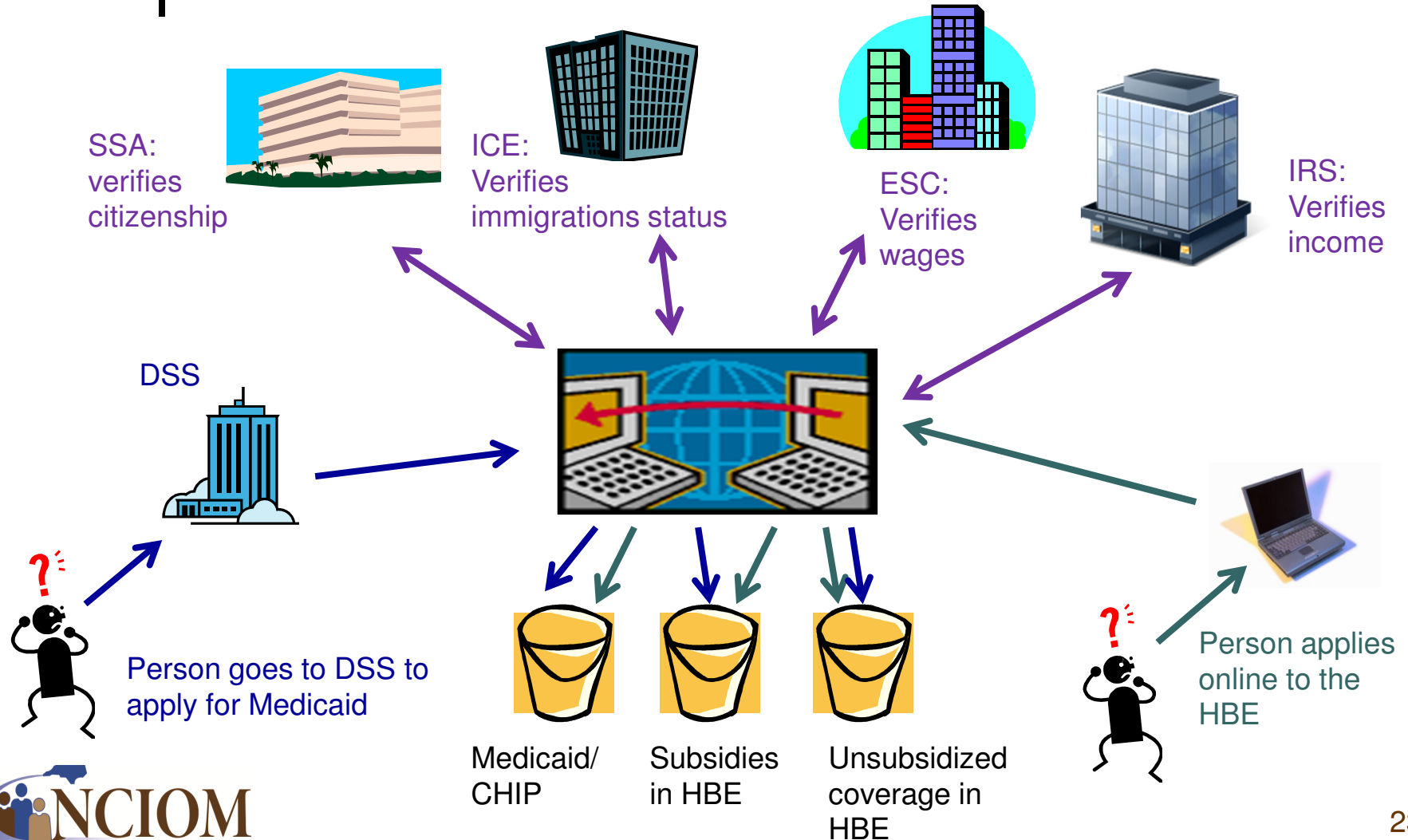
- States will be required to **simplify enrollment** and coordinate between Medicaid, CHIP, and the new Health Insurance Exchange. (Sec. 2201; 1413)
 - Secretary will develop a single streamlined enrollment form that will be used to apply for all applicable state health subsidy programs (Medicaid, CHIP, subsidy).
 - Form may be filed online, in person, by mail, or by telephone.
 - Person may file form with HBE or with Medicaid office.
- Electronic data matching (Sec. 1137, 453, 1942 of SSA)
 - Income eligibility: data matches with state unemployment compensation agency, and wage information reported to SSA and IRS.
 - Lawful immigration status with Immigrations Customs Enforcement (ICE).



Outreach

- **Must conduct outreach to vulnerable populations** (Sec. 2201)
 - Vulnerable populations include: children, unaccompanied homeless youth, children and youth with special health care needs, pregnant women, racial and ethnic minorities, rural populations, victims of abuse or trauma, individuals with mental health or substance-related disorders, and individuals with HIV/AIDS.
- **Hospitals can determine presumptive eligibility for all Medicaid populations** (Sec. 2202)

Simplified Application and Enrollment Process





Medicaid: Other State Options

- *Comprehensive coverage of clinical preventive services with enhanced federal funding.*
 - Medicaid is not required to provide coverage for all recommended clinical preventive services and immunizations, but will receive enhanced federal funding if it does so without cost sharing.
- ***Incentives for Medicaid recipients. Competitive grants to states to provide incentives to Medicaid recipients to promote healthy lifestyles or better manage chronic illnesses.***
 - North Carolina considering submitting an application focused on reducing childhood obesity.



Medicaid: Other State Options

- *Medicaid home and community based services (HCBS)*. States can expand HCBS with enhanced federal funding.
 - Immediate implementation unlikely if new options will increase costs.



Medicare

- **Enhances preventive services beginning Jan 2011**
(Sec. 4103-4105, 10402, 10406)
- **Phases out the gap in the Part D “donut hole” by 2020** (Sec. 3301, 3315, as amended by 1101 Reconciliation)
 - Pharmaceutical companies required to provide 50% discount on brand-name prescription drugs beginning in 2011 (Sec. 3301)
- Appropriates \$45M in additional funds (FY 2010-2012) to expand outreach and assistance to enroll low-income Medicare beneficiaries in Part D. (Sec. 3306)
 - **North Carolina Department of Insurance received \$1.7 million for outreach efforts.**



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ACA Insurance Reform: Immediate Implementation

- Federal high risk pool, which is administered in NC through Inclusive Health.
 - North Carolina eligible for up to \$145 million in federal funds to support high risk pool.
 - In February, North Carolina had the 6th highest number of enrollees in the federal high risk pool.
- Sliding scale tax credit for small businesses with 25 or fewer employees with average wages of \$50,000 or less, if employer pays at least 50% of the premium costs.
 - **NCIOM estimates that North Carolina small businesses could qualify for more than \$200 million in this tax credit.**



*Applies to new plans purchased or renewed after Sept. 23, 2010. Some of these protections do not apply to grandfathered plans.



ACA Insurance Reform: Immediate Implementation

- Insurance law changes, including:
 - Allowing parents to cover children on their plans up to age 26.
 - Eliminating lifetime limits and restricting annual limits in insurance plans. (Sec. 1001, 10101)
 - Prohibiting insurers from discriminating against children with preexisting health problems.**
 - Coverage of preventive services with no cost sharing.
- New insurance law requirements to ensure that consumers getting “value” for their insurance dollars.
 - Requires a minimum “Medical Loss Ratio” (MLR)—eg, that insurers spend at least a specific proportion of premiums on health care expenses.**

*Applies to new plans purchased or renewed after Sept. 23, 2010. Some of these protections do not apply to grandfathered plans.

** These provisions are causing difficulties for some insurers to implement. NC DOI considering applying for waivers to phase in MLR, and creating annualized open enrollment period for child-only plans.





Insurance Reform

- In 2014, insurers will be prohibited from:
 - Discriminating against people based on preexisting health problems. (Sec. 1201)
 - Including annual or lifetime limits for essential benefits. (Sec. 1001, 10101)
- Insurers are required to:
 - Limit the differences in premiums charged to different people based on age (3:1 variation allowed), and certain other rating factors (Effective 2014; Sec. 1201)
- NC Department of Insurance has greater responsibility for premium rate oversight, ensuring compliance with federal laws, and for consumer protections.



Essential Benefits Package

- HHS Secretary will recommend an **essential health care benefits package** that includes a comprehensive set of services:* (Sec. 1302)
 - Hospital services; professional services; prescription drugs; rehabilitation and habilitative services; mental health and substance use disorders; and maternity care.
 - Well-baby, well-child care, oral health and vision services for children under age 21. (Sec. 1001, 1302)
 - Recommended preventive services with no cost-sharing and all recommended immunizations. (Sec. 1001, 10406)
 - Mental health parity law applies to qualified health plans. (Sec. 1311(j))



* With some exceptions, existing grandfathered plans not required to meet new benefit standards or essential health benefits.



Essential Benefits Package

- Four levels of plans, all must cover essential benefits package: (Sec. 1302(d))
 - Bronze (minimum creditable coverage): must cover 60% of the benefit costs of the plan
 - **Silver: 70% of the benefits costs***
 - Gold: 80% of the benefit costs
 - Platinum: 90% of the benefit costs
 - Catastrophic plan (only available to people up to age 30 or if exempt from coverage mandate) (Sec. 1302(e))



Individual Mandate

- Citizens and legal immigrants will be required to pay penalty if they do not have qualified health insurance, unless exempt. (Sec. 1312(d), 1501, amended Sec. 1002 in Reconciliation)
 - Penalties: Must pay the greater of: \$95/person or 1% taxable income (2014); \$325 or 2.0% (2015); or \$695 or 2.5% (2016), increased by cost-of living adjustment*
 - **Some of the exemptions include people who are not required to file taxes, and those for whom the lowest cost plan exceeds 8% of an individual's income** (Sec. 1501(d)(2)-(4),(e))



*Families of 3 or more will pay the greater of the percentage of income, or three times the individual penalty amount. The maximum penalty is equal to the amount the individual or family would have paid for the lowest cost bronze plan (minus any allowable subsidy).



Subsidies to Individuals

- **Refundable, advanceable premium credits will be available to individuals with incomes up to 400% FPL on a sliding scale basis**

(\$43,320/yr. for one person, \$58,280 for two, \$73,240 for three, \$88,200 for a family of four in 2010).* (Sec. 1401, as amended by Sec. 1001 of Reconciliation)

- Individuals are generally not eligible for subsidies if they have employer-based coverage, TRICARE, VA, Medicaid, or Medicare (Sec. 1401(c)(2)(B)(C), 1501)
- In comparison: North Carolina's median household income in 2008 was \$46,574 (avg. household = 2.5 people).

*2010 Federal Poverty Levels are: \$10,830 for an individual, \$14,570 for a family of two, \$18,310 for a family of three, or \$22,050 for a family of four. US Census Bureau. North Carolina. Quick Facts. <http://quickfacts.census.gov/qfd/states/37000.html>



● ● ● | Employer Responsibilities

- Employers with 50 or more full-time employees required to offer insurance or pay penalty (Sec. 1201, 1513, amended Sec. 1003 Reconciliation)
- Employers with less than 50 full-time employees exempt from penalties. (Sec. 1513(d)(2))
 - Employers with 25 or fewer employees and average annual wages of less than \$50,000 can receive a tax credit. (Sec. 1421, Sec. 10105)



Health Benefits Exchange (HBE)

- States must create an HBE for individuals and small businesses. If the state does not create a HBE, the federal government will do so. (Sec. 1311, 1321)
 - Legislation is currently pending in the North Carolina General Assembly that would create a state-organized HBE.
- Exchanges will:
 - Certify *qualified health plans* to participate in the HBE.
 - Provide standardized information (including quality and costs) to help consumers choose between qualified health plans.
 - **Determine eligibility for the subsidy and coordinate enrollment and eligibility with Medicaid.**
 - **Contract with certified patient navigators.**



Qualified Health Plans

- To be certified, a qualified health plans must: (Sec. 1301, 1311, 10104)
 - Provide essential benefits package
 - Be licensed under state law
 - Offer at least one qualified health plan in silver and gold levels in the HBE
 - Agree to charge the same premium rate for each qualified health plan, whether or not offered through the HBE
 - Operate a single risk pool for the individual market, and a single risk pool for small employers (whether or not offered through the HBE)
 - Ensure sufficient choice of providers and **contract with essential community providers***
 - Be accredited and meet certain quality reporting and improvement requirements



*As a general rule, QHPs need not contract with essential community providers if they refuse to accept generally applicable payment rates. (1311(c)(2)). However, the ACA includes special payment protections for FQHCs. QHPs are required to pay FQHCs no less than Medicaid prospective cost-based methodology. (1302(g))



Patient Navigators

- HBE will provide grants to **patient navigators**. (Sec. 1311(i))
 - Navigators must have relationships with employers and employees, consumers, or self-employed individuals likely to enroll.
 - Navigators can include **community and consumer-focused nonprofits**; may also include agents/brokers, professional associations, Chambers of Commerce, etc.
 - Navigators must: distribute fair and impartial information concerning enrollment and availability of subsidies; facilitate enrollment into qualified health plans; provide referrals to consumer ombuds programs/other state programs to help with questions or complaints; and provide information in manner that is culturally and linguistically appropriate.
 - Navigators organizations may *not* be paid directly from insurers.
- Secretary will develop standards for navigator qualifications.





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ACA Prevention Provisions

- The ACA included new funding for a Prevention and Public Health Fund (\$500M FY 2010-\$2B FY 2015) to invest in prevention, wellness, and public health activities. (Sec. 4002)
 - Priority areas for the national public health agenda includes health promotion and disease prevention to address lifestyle behavior modification (including smoking cessation, proper nutrition, exercise, mental health, behavioral health, substance use disorder, and domestic violence screenings). (Sec. 4001)



New ACA Prevention Grant Funds

- North Carolina has already received:
 - \$2.2 million for maternal, infant, and early childhood home visiting programs.
 - \$1.8 million to assist pregnant and parenting women in high needs communities.
 - \$1.5 million for comprehensive sexuality education.
 - \$400,000 to enhance public health surveillance.
 - \$3.9 million for obesity prevention and tobacco cessation activities.
 - \$1.9 million for public health quality improvement activities.
- North Carolina planning for new potential grant opportunities: Community Transformation Grants.



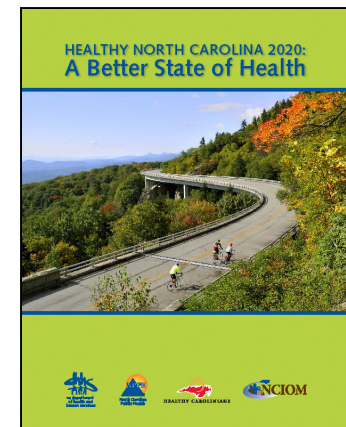
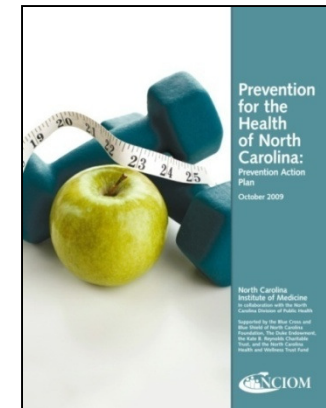
Community Transformation Grants

- Community transformation grants (Sec. 4201, 10403)
 - To be used for the implementation, evaluation, and dissemination of evidence-based community preventive health activities to reduce chronic diseases, prevent the development of secondary conditions, address health disparities, and develop evidence based effective prevention programs.
 - Grants must be multifaceted, including: policy, environmental, programmatic, and if appropriate, infrastructure changes to promote healthy living and reduce disparities.
 - Activities may focus on healthier school environments, active living communities, access to nutritious foods, physical activity opportunities, promotion of healthy lifestyle, prevention of chronic disease, worksite wellness, healthy food options, reducing disparities, and addressing needs of special populations.



Community Transformation Grants (CTG)

- CTG opportunities have not yet been released
- CTG grants can help North Carolina improve population health
 - DPH plans on applying for CTG grants to implement strategies identified in *Prevention for the Health of North Carolina*, and *A Better State of Health*





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● ● ● | **ACA Workforce Provisions**

- The ACA created National Workforce Commission to help establish national workforce priorities.
 - Thomas Ricketts, PhD, UNC-CH was appointed as one of 15 Commission members.
- ACA includes new efforts to expand and promote better training for the health professional workforce.
 - Including primary care, pediatrics, geriatrics, nursing, dental health, public health, mental health/substance abuse, allied health and direct care workforce.
- Workforce workgroup looking at short-term solutions to expand the health professional workforce (another group with a federal grant are exploring long-term solutions).



NC Workforce Grants

- North Carolina has received ACA workforce grants, including:
 - Primary care residency expansion (\$3.7 M UNC-CH; \$1.8M New Hanover Regional).
 - Physician Assistant training (\$1.3M Duke, \$1.9M Methodist).
 - Advanced nursing education expansion (\$1.3M Duke).
 - Public health training (\$643K, UNC-CH)
 - Personal and home care aide training (\$600K, NC DHHS).
- State workforce development grant (\$100K, Sheps Center, UNC-CH) exploring options to expand primary care workforce.



Workforce: Underserved Areas

- **National Health Service Corps: appropriates a total of \$1.5B over 5 years.** (FY 2011-2015) (Sec. 5207, 10503)
 - Loan forgiveness for agreeing to serve in health professional shortage areas (HPSAs).
 - Eligible providers include: primary care, dental, psychiatric (physician and mid-level providers), plus psychologists, licensed clinical social workers, psychiatric nurse specialists, marriage and family therapists, and licensed professional counselors.
 - NC Office of Rural Health and Community Care estimates that it will be able to recruit an additional 20-25 health professionals/year with the new NHSC funds.



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● ● ● | **ACA Quality Provisions**

- 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 (i.e., health outcomes, functional status, transitions, consumer decision making, meaningful use of HIT, safety, efficiency, equity and health disparities, patient experience). (Authorizes \$75M for each FY 2010-2014; Sec. 3013-3014)
- Plan for the collection and public reporting of quality data. (Sec. 3015, 10305, 10331)
- Move towards value based purchasing
- Funding to support comparative effectiveness research.



Quality Workgroup Implementation Efforts

- The Quality workgroup identified the existing quality initiatives already in place in North Carolina. For example:
 - Hospital Center for Hospital Quality and Patient Safety, NC Healthcare Quality Alliance, Community Care of NC.
- The workgroup examined the new quality provisions to determine:
 - If there are gaps between the ACA quality requirements and existing state efforts.
 - The type of education necessary for the public and providers to inform them of the new quality provisions.



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ACA New Models Overview

- The ACA includes new funding to test new models of care to improve quality and efficiency.
(Sec. 3021, 10306)
 - Some of the new models include: payment and practice reform in primary care, reverse co-location (primary care in community mental health agencies), care coordination and community-based teams for chronically ill individuals including people with mental illness, emergency psychiatric coverage in institutions for mental diseases, payment reform.
 - The ACA appropriates \$5 million (FY 2010) for design and implementation of models and \$10 billion to implement those models (FY 2011-2019).



NC New Models Supported by ACA

- North Carolina is nationally recognized for Community Care of North Carolina (CCNC), a patient-centered medical home, which has led to improved health outcomes and reduced costs for care of Medicaid recipients with chronic illnesses.
 - **North Carolina was recently awarded one of the first eight demonstration grants to test a multi-payer initiative building on CCNC.**
 - North Carolina is already implementing many of the “new models” in different parts of the state.



Potential New Models to Explore

- Workgroup developed a compendium of existing “new models” being tested in North Carolina. Some examples include:
 - Just for Us – Duke’s home visiting program for frail elderly.
 - **Telehealth monitoring – Roanoke Chowan community health center use of telehealth to help people with chronic illness manage their health.***
- Workgroup identified other promising “new models” that it is exploring, including:
 - Bundled payments based on “episodes of care.”**
 - Improving transitions of care between care settings.



*DMA considering payment changes to support telehealth monitoring.

**BCBSNC and CaroMount are about to test new episode of care payment for knee surgery.



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ACA Safety Net Provisions

- **The ACA appropriates new funding for community health centers (CHCs).** (Sec. 10503, Sec. 2303 of Reconciliation)
 - Includes a total of \$9.5B over five years for operations (\$1B in FY 2011 increasing to \$3.6B in FY 2015); and \$1.5B over five years for construction and renovation of community health centers (FY 2011-2015). (Sec. 10503, Sec. 2303 of Reconciliation)
 - Kate B. Reynolds Charitable Trust provided seed funding to the NC Community Health Center Association to help identify and assist communities in preparing grant applications for new FQHC funding. In recent funding cycle, North Carolina submitted 31 grant applications.



ACA Safety Net Provisions

- **Appropriates \$50 M each FY 2010-2013 to support school-based health centers** (Sec. 4101, 10402)
 - Includes capital but not operational funding.
 - North Carolina submitted at least 10 applications in latest grant round.
- **Support for community-based collaborative networks of care** (Sec. 10333; authorizes such sums as necessary FY2011-2015)
 - Defined as a consortium of health care providers with a joint governance structure (including providers within a single entity) that provides comprehensive coordinated and integrated health care services for low-income populations.
 - No funding was appropriated, but there is an effort to obtain funding in this year's budget.



ACA Safety Net Provisions

- **The ACA includes new requirements for charitable 501(c)(3) hospitals:** (Sec. 9007, 10903)
 - Must conduct a community needs assessment and identify an implementation strategy; have a financial assistance policy; provide emergency services; and limit charges to people eligible for assistance to amounts generally billed.
 - Public health is working with NC Hospital Association to develop coordinated approach to community health assessments.
- Workgroup is trying to help identify communities of greatest needs to try to target new safety net resources into those communities.
 - Identified areas include primary care, mental and behavioral health, dental, pharmacy, and urgent care.



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Fraud & Abuse Workgroup Implementation

- The ACA includes a number of new fraud and abuse provisions and efforts to reduce overutilization.
- Most of the provisions went into effect in 2010 or will be effective in 2011.
- The workgroup is examining the provisions to determine gaps in existing state laws, new legislation needed, and strategies for provider education.



Summary

- **NCIOM estimates that the ACA will cover more than 1.1 million uninsured by 2019.**
 - **NC Division of Medical Assistance estimates that more than 500,000 people will gain insurance coverage through Medicaid.**
 - **There are more than 700,000 uninsured North Carolinians who would be income eligible for subsidy in HBE.**
- The ACA imposes new requirements on states, insurers, health care providers, employers and individuals.
- The ACA offers the potential—but no guarantee—of improved health outcomes and reduced health care costs.



NCIOM Health Reform Resources

- Interim Report on health reform:
<http://www.nciom.org/wp-content/uploads/2011/03/HR-Interim-Report.pdf>
- Other North Carolina health reform resources include:
 - What Does Health Reform Mean for North Carolina? *NCMJ*, 2010;71:3
<http://www.ncmedicaljournal.com/archives/?what-does-health-reform-mean-for-north-carolina>
 - NCIOM: North Carolina data on the uninsured
<http://www.nciom.org/nc-health-data/uninsured-snapshots/>
 - Information about health reform workgroups available at:
<http://www.nciom.org/task-forces-and-projects/>
- Other prevention related resources include:
 - *Prevention for the Health of North Carolina: Prevention Action Plan*
<http://www.nciom.org/publications/?prevention-for-the-health-of-north-carolina-prevention-action-plan-7725>
 - Healthy NC 2020: A Better State of Health
<http://www.nciom.org/publications/?healthy-north-carolina-2020-a-better-state-of-health>





National Health Reform Resources

- Patient Protection and Affordable Care Act. Consolidated Bill Text
<http://docs.house.gov/energycommerce/ppacacon.pdf>
- US Health Reform website
www.healthcare.gov
- Congressional Budget Office. Selected CBO Publications Related to Health Care Legislation, 2009-2010.
<http://www.cbo.gov/ftpdocs/120xx/doc12033/12-23-SelectedHealthcarePublications.pdf>
- Kaiser Family Foundation
<http://healthreform.kff.org/>



Sliding Scale Subsidies

Individual or family income	Maximum premiums (Percent of family income)	Out-of-pocket cost sharing* (Amount family pays out-of-pocket)	Out-of-pocket cost sharing limits**
<133% FPL	2% of income	6%	\$1,983 (ind)/\$3,967 (fam) (1/3 rd HSA limit)
133-150% FPL	3-4%	6%	\$1,983 / \$3,967
150-200% FPL	4-6.3%	13%	\$1,983/ \$3,967
200-250% FPL	6.3-8.05%	27%	\$2,975/ \$5,950 (1/2 HSA limit)
250-300% FPL	8.05-9.5%	30%	\$2,975/ \$5,950
300-400% FPL	9.5%	30%	\$3,967/ \$7,934 (2/3 ^{rds} HSA limit)



*Out-of-pocket cost sharing includes deductibles, coinsurance, copays.

**Out of pocket limits do not include premium costs. Annual cost sharing limited to: \$5,950 per individual and \$11,900 family in 2010 (HSA limits) (Sec. 1302(c), 1401, 1402, as amended by Sec. 1001 of Reconciliation)



Income Eligibility for Subsidized Insurance (2010, 2014)

Annual income eligibility based on family size of four
(based on 2010 federal poverty levels)

	<u>Current:</u> Eligibility for Medicaid or NC Health Choice (2010)	<u>New:</u> Eligibility for Medicaid or NC Health Choice (2014)	<u>New:</u> Eligibility for Subsidy in the Health Benefit Exchange (2014)
Child	≤\$44,100	≤\$44,100	\$44,100-\$88,200
Parent of dependent child	≤\$7,128	≤\$30,429	\$30,429-\$88,200
All other adults (non-disabled, non-elderly)	Not eligible	≤\$30,429	\$30,429-\$88,200