

Federal Health Reform: What It Means to Individuals Living with Mental Illness

NAMI North Carolina's 26th Annual
Conference

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A Word About the NC Institute of Medicine

- Quasi-state agency chartered in 1983 by the NC General Assembly to:
 - Be concerned with the health of the people of North Carolina
 - Monitor and study health matters
 - Respond authoritatively when found advisable
 - Respond to requests from outside sources for analysis and advice when this will aid in forming a basis for health policy decisions

NCGS §90-470



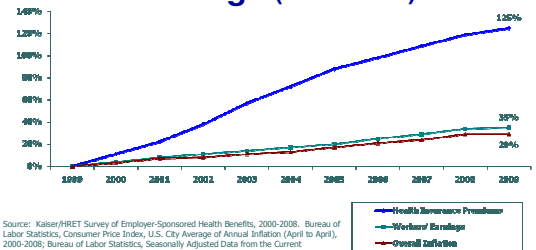
Background

- Estimates of the uninsured (2008-2009):
 - 2008 US Census estimates: 1.4 million non-elderly uninsured in North Carolina (17%)
 - 2009 NCIOM estimate after downturn in the economy: 1.75 million non-elderly uninsured (21%)
- Lack of health insurance impacts on a person's health, as well as a family's financial security
 - People who are uninsured are less likely to receive preventive services, and more likely to end up in the hospital for preventable conditions
 - Decline in health insurance coverage directly related to rising health care costs

Source: NCIOM. Health Care Costs and Insurance Coverage in Five Southern States. Data Snapshot. 2009-3. North Carolina's Increase in the Uninsured: 2007-2009; US Census, Historical Health Insurance Tables, HI6.

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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), 2000-2009; Bureau of Labor Statistics, Seasonally Adjusted Data from the Current Employment Statistics Survey, 2000-2009 (April to April). Claxton G. et al. Job-Based Health Insurance: Costs Climb at a Moderate Rate. Health Affairs. Sept. 15, 2009.



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National Health Reform Legislation

- Patient Protection and Affordable Care Act (HR 3590) (signed into law March 23, 2010)
- Health Care and Education Affordability Act of 2010 (HR 4872) (also referred to as "reconciliation")
- The combined bills are often referred to as the Affordable Care Act (or ACA)



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Basics of National Health Reform--Overview

- Overview of health reform legislation
- Changes in public coverage
- Private coverage
- Other provisions
- Cost containment and financing
- CBO estimates



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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.
- New funding for prevention, expansion of the health workforce, long-term care services, increasing the healthcare safety net, and improving quality



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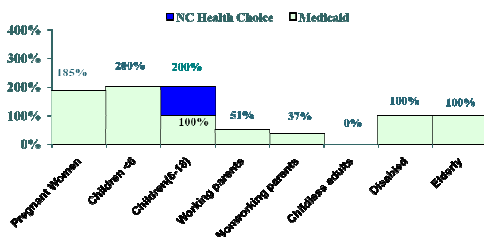
Basics of National Health Reform--Overview

- Overview of health reform legislation
- Changes in public coverage
 - Medicaid, CHIP and Medicare
- Private coverage
- Other provisions
- Cost containment and financing
- CBO estimates



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Existing NC Medicaid Income Eligibility (2010)



KFF. State Health Facts. Calculations for parents based on a family of three.

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Expansion of Public Programs

- Expands Medicaid to cover all low-income people under age 65 (including childless adults) with incomes up to 133% FPL (begins FY 2014) (Secs. 2001, 2002)

Family Size	133% FPL/yr. (2009)
1	\$14,404
2	\$19,378
3	\$24,352
4	\$29,327

- Special outreach requirements to vulnerable populations, including people with mental illness or substance use disorders (Sec 2201).



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CHIP (NC Health Choice)

- States must maintain current income eligibility for children in Medicaid and CHIP until 2019 (Sec. 2101(b), 10203).



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Medicare

- Enhances preventive services, including annual wellness visit, including screening for mental health conditions (Effective Jan 1, 2011 Sec. 4103-4105, 10402, 10406)
- Phases out the gap in the Part D "donut hole" by 2020 (Sec. 3315, as amended by 1101 Reconciliation)
 - \$250 rebate in 2010
 - 50% discount on brand-name drugs in 2011 (Sec. 3301)
- Strengthens the financial solvency of the Medicare program
 - Extends the life of the Medicare trust fund by 12 years



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Basics of National Health Reform--Overview

- Overview of health reform legislation
- Changes in public coverage
- **Private coverage**
 - **Standardized benefit package**
 - **Individual mandate and subsidies**
 - **Employer responsibilities**
 - **Health insurance “exchanges” and insurance reform**
- Other provisions
- Cost containment and financing
- CBO estimates



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Essential Benefits Package


- HHS Secretary will recommend an essential health care benefits package that includes a comprehensive set of services¹; (Sec. 1302; Sec. 2713 of Public Health Service Act, amended in Sec. 1001)
 - Hospital services; professional services; prescription drugs; rehabilitation and habilitative services; and maternity care
 - More extensive 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))



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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))




*Subsidies tied to the second lowest cost silver plan in the HIE.

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Individual Mandate

- Citizens and legal immigrants will be required to pay penalty if they do not have qualified health insurance, unless exempt. (Sec. 1312(d), 1501, amended Sec. 1002 in Reconciliation)
 - Penalties: Must pay the greater of: \$95/person or 1% taxable income (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).

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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>

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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) (1/3rd 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 (2/3rds 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)

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Employer Responsibilities

- Employers with more than 50 employees will be required to pay into fund if they do not provide coverage that meets minimum requirements. (Sec. 1513, amended Sec. 1003 Reconciliation)
 - If employer does not offer coverage, the employer must pay \$2,000 per full-time employee, excluding first 30 employees.
 - If an employer does offer coverage, but at least one full-time employee qualifies for and receives a subsidy, then the employer must pay \$3,000 for any full-time employee who receives a subsidy (but in no event more than \$2,000 per FT employee, excluding the first 30 employees).
- Employers with 50 or fewer employees exempt from penalties. (Sec. 1513(d)(2))



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Subsidies for Small Employers

- Employers with 25 or fewer employees and average annual wages of less than \$50,000 can receive a tax credit. (Sec. 1421, Sec. 10105)
 - *Phase I (2010-2013)*: Sliding scale tax credit of up to 35% if for-profit employer provides coverage and pays at least 50% of total premium cost.
 - *Phase II (2014-later)*: Maximum of 50% tax credit for up to 2 years. Subsidies only available for coverage purchased through the Health Insurance Exchange.



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Health Benefits Exchange

- States will create a Health Benefits Exchange for individuals and small businesses. (Sec. 1311, 1321)
 - Limited to citizens and lawful residents who do not have access to employer-sponsored or governmental-supported health insurance and to small businesses with 100 or fewer employees. (Sec. 1312(f))
- Exchanges will:
 - Provide standardized information (including quality and costs) to help consumers choose between plans
 - Determine eligibility for the subsidy



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Health Benefits Exchange (HBE)

- “No wrong door approach” between Medicaid and HBE (Sec. 1311, 1411, 1413)
 - Individuals who apply for health insurance through the HBE will have their eligibility determined for Medicaid; those who apply for Medicaid will have their eligibility determined for HBE subsidies
- Patient navigators to help link individuals to Medicaid or private insurance through HBEs



Immediate Insurance Reform

- The ACA included immediate changes in insurance laws which may help some people with mental illness
 - Funding for a federal high risk pool that provides more affordable coverage to people with preexisting health problems (Effective July 1, 2010, Sec. 1101)
 - Insurers cannot exclude children based on their preexisting health problems (effective for plans renewed or purchased after September 23, 2010)
 - Insurers cannot impose lifetime limits on health coverage, and must limit annual limits, and cannot rescind policies (effective for plans renewed or purchased after September 23, 2010, Sec. 2711, 2712, of the Public Health Service Act as amended by Sec. 1001 of ACA)



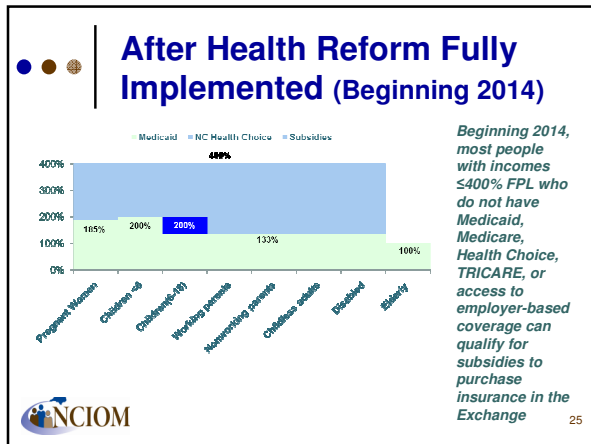
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Insurance Reform: 2014

- Insurers are prohibited from:
 - Discriminate against people based on preexisting health problems (Effective 2014; 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)



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- ## Basics of National Health Reform--Overview
- Overview of health reform legislation
 - Changes in public coverage
 - Private coverage
 - **Other provisions**
 - **Prevention and Wellness; Workforce; Quality and New Models of Care; Safety Net; Long-Term Care**
 - Cost containment and financing
 - CBO estimates
- 26

- ## Prevention and Wellness: Overview
- Federal government providing more funding to support prevention efforts at national, state and local levels
 - Grant funds will be made available for prevention, wellness and public health activities
 - Some of the focus areas include: healthy lifestyle changes, reduction and control of chronic diseases, health disparities, public health infrastructure, obesity and tobacco reduction, improved oral health, immunizations, maternal and child health
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- ## Prevention: Mental Health & Substance Abuse
- Creates National Prevention, Health Promotion and Public Health Council and task forces on clinical preventive services and community preventive services (Sec. 4001, 4003)
 - Priority areas includes **substance use disorders**, and lifestyle behavior modification (including smoking cessation, proper nutrition, exercise, **mental health**, behavioral health, substance use disorder, and domestic violence screenings)
 - Appropriates funds for a Prevention and Public Health Fund (\$500M FY 2010-\$2B FY 2015) to invest in prevention, wellness, and public health activities (Sec. 4002)
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- ## Prevention: Mental Health and Substance Abuse
- Community transformation grants to state and local government agencies and community-based organizations. (Authorizes funds as necessary, Sec. 4201, 10403)
 - Activities may focus on healthier school environments, active living communities, access to nutritious foods, **social and emotional wellness**, chronic disease, worksite wellness, reducing disparities.
 - Transfers \$50M to CMS for Healthy Aging grants to states/local health departments to test interventions with Medicare population. (Authorizes funds as necessary for pre-Medicare, Sec. 4202)
 - Interventions may focus on **mental health and substance use disorders**
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- ## Workforce Overview
- Increased efforts to expand and promote better training for the health professional workforce
 - Includes loan forgiveness and scholarships to train primary care, pediatrics, geriatrics, nursing, dental health, public health, **mental health/substance abuse**, allied health and direct care workforce
 - Increased emphasis on increasing the supply of health professionals in underserved areas
 - Enhanced training in prevention, quality initiatives, interdisciplinary care, community based education, and diversity
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Workforce: Mental Health and Substance Abuse

- 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**



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Workforce: Mental Health and Substance Abuse

- Primary care extension grants: Funds to educate primary care providers about preventive medicine, health promotion, chronic disease management, **mental health and substance abuse**, evidence-based therapies, and working with community-based health extenders (Authorizes \$120M in each FY 2011, 2012 and sums necessary in FY 2013-2014, Sec. 5405)
- **Child and adolescent mental and behavioral health loan repayment if serve in underserved areas** (Authorizes \$30M in each FY 2010-2014, Sec. 5203)
- **Mental and behavioral health:** Grants to higher education schools to develop, expand, or enhance mental health and substance abuse training (Authorizes \$8M for social work, \$12M for psychology, \$10M for child and adolescent mental health, \$5M for paraprofessional child and adolescent health for FY 2010-2013, Sec. 5306)



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Quality Overview

- Providers and payers will be required to report data to measure quality of care
 - Secretary will develop quality measures for different populations and organizations
 - Data will be made available to the public
 - Increased emphasis on value-based payments to providers and insurers



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Quality: Mental Health

- **Research on postpartum depression, and grants to public or nonprofits to operate programs to address postpartum depression** (Authorizes \$3 M in FY 2010, Sec. 2952)
- **Centers for Excellence for Depression** (Sec. 10410)



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New Models of Care: Mental Health and Substance Abuse

- State option: Health homes for people with chronic illness (Effective Jan. 1, 2011; Sec. 2703)
 - Includes people with **at least one serious and persistent mental health condition**
- **Emergency psychiatric demonstration project for up to 3 years** (Effective FY 2011-2015; Sec. 2707)
 - Payment to private Institutions of Mental Diseases (IMD) for Medicaid eligibles, ages 21-64, who need psychiatric care to stabilize threats to self or others
 - Appropriates \$75M for FMAP for participating states



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New Models of Care: Mental Health and Substance Abuse

- **Co-location of primary and specialty care in community-based mental health settings.** (Authorizes \$50M in FY 2010 and such sums as necessary in FY 2011-2014, Sec. 5504)
- Community-based interprofessional health teams to support patient-centered medical home: HHS Secretary will establish grants program.
 - Teams may include medical specialists, nurses, pharmacists, nutritionists, dietitians, social workers, **behavioral and mental health providers (including substance use disorder prevention and treatment providers)**, doctors of chiropractic, licensed complementary and alternative medicine practitioners and physicians' assistants
- Medication management: HHS Secretary shall establish grants or contracts to provide medication management for people with 4 or more medications, high risk medications, and/or chronic diseases to reduce overall costs. (Authorizes sums necessary, Sec. 3503, 10328)



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● ● ● Safety Net Overview

- Federally qualified health centers: Appropriate a total of \$9B over five years for operations, \$1.5B for construction and renovation (FY 2011-2015) (Sec. 10503, Sec. 2303 of Reconciliation)
- School based health centers: Appropriates \$50M in each FY 2010-2013 (Sec. 4101, 10402)
 - **Must provide comprehensive primary care, mental health and substance use disorder assessments, crisis intervention, counseling, treatment, and referrals to other services (including emergency psychiatric care, community support programs, inpatient care, outpatient programs)**
 - **Priorities to communities that have barriers to primary health care and mental health and substance use disorder services for children and adolescents**



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● ● ● Long-Term Care

- Establishes a national voluntary insurance program to purchase community living assistance services and supports (CLASS) financed through payroll deduction. (Sec. 8001-8002, 10801)
- New Medicaid state options to expand home and community-based services



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● ● ● Cost Containment & Financing

- Reduction in existing health care costs through:
 - Increased emphasis on: reducing fraud & abuse, administrative simplification, reducing excess provider/insurance payments
- Increased revenues through:
 - Fees paid by individuals/employers for failure to have/offer insurance
 - Taxes/fees on insurers, pharmaceuticals, tanning salons, "Cadillac" insurance plans, wealthier individuals



*Cadillac plans defined as plans that exceed \$10,200 for individual coverage and \$27,500 for family coverage (effective 2018), with higher thresholds for people in high-risk professions or retirees.

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● ● ● Congressional Budget Office (CBO) Projections

- Covers 92% of all nonelderly residents (94% of legal, nonelderly residents)
 - Would cover an additional 32 million people (leaving 23 million nonelderly residents uninsured by 2019)
- Expansion of insurance coverage and new appropriations included in PPACA will cost \$938 billion over 10 years.
 - However, with new revenues and other spending cuts, PPACA is estimated to reduce the federal deficit by \$124 billion over 10 years.*



* More recent CBO estimate suggests that costs would increase by \$115 billion over 10 years if Congress funds all the provisions that are authorized at certain levels but not yet appropriated. Sources: CBO letter dated March 20, 2010, May 11, 2010.

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Other NCIOM Resources

- What Does Health Reform Mean for North Carolina?
North Carolina Medical Journal, May/June 2010;71:3
- Other resources on health reform are available at:
www.nciom.org/data/healthreform.php.



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Useful Resources

- Senate Bill: Patient Protection and Affordable Care Act (HR 3590 signed into law March 23, 2010)
http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=111_cong_bills&docid=f:h3590enr.txt.pdf
- Health Care and Education Reconciliation Act of 2010 (HR 4872 signed into law March 30, 2010)
http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=111_cong_bills&docid=f:h4872eh.txt.pdf
- Kaiser Family Foundation
<http://www.kff.org/healthreform/upload/0061.pdf>
- Congressional Budget Office
<http://www.cbo.gov/ftpdocs/113xx/doc11379/Manager'sAmendmenttoReconciliationProposal.pdf>
http://www.cbo.gov/ftpdocs/114xx/doc11490/LewisLr_HR3590.pdf
http://www.cbo.gov/ftpdocs/114xx/doc11493/Additional_Information_PPACA_Discretionary.pdf



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http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=111_cong_bills&docid=f:h4872eh.txt.pdf
- Kaiser Family Foundation
<http://healthreform.kff.org/>
- Congressional Budget Office
<http://www.cbo.gov/ftpdocs/113xx/doc11379/Manager'sAmendmenttoReconciliationProposal.pdf>
http://www.cbo.gov/ftpdocs/114xx/doc11490/LewisLr_HR3590.pdf
http://www.cbo.gov/ftpdocs/114xx/doc11493/Additional_Information_PPACA_Discretionary.pdf



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Useful Information: North Carolina

- NCIOM: North Carolina data on the uninsured
<http://www.nciom.org/data/uninsured.shtml>
- Sheps Center for Health Services Research, UNC-CH: State profiles of Medicaid and CHIP in rural and urban areas
<http://www.shepscenter.unc.edu/medicaid/profiles/>
- Kaiser Family Foundation: State Health Facts
<http://www.statehealthfacts.org/>



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