North Carolina
State Health Plan
FOR TEACHERS AND STATE EMPLOYEES

Impact of the Affordable Care Act (ACA) on the State Health Plan

Joint Study Committee on the Affordable Care Act and Implementation Issues

March 18, 2014

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A Division of the Department of State Treasurer

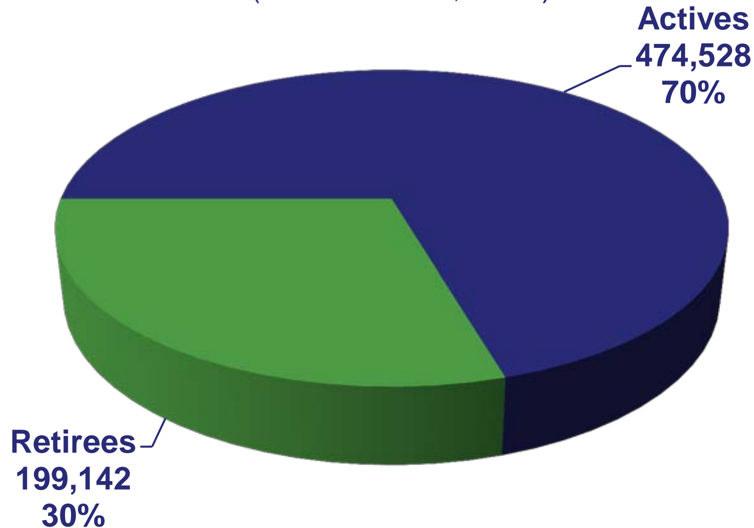
Presentation Outline

- Background Information
- Financial Impact of ACA
- Other Changes Due to ACA
- Future Considerations
- Conclusions

State Health Plan Membership

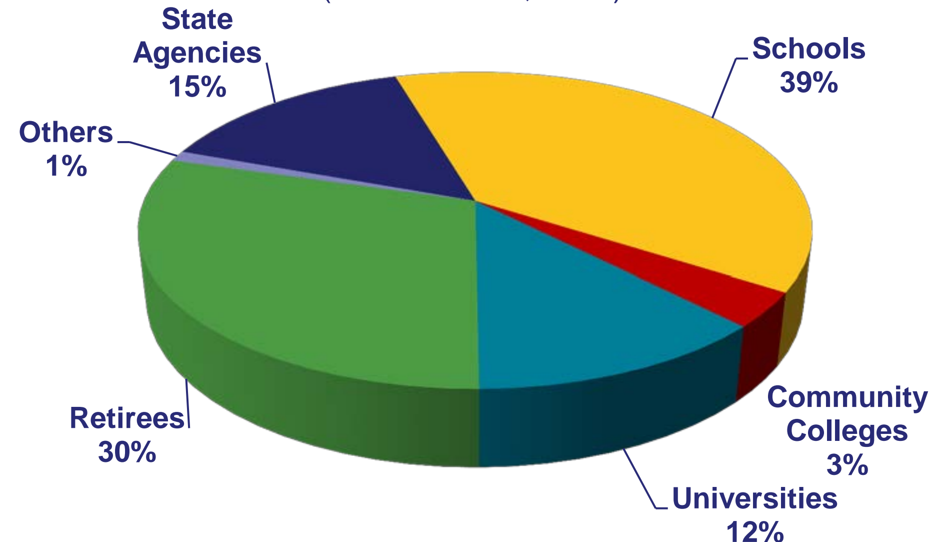
- The State Health Plan covers more than 673,600 active and former employees and their dependents
- The schools are the largest employing entity in the Plan, with 39% of members

Membership by Subscriber Status
(December 31, 2013)



Notes: Dependents are included with respective subscriber group. COBRA and direct bill members are included with Actives.

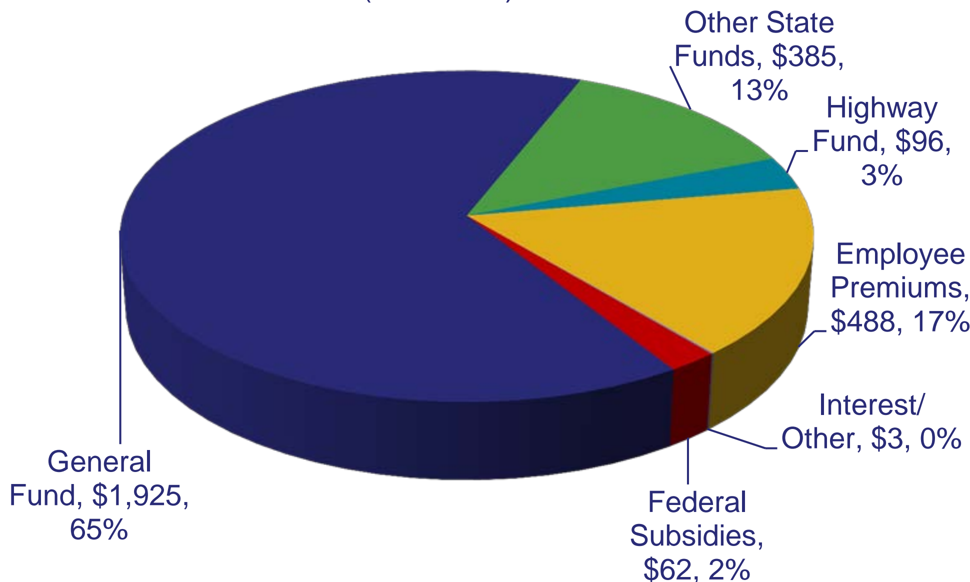
Membership by Entity
(December 31, 2013)

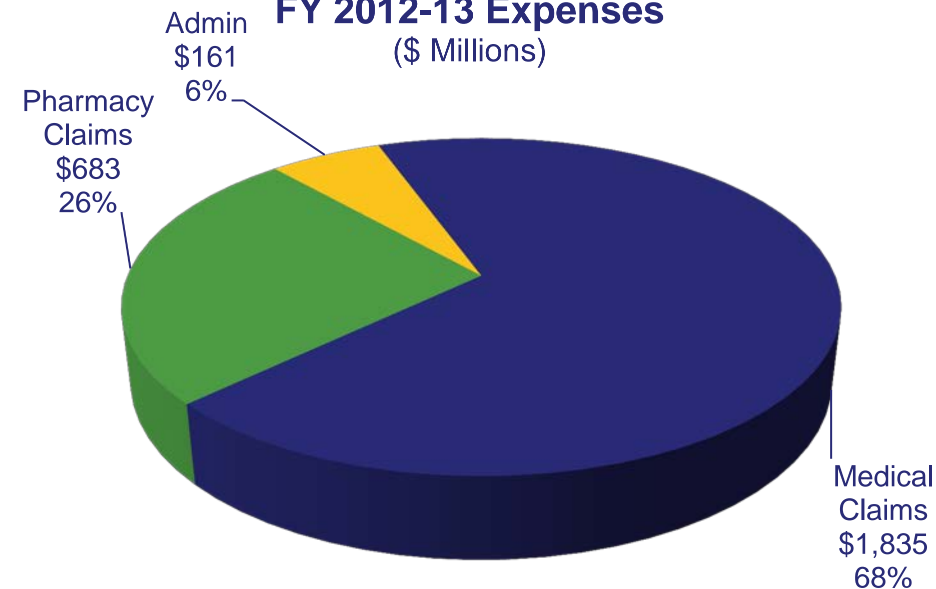


Notes: Dependents are included with respective subscriber entity. Schools include charter schools and traditional public schools.

State Health Plan Finances FY 2012-13

- State Health Plan Revenues come primarily from employer contributions
- Most of the State Health Plan's $2.679 billion expenditures are for claims



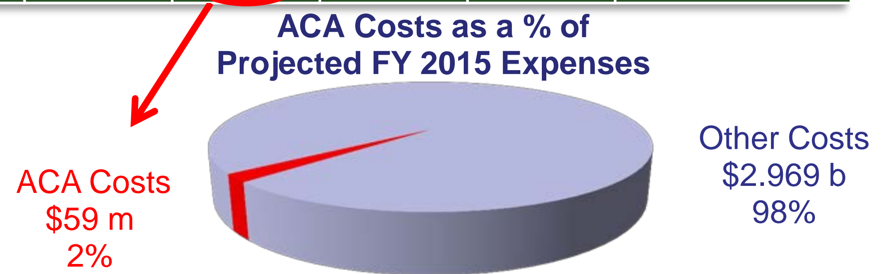


Total State Employer Contributions = $2.4 billion, 81% of total funding.

Financial Impact of Affordable Care Act

	($ Millions) FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017	7-Year Total
Revenue from ACA								
Early Retiree Reinsurance	$45.3	$42.2	($0.6)	$0.0	$0.0	$0.0	$0.0	$86.9
Increased Expenditures due to ACA (Estimated)								
Cover Dependents to Age 26		($15.6)	($15.6)	($16.9)	($18.3)	($19.9)	($21.6)	($107.9)
Reinsurance Fee					($34.6)	($21.0)	($14.2)	($69.9)
PCORI Fee					($0.6)	($1.2)	($1.3)	($3.1)
Preventive in CDHP				($1.5)	($2.5)	($3.1)	($4.1)	($11.2)
Essential Health Benefits				($1.3)	($2.9)	($3.1)	($3.4)	($10.8)
Net Financial Impact on Plan	**$45.3**	**$26.6**	**($16.1)**	**($19.8)**	**($59.0)**	**($48.4)**	**($44.5)**	**($116.0)**

For FY 2015 ACA costs represent a small percentage of total Plan costs



Early Retiree Reinsurance Program (ERRP)

- Incentive for employers to continue coverage for early retirees
- Early retirees are defined as former employees who are retired, do not have Medicare, and are between the ages of 55 and 65
- Reimbursed employers 80% of incurred claims between $15,000 and $90,000 per benefit year
- $5 billion in total Federal funding available June 1, 2010 through Dec 31, 2013 or when funding runs out
  - Plan received notice in February 2012 that funds are depleted
  - Plan has approximately $22 million in outstanding claims and is on a waiting list should additional funds become available
- State Health Plan received $86.9 million in ERRP funds
  - Federal Centers for Medicare and Medicaid Services (CMS) currently conducting an audit of the Plan eligibility and use of ERRP funds

Coverage for Dependents

- Effective July 1, 2011, the Plan extended eligibility for dependent coverage to age 26, regardless of student or marital status, or whether the dependent resides with the subscriber
  - The initial requirement provided that if the dependent or dependent spouse was eligible for health coverage under a group health policy, they were not eligible for coverage as a dependent under the State Health Plan until 2014 or when the Plan is no longer "grandfathered," whichever is sooner.

Transitional Reinsurance Program Fees

- Supplemental payments to insurers with high risk pools in individual and group markets
- Funding: Plan Sponsors will pay per member per month (PMPM) fee for their active and non-Medicare primary covered lives

Three year program with declining PMPM fee, effective 2014 calendar year (CY)

Due	Targeted Federal Assistance	PMPM *(estimated)*	Projected Cost
FY 2015	$10 billion	$5.25	$34.6 million
FY 2016	$6 billion	$3.15	$21.0 million
FY 2017	$4 billion	$2.10	$14.2 million

Patient-Centered Outcome Research Institute (PCORI) Fees

- Formerly the Comparative Effectiveness Research Fee
- Used to fund a portion of the Patient-Centered Outcome Research Institute Trust Fund
  - The research evaluates and compares health outcomes and the clinical effectiveness, risks, and benefits of medical treatments and/or services
- Increasing per member per year fee through program expiration in 2019
  - Year 1: $1 per covered life
  - Year 2: $2 per covered life
  - Year 3 + : Annual amount indexed to national health expenditures
- The Plan pays the fee for members enrolled in the 80/20, 70/30, and CDHP plans, while the Medicare Advantage carriers are responsible for the fee associated with members enrolled in one of the MAPDP offerings

Grandfathering Requirements under ACA

From a group coverage perspective, "grandfathered plans" are plans that were in existence when Health Care Reform was passed in March 2010. "Grandfathered status" exempts plans from certain ACA requirements .

- Requirements not applicable to grandfathered plans include:
  - 100% coverage of preventive medical services and prescription drugs
  - New appeals and claims requirements
  - Coverage for routine costs associated with approved clinical trials
- To maintain grandfather status, must limit benefit changes:
  - Any increase in coinsurance
  - An increase in the deductible or out-of-pocket maximum greater than 15% + medical inflation
  - An increase in a copayment equal to $5 (adjusted for medical inflation) or medical inflation + 15%, whichever is greater
  - Decrease in employer contribution by more than 5% below the contribution rate (as of 3/23/2010)

80/20 and 70/30 PPO Plans are Grandfathered

Consumer Directed Health Plan (CDHP)

- New 2014 benefit option for active employees and early retirees
- As a new option, the CDHP is not a grandfathered plan
- Provides 100% or first dollar coverage for preventive medical services and prescription drugs as required by the ACA

Note: Effective January 2014, the 80/20 PPO plan includes 100% coverage for preventive care, but the change was approved by the Board of Trustees as a benefit enhancement and is not related to the ACA.

Essential Health Benefits

- Essential Health Benefits (EHB)– The ACA requires that health plans offered in the individual and small group markets offer a comprehensive package of items and services.

- 10 categories of services comprising EHB:
  1) ambulatory patient services;
  2) emergency services;
  3) hospitalization;
  4) maternity and newborn care;
  5) mental health and substance use disorder services, including behavioral health treatment;
  6) prescription drugs;
  7) rehabilitative and habilitative services and devices;
  8) laboratory services;
  9) preventive and wellness services and chronic disease management; and
  10) pediatric services, including oral and vision care.

Essential Health Benefits

- For 2014 and 2015, USDHHS has defined EHB by reference to a "benchmark plan" that each state will select.
- The benchmark plan for North Carolina is the BCBSNC Blue Options PPO Plan. However, as a self-funded benefit plan, SHP may choose any benchmark plan to follow.
- Large employer plans, including the State Health Plan, are not required to cover EHB; however, for any EHB covered by their plan, the large employer cannot impose annual or lifetime dollar limits. Actuarially equivalent treatment or service limits may be applied.
- Board of Trustees eliminated annual dollar and lifetime limits on several EHBs, effective January 1, 2014:
  - Cranial Bands
  - Hearing Aids
  - Infertility and Sexual Dysfunction

Other Changes Due to ACA

- Waiting periods for pre-existing conditions
  - Effective July 1, 2011, eliminated the pre-existing condition exclusion for members under age 19
  - Effective January 1, 2014 eliminated the pre-existing condition exclusion for all members

- Retroactive dis-enrollments
  - Members cannot be retroactively dis-enrolled from the Plan except in cases of intentional misrepresentation or fraud

Future Considerations and Potential Impacts

Newly Eligible Employees:

- ACA requires large employers to offer coverage to employees who work *30 hours* or more, or pay a penalty
  - Costs will increase for employing units (State agencies, universities, school systems, colleges, etc.) that use non-permanent employees working 30+ hours/week
  - This may increase Plan membership but will not directly impact net Plan finances, as a monthly premium will be received for each newly eligible enrolled
  - Federal government is not applying the penalty in 2014 and recently adjusted the penalty provisions for 2015 to reduce the impact on employers

- The State Health Plan is working with the Office of State Human Resources, the University and Community College systems and the Department of Public Instruction to develop a potential benefit option for the newly eligible employees

Future Considerations and Potential Impacts

- Individual Mandate
  - Will previously uninsured dependents join the Plan?
- Health Insurance Exchanges/Marketplaces
  - State Health Plan dependents are not eligible for exchange subsidies
    - Will exchange prices for individual coverage drive more dependents into the Plan?

      OR
    - Will the accessibility of other health insurance options result in fewer dependents on the Plan?
- Reduced Funding for Medicare Advantage Plans
  - Future federal subsidies for Medicare Advantage providers may be constrained by ACA
  - This may result in a more rapid increase in premium costs for the Plan's Medicare Advantage products

Future Considerations and Potential Impacts

- Loss of Grandfather Status
  - Adding 100% preventive care to the Traditional 70/30 Plan would cost an estimated $20-25 million annually
  - Enhanced 80/20 Plan would be prohibited from eliminating 100% preventive care; current budget assumes $24-30 million annually for 80/20 members
  - Cost associated with coverage for clinical trials is unknown
- 40% Excise Tax on “High Cost” Plans begins in 2018
  - Plan is currently under the projected 2018 “high cost” threshold of $10,200 annually for individual coverage or $27,500 annually for family coverage
  - The threshold will increase with the Consumer Price Index-All Urban Consumers (CPI-U), but medical inflation usually exceeds growth in CPI-U

Summary and Conclusions

- ACA has required the Plan to make changes and to monitor federal regulations more closely; *however*
  - Changes have been manageable to date, and
  - Have not prevented the Plan from implementing the Board's vision
- ACA has and will increase Plan costs; *however*
  - The increase does not account for a significant proportion of Plan costs
- As a large self-insured plan that already provided comprehensive benefits to members, the impact of ACA on the Plan has been relatively minor; *however*
  - The law will continue to affect the healthcare landscape well into the future, and many of the long-term effects are unknown
- ACA is likely to continue to have an impact on the Plan and the State:
  - *The cost of compliance for state and local employing units whose work forces include large numbers of newly eligible employees may be significant*
  - Future effects are difficult to predict

Appendix

- Statutory Authority, Governance & Oversight
- Board of Trustees
- Legislative Directives
- 2014 Plan Options

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www.shpnc.org

www.nctreasurer.com

Statutory Authority, Governance & Oversight

- Statutory authority set out in Article 3B of Chapter 135, N.C.G.S.
- Effective January 1, 2012, the Plan became a division of the Department of the State Treasurer
    - Historically the Plan reported directly to the General Assembly via a legislative oversight committee
- Executive Administrator is appointed by the Treasurer to oversee the day to day operations of the Plan
- State Treasurer has broad authority to administer the Plan and may delegate powers and duties to the Executive Administrator, Board of Trustees or Plan staff, but ultimately maintains responsibility for the performance of those powers and duties and the Plan

State Health Plan Board of Trustees

Fiduciary board with statutory duty to:

1. Approve benefit programs, as provided in G.S. 135-48.30(2)
2. Approve premium rates, co-pays, deductibles and coinsurance maximums, as provided in G.S. 135-48.30(2)
3. Oversee administrative reviews and appeals, as provided in G.S. 135-48.24
4. Approve contracts in excess of $500,000, as provided in G.S. 135-48.33(a)
5. Consult with and advise the State Treasurer
6. Develop and maintain a strategic plan

10 Members, 2 Ex Officio and 8 Appointed

- State Treasurer (votes only in the event of a tie)
- Director of the Office of State Budget and Management (non-voting)
- Governor, State Treasurer, House of Representatives and Senate each appoint 2 members
  - Active employee and teacher, retired employee and teacher
  - Experts in actuarial science, health economics, benefits and administration, and policy and law

Legislative Directives & Guidance

SB 323 [State Health Plan Changes SL 2011-96] and HB 578 [State Health Plan Changes SL 2011-96] set out certain requirements and authority for the Plan:

- ❑ Examine the issue, costs and mechanics of moving to a **calendar year**
- ❑ **Find savings** through wellness programs, Medicare Advantage plans, alternative plan designs, or other resources
- ❑ Any savings and available cash reserves may be used to **offer a premium-free plan** option to employees for FYs 2012 & 2013. Premium free option required no later than July 1, 2013
- ❑ Strive to **keep all premiums low** by finding savings through wellness programs, Medicare Advantage plans, alternative plan designs, or other resources

- ✓ Conversion will begin July 1, 2013; operate on **Calendar Year basis in 2014**
- ✓ Board approved benefit design includes wellness programs & incentives, Medicare Advantage options, and a new Consumer Directed Health Plan **expected to save in excess of $400 million over the next four years**
- ✓ **Basic 70/30 PPO option** offered to active employees on premium free basis since June 1, 2011 and will continue to be available through calendar year 2015
- ✓ Board approved benefit design will **lower the average annual premium increases** for employees & retirees and the State over the next four years

Health Plan Options for 2014

Active Employees/Non-Medicare Retirees

Enhanced 80/20 Plan	NEW: Consumer-Directed Health Plan (CDHP) with HRA	Traditional 70/30 Plan
• $0 ACA Preventive Services • $0 ACA Preventive Medications • Offer reduction in employee-only premium for the completion of specific wellness activities: ✓ Attest to being a non-smoker or to participating in a smoking cessation program ✓ Select a primary care provider (PCP) ✓ Complete a health assessment • Opportunities to reduce medical copayments	• A high-deductible medical plan • A Health Reimbursement Account (HRA) to help offset the deductible • $0 ACA Preventive Services • $0 ACA Preventive Medications • CDHP Preventive Medication List ($0 deductible) • Offer reduction in employee-only premium for the completion of specific wellness activities: ✓ Attest to being a non-smoker or to participating in a smoking cessation program ✓ Select a primary care provider (PCP) ✓ Complete a health assessment • Opportunities to increase HRA	• Basic 70/30 Plan with a new name • No $0 ACA Preventive Services • No $0 ACA Preventive Medications • No wellness incentives available

Health Plan Options for 2014

Medicare Primary Retirees

Medicare Advantage Base

- Offered by Two Carriers:
  1. Humana
  2. UnitedHealthcare
- Benefits are the same for each carrier
- Fully insured medical plan with integrated pharmacy
- Enhanced Benefits:
  - No deductibles
  - Wellness programs & disease and case management services
  - SilverSneakers®

Medicare Advantage Enhanced

- Offered by Two Carriers:
  1. Humana
  2. UnitedHealthcare
- Benefits vary by carrier
- Fully insured medical plan with integrated pharmacy
- Enhanced Benefits:
  - No deductibles
  - Wellness programs & disease and case management services
  - SilverSneakers®

Traditional 70/30 Plan

- Basic 70/30 Plan with a new name